

# PRIMARY CARE NETWORK



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## Call for PCG clinical governance leads to play big role in revalidation

**PCG clinical governance leads could play a big part in implementing the process of revalidation for all GPs once a system has been agreed, a major conference in London was told.**

'There's an enormous amount of expertise out there - let's use it,' said Dr Graham Archard, clinical governance lead for the NHS Alliance.

He told the conference that PCG clinical governance leads were a huge resource, were already in place and could help to implement the system in a non-threatening way.

They had a knowledge of local performance, trends and improvements. 'They have established a local rapport with practices and built up trust, and they are skilled in carrying out a multi-professional assessment of clinical care as local performance relies on all the disciplines,' he said.

'GPs' performance can be affected by the team performance and this should be taken into account. In addition, clinical governance leads have established good relationships with the educators in their areas, which is important. We need to ensure that clinical governance is given proper protected time and a proper career structure. There needs to be dedicated funds for it and reimbursement for GPs who go part-time,' he said.

Draft proposals for revalidation drawn up by the Royal College of General Practitioners and the BMA's General Practitioners Committee were launched at the conference, *Revalidation in General Practice - The Way Forward*, organised jointly by the two bodies.

General Medical Council president Sir Donald Irvine told the conference that a system of revalidation should bring a more systematic approach to spotting bad practice. For most doctors it would be a question of documenting their current educational status, including any postgraduate education activities, any clinical assistant work and any tutoring responsibilities.

In reply to a question by Dr Terry John, a PCG clinical governance lead in east London, Dr Irvine said it would be employers' responsibility to ensure that doctors had time to devote to any preparation for revalidation.

There have been reports that GMC fees may have to increase by up to £500 to cover the costs of the system. But Dr Irvine said: 'Employers should bear some of the cost of revalidation, and as GPs are independent contractors, this means the NHS and GPs themselves.'

On meeting standards, he said some health

authorities had already taken steps to encourage improvements. Northumberland, his own HA, had made funds available for practices to take part in schemes such as the *Investors in People* and other quality assessment schemes. He suggested this could be taken up by other HAs around the country.



Dr Graham Archard

GPC chairman Dr John Chisholm said there needed to be a link between an annual appraisal of GPs, which has been proposed, and revalidation, which is expected to be either on a three-yearly or five-yearly basis. Appraisals should be a tool for the personal development and awareness of the GP him or herself.

'Revalidation will include local profiling of performance, periodic external peer review and evidence to enable reappraisal of a doctor's entry in the register,' said Dr Chisholm.

'The purpose will be to enhance public trust in doctors and demonstrate that the vast majority are fit to practise. It should also give those who are not revalidated a chance to put things right.'

Dr Chisholm said that for the first time there was 'a promise of substantive resources' for revalidation in the NHS Plan and this was linked to a mandatory reporting scheme and database of

Continued on page 3

## EDITORIAL COMMENT

The RCGP and BMA's conference on revalidation was important and useful in bringing all the stakeholders together. Much still needs to be done before the system is in place by the National Plan's 2001 deadline, and many PCGs/PCTs will no doubt heed Dr Graham Archard's call for clinical governance leads to play a big part in implementing the process. Hopefully, they will also listen to Patricia Wilkie, lay chair of the RCGP liaison group, who says that 'lay members need to be involved in the national and local revalidation groups...'. However, her concerns that lay members will not be treated as colleagues in these groups reflects the experiences of the PCG lay board member who has had an 'uphill struggle getting my PCG to take my views seriously.' See back page, *From the Grassroots*, 'Why won't they listen?'

To ensure PCN provides more coverage about the activities and concerns of lay members, from next month we welcome aboard Dr Nicholas Reeves, chair of the National Association of Lay People in Primary Care, whom we have recruited as an editorial adviser.

Lay members can and are making positive contributions to many primary care organisations, but it appears some boards aren't yet giving them a proper chance.

Jenny Sims, Editor

NEWS IN BRIEF

**Extended powers for commissioning groups**

The powers of Regional Specialised Commissioning Groups (RSCGs) for specialised services are to be extended to allow PCGs and PCTs to have an input. New directions are likely to be published this month aimed at enabling the groups to function more effectively, said Health Services Director Dr Sheila Adam. They will direct health authorities to carry out decisions made by RSCGs and set out the role of PCGs/PCTs in commissioning special services.

**Clarion call**

InnovationsNetwork, run by the charity Primary Care Mental Health Education (PrimHE), has been relaunched as Clarion to allow patients and carers as well as health professionals to discuss mental healthcare issues.

Clarion is at [www.primhe.org/clarion](http://www.primhe.org/clarion)

**Guidelines website**

Medendum Group Publishing has launched a new website, *eGuidelines* which allows free access to material published in *Guidelines* and *Guidelines in Practice*. Useful for healthcare professionals engaged in delivering clinical governance. The website is [www.eguidelines.co.uk](http://www.eguidelines.co.uk) The partner site for patients is [www.healthnetUK.com](http://www.healthnetUK.com)

**Arts in health**

The National Network for the Arts in Health interactive website has been redesigned to meet growing demands. It now has a public and members only section at [www.nnah.org.uk](http://www.nnah.org.uk)

**NICE on Ritalin**

NICE's new guidance on Ritalin (methylphenidate) which is currently prescribed to children suffering from ADHD (attention deficit/hyperactivity disorder), says the drug should be prescribed after a full assessment by an expert in the field. There are thought to be about 45,000 children aged six to 16 in England with ADHD not currently receiving the drug. Full guidance on [www.nice.org.uk](http://www.nice.org.uk)

**Age discrimination and social care**

Discrimination on the basis of age happens in many areas of health and social care, according to King's Fund researchers. The briefing paper, *Age Discrimination and Social Care*, says many GPs are reluctant to provide annual health checks for people over 75, missing a valuable opportunity to identify potential health problems and to give advice on healthy living. Available at [www.kingsfund.org.uk](http://www.kingsfund.org.uk)

# Using telemedicine to improve Coronary Heart Disease services

**'Call to Needle Time' targets in the National Service Framework (NSF) for coronary heart disease will only be achieved with the use of telemedicine to transmit ECGs from the home or ambulance to the acute hospital. This is a major conclusion of a study by the Institute of Healthcare Management's Telemedicine and Telecare Programme into the potential for using telemedicine to improve coronary heart disease services.**



Ian Jardine

The study was undertaken in the Hillingdon PCT area and involved GPs, community and hospital nurses, cardiologists from Hillingdon and Harefield hospitals, and local managers. It was sponsored by Merck Sharp & Dohme.

Other key finding were:

- Telemedicine has the potential to enable better care for chronically disabled coronary patients and those needing rehabilitation.
- There needs to be a much better sharing of information about individual patients between GPs and hospital doctors and nurses working in all settings.

The NSF for CHD recognises the critical importance of giving patients with heart attacks thrombolytic and analgesic drugs as soon as possible. It lays down a target of 60 minutes from the time the patients calls for help to the administration of the drug. To achieve this with the present arrangements is extremely difficult. For the ambulance service to respond to a call, make an initial assessment of the patient, carry them to the ambulance and get them to the A&E department can take 30 minutes or more. The hospital then has to triage the patient and carry out ECG tests to confirm diagnosis and then prescribe and administer the drugs. Although this can be done within 30 minutes the timing is tight and does not allow for any contingencies. If the patient is a long way from hospital or there is heavy congestion it becomes impossible.

Telemedicine can overcome some of these problems. The paramedics can take the ECG and transmit this with a brief history to the hospital for diagnosis. Arrangements can then be made for the patient to be treated immediately on arrival at the hospital with them being admitted directly to the coronary care unit or even by the paramedic en route. Doing this will reduce deaths, long term disability and the length of hospital stays.

Telemedicine can also do a great deal to help patients in their own homes.

- A range of physiological signs can be monitored remotely yielding higher quality data than is obtainable in hospital.
- Using the home television and a cheap small video camera, district or specialist cardiac nurses can 'visit' patients much more frequently than is normally practical.
- Physiotherapists can use the same equipment to ensure patients ongoing compliance with rehabilitation programmes.

These will tend to focus care and treatment in the community and increase patients' involvement in managing their own health

Redesigning the way care is provided using these techniques will reduce admissions and allow patients back home earlier as well as providing a better service to them and their relatives. It could even prove to be a better and a cheaper way of doing it.

But the potential of using these new technologies should not divert attention from the basics of good care. Agreeing the information to be exchanged between the GP and cardiologist on referral and discharge would do a lot to improve present arrangements even before the appearance of the comprehensive Electronic Health Record.

**Ian Jardine** IHM Telemedicine and Telecare Programme Team

\* Copies of the report from Pat King on 01992 452183  
E-copies of the report & further information on telemedicine from: [Ian.Jardine@TelemedicineAlliance.co.uk](mailto:Ian.Jardine@TelemedicineAlliance.co.uk)

## BMA calls on government to retain CHCs

**The abolition of Community Health Councils (CHCs), set out in the NHS Plan, would threaten patient advocacy says the British Medical Association which has called on the government to retain them.**

BMA chairman Dr Ian Bogle has written to Health Secretary Alan Milburn expressing the BMA's concerns. Patients should be independently represented and any new structures set up to look after their interests should have statutory powers, he said.

The NHS Plan sets out new arrangements for patient involvement in decision making (see PCN Issue 24, page 4). But Dr Bogle argued:

'The new arrangement must be independent of NHS structure and carry with them the statutory powers to preserve advocacy, scrutiny and inspection. It is vital that they strengthen, not weaken, the roles currently held locally.'

He added: 'Many doctors work very closely with the local patient representative groups and have benefited from their collaboration. CHCs must not be abolished until all the new systems replacing them are established and there is a national structure to oversee them.'

Donna Covey, director of the Association of Community Health Councils for England and Wales said: 'We are delighted the BMA has taken such a strong position on patients rights.'

# Lessons Learned: Improving next year's HImP

Reports from two of our HImP & HIP Awards of Excellence 2000 winners

## Central Southampton PCT (formerly PCG)

(Joint first in the Special Primary Care Strategy Award)

### Package priorities

The HImP should set the strategic direction of the organisation. Tensions often arise as NHS resources are released in a 'tagged' way and the strategic groups at Health Authority level make decisions about relative priorities and commit resources to providers with little/minimal PCG/T involvement.



Fiona Richardson

One of the key lessons to learn early on is how to package priorities in different ways so that maximum flexibility exists when it comes to matching to tagged resources. For example, we wished to develop a liaison psychiatry service; sources of funding were:

- mental health modernisation fund
- winter pressures fund
- unallocated growth.

We eventually sourced the service from the winter pressures fund and used the mental health modernisation fund for enhancing the community mental health team and the unallocated growth for a community rehabilitation service.

In moving forward PCGs need to work much more closely with Community Trusts if there is to be a shift in investments to prevent ill health. Currently, when sitting at the Service and Financial Framework (SFF) table, we are to a degree, competing. The bidding mentality is still very much alive and at times one wonders if the HImP is setting the strategic direction truly.

As PCTs emerge there will be fewer 'bidders' at the table allowing a stronger link between HImPs and resources to be established. Also the new organisations will have developed HImPs reflecting individual perspectives. Priorities that have been on the shelf for a number of years will be internally debated and their relative importance agreed prior to SFF debates. Currently although there is joint development of the HImP, Trusts tend to use the SFF to debate their priorities, which may not be prioritised highly by PCGs. Basic 'core services have historically failed to attain a high priority against something new. For example, we had a projected 17% growth in 0 - 4 year olds over five years (the first 6% happened last year), our health visiting service workload was already twice that of some areas in the Health Authority. We have been able to invest £90,000 in the service. Prior to establishment of the PCG, health visiting services were in fact identified as an area that should be reviewed for disinvestment (similarly maternity services).

The future is becoming increasingly complex as PCG/Ts need to work much more closely with Local Authorities. New Deal for communities, Surestart, inner-city regeneration all have much longer planning and delivery timescales than HImPs but in order to work effectively partnerships and commitments need to be made now. The annual cycle of SFF makes it difficult to work effectively with Local Authorities. The NHS Plan indicates that this will change and being able to work to a much longer timescale in developing joint services will allow more mature relationships to develop that can tackle the social cohesion agenda.

In conclusion to maintain commitment and enthusiasm it is important to be able to show progress year on year in local and national priorities.

**Fiona Richardson,**  
Chief Executive, Central Southampton PCT

## North & East Devon Health Authority

(Joint first in the English HA Outside a Health Action Zone category)

### Valuing process

Local Agencies set themselves two central challenges in our present HImP.

- 1) All strategies for Health Improvement and Service Modernisation to derive from one, coherent, locally relevant, people focused HImP
- 2) Every statement in the HImP to be the product of a standing group which had the right people, from the right organisations to take the most informed decisions possible, at the right time.

Local Government's response was particularly welcome, setting up local Community Planning Fora with PCGs to address determinants of health.

Our major lesson was that concentrating on processes is the key to engagement, commitment and the quality of decisions. Assuring even better processes will remain central to how we use the HImP to deliver the NHS Plan in North & East Devon next year.

**John Bewick,**  
Director of Health Improvement,  
North & East Devon Health Authority



John Bewick

## Continued from Page 1

adverse healthcare events which the government wanted to have in place by 2001.

Local revalidation groups would also have a role in collating assessments of GPs and letting doctors know how they compared to others in their area. These needed to include service GPs, academic GPs and lay members.

RCGP chair Professor Mike Pringle said that proposals had already been put forward for revalidation in Scotland, Wales and Northern Ireland by government bodies and they had got them 'broadly right.' But there was still uncertainty about the proposals for England which had not yet been finalised.

He said the system should have several elements:

- evidence of communication skills – a

variety of methods could be used including questionnaires to 50 consecutive consulting patients;

- evidence of a practice complaints procedure;
- review of basic clinical equipment;
- review of medical records to ensure legibility and clarity;
- review of teamworking;
- review of practice resources – PCGs and PCTs should be able to submit a report comparing practices in their area.

Dr Krishna Korlipara, chair of the GMC's GP consultation group on revalidation, said that so far it had received 720 responses, including 257 from medical organisations. The next steps would be piloting a scheme in several areas, an evaluation of costs and benefits and an economic evaluation which would be carried out by London's City University.

Patricia Wilkie, lay chair of the RCGP patient liaison group, said that lay members would need to have an involvement in defining the criteria which underpinned revalidation.

'We need to be involved in the national and local revalidation groups and to have an opportunity to influence the way in which GPs are assessed. Obviously, we would like to see a great emphasis on things such as communication skills,' she said.

But she also expressed some concern about the 'clubbiness' of doctors in the local revalidation groups. 'There is an informal network among doctors and I am concerned about whether lay people will be treated as colleagues in these groups,' she said.

She added that she did not come away from the conference a 'happy woman' due to the limited nature of patient consultation so far.

**Paul Dinsdale**

## PCG Boards overworked and underpaid

PCG chairs and Board members are highly committed but their remuneration does not reflect their hours worked, according to a BMA survey of 277 out of a possible 481 PCGs.

The survey, carried out six months after the launch of PCGs aimed to provide a snapshot of progress, the resulting 16-page report says: 'Payments to chairmen were found to range between £5,000 and £22,000.... While remuneration reflected central guidance, the time commitment of PCG Board members was found to exceed Health Department expectations.'

It points out variations in payments to chairmen are likely to be due to local factors and activities such as the level of PCG and the size of the population served, and that NHS Executive guidance suggests reimbursements are to cover an estimated weekly commitment of one to two days.

However, it says: On average, irrespective of PCG level, 53% of the chairmen were committing at least two days a week to PCG work (ie to 16 hours); 17% of chairmen committed hours in excess of these figures.'

Payments to board members ranged from £1,000 to £7,000 but generally were within recommended reimbursement levels. But, 'locum fees for board members were often reported to be below recommended levels.'

Time commitment for board members was about 2 to 2.5 days a month but the maximum time reported was 24 hours a week.

A follow-up survey of PCGs/PCTs was launched last month. The report is available at [www.bma.org.uk](http://www.bma.org.uk)

Lynn Young, RCN community health adviser, said: 'PCG Board nurses have experienced phenomenal demands and a number have resigned as a result of conflicts between work and PCG pressures. While nurses did not develop an interest in PCG activities for financial reasons, there is no doubt that a more realistic financial reward would be welcome.'

And she warned: 'PCTs cannot be successful organisations without the full commitment of able nurses.'



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## FROM THE GRASSROOTS

### A lay member asks: 'Why won't they listen?'

*This is the launch of a new regular slot offering space to any Board member to air a grievance, offer an opinion or seek advice. If requested, names will not be published.*

Many nurse Board members complain their appointments are but 'a token gesture,' that they have no power and their views are ignored. In my experience, this is doubly true for lay board members.

Personally, I have had an uphill struggle getting my PCG to take my views and suggestions seriously and have been made to feel they are unimportant and valueless, regardless of my lifetime's skills and experience.

For example, as a result of being told repeatedly by the government we must get

patients' views and involve them in the decision-making process, I tried to encourage the setting up of practice-based patient participation groups. I contacted all the GP practices in the PCG to stimulate interest. The result was that I was reminded that nowhere in the GPs' contract was there any requirement to establish such groups!

These same GPs spent most of the meetings in the PCG's first year whinging about money - but only as far as it affected them. They do not appear to be interested either in patient involvement or improving communication. I have suggested displaying information about the PCG on practice notice boards, but this has been rejected because they said no-one would read it!

I don't want confrontation, but I feel frustrated and defensive. How do other lay members get their voices heard and heeded?

Will the lay members of Trust Boards be any more successful, or will the real power stay with the Executive Committee?

*\*Replies please to the editor.*

## PCG TIPS: Books and reports

### ***A Practical Guide to Primary Care Groups and Trusts***

**Edited by Michael Dixon & Kieran Sweeney**

This book describes the work of PCGs in their first months and describes everything from the initial aims of PCGs through to PCTs and the future. The contributors, practised members of PCGs, describe their experiences and the lessons they have learnt. The book explores how organisations will evolve and provides guidance on theory, people and functions. Essential reading for members of PCG teams and those with, or aspiring to, PCT status.

**Published by Radcliffe Medical Press £22.50  
ISBN 1-85775-491-3**

### ***Nurses and Nursing: Influencing Policy***

**Edited by Pippa Gough and Nicola Walsh**

Chris Ham's foreword says: 'This book explores the ways in which nurses can be more involved in shaping the development of health policy. It looks at the dynamic between policy formulation and policy implementation, and the nurses' role within this.'

...The contributors identify what knowledge and skills are needed by nurses if their day-to-day experiences are to be used and translated into the central policy-making process. All offer sound and timely analysis as well as practical ideas on how the nursing voice can be communicated into policy-making arenas at national and local level. It will be useful not only to nurses but also to other professionals working in the NHS.'

**Published by Radcliffe Medical Press £17.95  
ISBN 1-85775-353-4 Tel: 01235 528820**

### ***Health Action Zones - The Engagement of the Voluntary and Community Sector***

**By Julia Unwin and Peter Westland**

This short report provides insights into the issues which central and local government, the voluntary and community and funders sector need to address to ensure that the engagement is effective.

**Available free from The Baring Foundation on  
020 7767 1348**

### ***The NHS Alliance guide to setting up a primary care trust***

Michael Dixon writes in the foreword: 'This document should be an essential resource for all PCGs becoming PCTs in their various stages of development. It summarises all current DoH guidance on primary care trusts in an easily readable form, which avoids some of the necessary repetition of current official guidance.'

**Edited by Peter Merry**

**JMH Publishing. The 65-page booklet is available free to members £10 to non members from the NHS Alliance on 01777 869080**

### ***Using Standing Orders and Standing Financial Instructions. A Guide for Primary Care Groups*** **Produced by County Durham Health Authority**

This useful short guide includes frequently asked questions and answers. It is intended to help the boards and staff of Primary Care Groups understand when they might need to refer to Standing Orders, Standing Financial Instructions and other aspects of the regulatory framework when acting on behalf of the PCG. The guide is not exhaustive, and boards and staff of PCGs will need to consult the official documents. References are given following each question and answer.

**Available from the NHS Alliance at  
[www.nhsalliance.org](http://www.nhsalliance.org)**

### ***Rehabilitation and intermediate care for older people***

**King's Fund Briefing October 2000**

This four page document is part of the King's Fund's three-year programme to raise awareness about rehabilitation and provide guidance about good practice. It defines rehabilitation, explains why it is important, describes services and suggests that with the care of older people now a political priority, 'there has never been a better opportunity to develop the right kind of support.'

**For more information call 020 7307 2400, fax 020 7307 2801 or [www.kingsfund.org.uk/rehab](http://www.kingsfund.org.uk/rehab)**