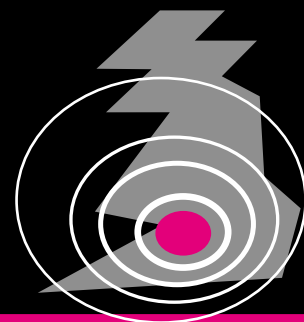


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JANUARY 2001
ISSUE 28

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Services for older people move up the health agenda

Older people are rocketing up the government's pre-election agenda as they seek to implement the National Plan. The Queen's Speech not only announced £1bn for new GP premises, but promised, via the new Health and Social Care Bill, that if local health and social services aren't working well together, a new Care Trust will take over. And nursing in nursing homes will be paid for.

The National Service Framework (NSF) for older people was due to be published soon after we went to press, but the DOH started the NSF process 18 months ago with one internal, one external reference group, and seven groups that met to deal with specific issues.

The Older People's Task Force was chaired by Professor Ian Philp, of the Northern General Hospital in Sheffield, who was made 'National Director for Older People's Services' in November.

A member of the Older People's Task Force throughout, and the geriatrician on the brand new one set up to implement their part of the Plan, is Dr David Black, Medical Director of Queen Mary's, Sidcup, chairman of the joint Royal College of Physicians/British Geriatrics Society committee.

'The task force is looking at policy as it's written and helping advise civil servants on whether it makes sense, and if it's going to work in practice,' said Dr Black.

The Plan not only referred to the up-coming NSF, but to intermediate care, Care Trusts, Care Direct, (evolving from NHS Direct), and funding arrangements for residential and nursing homes.

But what does he, as representative geriatrician amongst the social workers, GPs, Trust and lay members on the task force, hope comes out of the final NSF?

'There are four key areas. Firstly, we would like to see excellence in stroke service, and those services available to all patients wherever they are around the country,' (currently only 50% have one, despite clear, evidence based models of care). Secondly, 'There has been a lot of evidence over the last two years about how we should be managing falls in this country, and we'd like to see

proper falls services and people having access, however they present, to quality services that can manage falls and help prevent them in the future. Thirdly, we're fully supportive of the concept of intermediate care, particularly where it is step-down care, and allowing rehabilitation and re-enablement of people before they go home or make final life choices about their environment. And, from a geriatrician point of view, there is a lot of evidence that if you have specialist in-pat to comprehensive geriatric assessment you get better outcomes. So we'd like to see good partnerships between primary and secondary care; there shouldn't be just one or the other.'

Health Authorities may have the resources, but will they agree to fund quality services? There are only 850 consultant geriatricians in the country. The RCP argues for 1100 now, to increase to 1350 over five years, and doctors are keen, but no NSF so far has stipulated consultant numbers. And will the beds be there for intermediate care?

Continued on page 3

EDITORIAL COMMENT

The National Service Framework for Older People was expected to be published 'soon' said the Department of Health as we went to press, and unless there are delays, we hope to report on it in the next issue. Meanwhile, we have talked to a range of professionals concerned with services for older people, including a Task Force member, who all agree improvements are long overdue.

We bring you news of the NHS Leadership Programme focusing on the relationships between PCT board chairs, executive chairs and chief executives. And we draw your attention to two topics which have not been in the limelight, but which PCGs and PCTs need to be aware of and involved in.

These are the Workforce Development Confederations (see page two) and local government scrutiny of NHS organisations (back page).

A number of lay board members have contacted PCN to thank us for our November lead story on the role of lay members in PCTs and ask if we would continue to foster debate on the subject. In response, we publish a letter in From the Grassroots (back page). Letters of reply will be welcomed. Finally, we would like to thank editorial adviser Judy Wilson for all her hard work as she is leaving because of other commitments, and welcome her successor Nick Reeves.

Jenny Sims, Editor

NEWS IN BRIEF

Dial 0845 4647

Not as catchy as 999, but Health Secretary Alan Milburn wants the NHS Direct number to become as well known as the number for the emergency services. The nurse-led 24-hour telephone advice line now covers the whole of England and has received more than 3.5 million calls since it was launched in March 1998. Future developments for the service include further integration of out of hours care, handling category C ambulance calls and working with GPs to pilot NHS Direct centres assessing 'in-hours' calls. It expects to take between 15-20 million calls per year.

Missed opportunity

The government's pledge to reduce hospital waiting times is good news for patients but it may be achieved at the expense of greater fairness in the NHS, according to a King's Fund report published in December. Writing in *Health Care UK Winter 2000*, Anthony Harrison argues that the NHS has no reliable system of ensuring that waiting times for hospital care are set according to people's needs. The NHS Plan, he says, has missed an opportunity to address this failure. Available from the King's Fund bookshop on 020 7307 2591, price £9.99.

Boost lay membership

In response to the General Medical Council's consultation on its future, the BMA welcomed its commitment to radical change and plans to separate the GMC's judicial and investigatory functions, and to boost lay membership. However, Dr Ian Bogle, chair of BMA council, said: 'We do not think the current proposals for a small Executive Board give the right degree of accountability, but we will keep up the dialogue and I am sure we will find a workable solution.'

PMS pilots

New models of primary care are being introduced along with a more strategic approach to planning and collaborative working, according to an evaluation of 27 first wave pilots carried out by the National Primary Care Research and Development Centre.

The 16 page report is available at www.npcrdc.man.ac.uk

LEADERSHIP

Three at the top: How is it working?

As part of its programme for support for PCT chief executives and chairs, The NHS Leadership Programme is sponsoring a research and development project being carried out jointly by the Health Services Management Centre at the University of Birmingham and LSE Health and Social Care at the London School of Economics. Called Three at the Top the project is focusing on the working relationships between board chairs, executive chairs and chief executives.

Over the last six months the LSE researchers have made two sets of visits to each of the 17 first wave PCTs and collected a rich set of information on the career backgrounds of chairs and chief executives, their appointment processes, how they are defining their roles and responsibilities and early evidence on their joint working arrangements. This information is being drawn upon in a series of development workshops being led by the Birmingham team.

A distinctive feature of first wave PCTs is the existence of a cadre of young (often female) chief executives. Their mean age is just over 41 years, with five female chief executives of 42 years or less.

For the most part, the three-way relationship appears to be working well, with a clear understanding of respective roles and

responsibilities. Before the first wave PCTs came into existence, there was a widespread view that the relationship would be prone to divisions and breakdowns. Early research does not suggest this is happening.

On the other hand, there are some concerns. Appointments of non-executive members were seriously delayed in many cases. This proved to be a real obstacle to boards' ability to develop their business. There are also many instances of executive chairs finding their roles changed from the time when they often chaired the PCG. This requires quite significant adjustments. Effective joint working between the Executive Committee and the Board still remains to be established in many places, as does ambiguity over responsibility for the development of strategy.

Clearly the Three at the Top are still in the early stages of their joint working and much remains to be done. Our research and development project aims to track progress and feedback information for the use of first and subsequent wave PCTs.

For more information about this work contact Professor Ray Robinson at the London School of Economics
Tel:0207 955 6233 or e-mail r.robinson1@lse.ac.uk



Professor Ray Robinson

**Workforce Development Confederations:
Are you playing an active part?**

PCGs and PCTs have increasing and demanding agendas. It would not be surprising if the establishment of the new Workforce Development Confederations has passed them by.

However, it is vital that PCGs and PCTs play an active part in these new organisations. The boundaries are to be announced soon and the Confederations will take over their duties on 1 April 2002.

NHS Human Resources Director, Hugh Taylor's letter of 16 October makes it clear the Confederations will have a wide range of responsibilities for workforce planning, undergraduate and postgraduate education and a focus for human resource strategies where these are appropriate at an above employer level.

What is new is that Confederations will be responsible for all staff groups - medical and non-medical. There will be close working with Postgraduate Deans and medical schools. The Medical and Dental Education Levy (MADEL) will be within the Confederations budget as well as the facilities and clinical placement elements of the Service Increment For Teaching (SIFT) and the Non-Medical Education and Training levy (NMET). Very substantial resources are involved. The budget of a large Confederation may be more than £100million. Co-ordination of the

strategic management of local education centres, libraries and skills laboratories will also be within their remit. The new Confederations are likely to be bigger than many of the existing Consortia and this may raise problems for PCGs and PCTs.

The NHS Plan requires a huge expansion in education and training. Confederations will be held responsible for delivering this vital pre-condition of improved services.

Workforce planning and education and training are vital areas for PCGs and PCTs. It is vital that they check who is representing them on the existing Consortia. How well does this work? Is the voice of primary care heard effectively? Are PCGs/PCTs involved in the discussions on the boundaries of the new Confederations? Are they thinking about who their representatives will be when the Confederations are established?

It is not easy for PCGs and PCTs to cover every subject area in the crowded agenda of the post NHS Plan. However, this issue is too important to be forgotten.

Ken Jarrold CBE

Chief Executive, County Durham & Darlington Health Authority
Chairman, Durham & Teeside Education & Training Consortium

Dr Rodger Thornham

Chairman, North Tees PCG
Representative Durham & Teeside Education & Training Consortium

Managing change and risk

By Robert Sloane

Acting Chief Executive Bournemouth Primary Care Trust



District Audit have been centrally and successfully involved in the organisational development of the 'second wave' Bournemouth Primary Care Trust which was established on 1 October 2000.

The decision to involve District Audit was taken by the Project Team constituted by Dorset Health Authority to implement the new organisation.

Key figures on the project team were the chairmen and general managers of the two Bournemouth PCGs who acted as 'sponsors' of the Level 4 Primary Care Trust. They were clear about the benefits to patients that the integrated providing and commissioning mechanism could bring. They were equally aware of the full and onerous weight of the corporate and clinical governance mantle which the fledgling organisation would become responsible for within a wider accountability framework.

They also realised that to be successful in the New NHS the leaders of PCTs would need to be adventurous in working across organisational boundaries in uncharted yet accountable territories. But the freedom to operate in this environment and take calculated risks would itself depend on meeting all of the mandatory internal control standards as a matter of course.

The purpose in involving District Audit was therefore intended to assist the change management process and create an awareness of risk in order to devise proactive handling strategies.

This approach seemed to chime well with the new emphasis from District Audit which entails a greater sensitivity to client need, particularly

around bespoke VFM work and a move towards organisational audit and 'whole system' working.

In practical terms District Audit involvement via a Senior Specialist has been a key facilitating influence in the Bournemouth Primary Care Trust Implementation Programme. Dedicated time in the form of Development Days has enabled both sponsoring Primary Care Groups to examine a number of key governance issues in depth. This has been as much about external navigation in a multi-agency environment as it has been about developing internal systems and processes on which earned autonomy will depend.

For the Bournemouth Primary Care Trust involving District Audit has brought rigour, independence and an intrinsic understanding of risk to the organisational development process. The costs of expensive management consultancy have been avoided and the outputs captured within a national reference framework.

A further benefit has been the extent to which District Audit, knowledgeable about Local Authority systems and processes has helped to think about the accountability framework which will govern new forms of partnership working.

For District Audit the benefits would be seen as: gaining a working knowledge of the hybrid Primary Care Trust organisations and the complex environment in which they will operate. As a result of this exercise their consultancy credibility from a client perspective has been heightened without detriment to their regulatory independence.

For third and successive wave Primary Care Trusts District Audit will be able to draw on their work in Bournemouth (and other places) to help inform a national reference framework.

Dr Dearden added: 'At the moment, almost 95% of the money goes into secondary care, but primary care is being asked to innovate. In Wales we got £120m, £20m of which went on computers, and the rest went straight to Health Authorities, then to Trusts, and the Local Health Groups have not seen one penny of it. How can we innovate? The Trusts won't buy extra health visitors out of that money, or extra district nurses, or community therapists, they'll buy more operations to lessen waiting lists.'

Caroline Glendinning, reader in social policy at the National Primary Care Research and Development Centre speaking at a recent conference on the NSF said older people should receive as good a service as anyone else.

'Older people are major users of health and social services, yet the services they receive are often fragmented and sometimes arrive too late,' she said.

Di Latham

New tasks for NICE

In a bid to end the postcode lottery of infertility treatment, Health Secretary Alan Milburn has asked the National Institute of Clinical Excellence (NICE) to update existing clinical guidelines produced by the Royal College of Obstetricians and Gynaecologists by the end of 2001.

A survey has shown massive variations in access to treatment around the country, with some health authorities spending around £1/2 million a year and others nothing at all.

Speaking at the NICE 2000 conference in Harrogate, Mr Milburn said: 'It was right for the NHS to first target cancer, coronary heart disease and mental health services in the modernisation programme. However, now the NHS has record funding secured – in the five years to 2004 it will rise by a third in real terms – it is time to tackle infertility.'

The NHS Confederation said infertility was an area 'ripe for investigation by NICE.' Chief Executive Stephen Thornton said: 'The reason, historically, why some HAs have denied access to treatment has been because they could not afford to pay for it not because they considered it ineffective.'

RELENZA

The NHS should not use Zanamivir (Relenza) to treat flu in people who are otherwise healthy. These patients are advised not to visit their GP but to stay at home and obtain medicines from their chemist to relieve symptoms.

Dr Michael Dixon, chair of the NHS Alliance said the decision could 'blow away' primary care drugs budgets as there was no indication that additional funding will be made available.

He added: 'The Relenza debacle shows that we need two different grades of NICE decision. One category (i.e. cancer treatments) which are "must dos" for all PCGs/PCTs and Health Authorities. Another, where NICE says that a treatment can be offered within the NHS dependent upon the local decisions of primary care professionals and people. With Relenza we have moved somewhat illogically from a position of "should not be offered within the NHS" to "must be offered within the NHS," but the evidence is not yet conclusive.'

Continued from page 1

Dr Black says it depends on the attitude of Local Authorities. 'It's supply and demand to a certain extent. If they're not economic, people will close homes down, it will depend on how much the Local Authorities are prepared to pay.' However, he points out that large companies are keen to support intermediate care, rather than have to depend on long-stay clients.

Another concern about NHS services for older people is discrimination. Janice Robinson, Director of Health and Social Care at the King's Fund who has written a report on the subject says it is 'patchy'.

But Cardiff GP Andrew Dearden, chair of the BMA's Community Care committee points out: 'There is a big difference between a straightforward and unacceptable discrimination. An operation may be less efficient in over 70s. It's about risk management.'

FROM THE GRASSROOTS

**A lay member asks:
'What skills do I lack
to go to a PCT?'**

I am writing in response to your article on the role of lay members in PCTs (November issue). As a PCG lay member I have been concerned with the developments of PCTs primarily because of the loss of lay membership at the executive committee level. This worry has been enhanced by local seminars on going to PCT status where it has been emphasised that future Trust Boards will have lay members with relevant skills and knowledge.

As a hard working lay member I would like to know what skills I lack, or is it, as I feel, that as a person firmly rooted in the community my networks and knowledge are no longer recognised as relevant to a PCT?

I am presently in full time employment, take annual leave and lieu time to fulfill my PCG obligations and am committed to the work and involved with a number of sub-groups.

Any further information regarding the developments would be appreciated.

I would also like to become a member of the National Association of Lay People in Primary Care (NALPPC) – can you help?

Thank you,
Linda Clark

2 Fairfield, West Kyo, Stanley, Co.
Durham DH9 8TR. Tel. 01207 282879

*The National Association for Lay People in Primary Care (NALPPC) is currently engaged in discussions with the NHS Executive about ways of addressing its many concerns about the role of lay people in PCTs.

Any Lay Members of PCGs or Non-Executive Directors or Chairs of PCTs wishing to join the Association should contact the NALPPC at: St James Medical Centre, St James Street, Taunton, Somerset, TA1 1JP.



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SCRUTINY NHS put under local government microscope

One of the most significant of the various proposals in the NHS Plan to improve patient and citizen involvement in the NHS is the establishment of the right for local authorities to scrutinise the NHS. Local government is already introducing a formal scrutiny process for its own services. The NHS Modernisation Bill establishes the legislative framework for the extension of the local government scrutiny function to cover NHS organisations and services.

The scrutiny role carried out by Community Health Councils (which will be abolished in the Bill) did not fully cover primary care. However PCTs and PCGs will be covered by the new scrutiny function. This is therefore going to be a whole new experience for primary care. It may be true to say that it is not an experience that is anticipated with any great degree of enthusiasm in some quarters!

There are undoubtedly some concerns that this scrutiny could be used by local politicians in some areas for, at best, point scoring or, at worst, bloodletting at the expense of local health services and health service organisations.

However the NHS Confederation and the Local Government Association (LGA) have been working closely together and with the Department of Health on the development of the scrutiny proposals and are committed to making scrutiny a positive and productive process for all those involved.



Alastair Henderson

There are still many questions of detail to be resolved but the Confederation and the LGA are agreed on the key issues which should underpin scrutiny.

Firstly, there must be flexibility for local partners to develop scrutiny arrangements. Which tier of local authority would conduct the scrutiny remains an issue. What is suitable for a teaching trust covering a large geographical area may not be

suitable for a PCT. For some health bodies there will be real issues over scrutiny and local authority boundaries.

Secondly, the emphasis must be placed on a partnership approach to scrutiny. Neither health partners nor local councils should see this process as adversarial. Nor must the introduction of a formal scrutiny process set back the good relationships and working arrangements that are developing in so many areas.

Thirdly, scrutiny must look at the wider picture and not get bogged down in picking over individual operational issues. There is also a need to ensure that the focus is not just on health organisations, but also on the whole health economy of an area. Indeed the potential for looking at the provision of services by both the NHS and local authority in a particular area is exciting.

Clearly there is the possibility for scrutiny to be a negative experience and it is up to all those involved to ensure this does not happen. But if scrutiny does develop along the lines I set out above – and I am genuinely optimistic that it can – it should be a beneficial and positive experience for local government, the NHS – and patients – alike.

Alastair Henderson

Policy Manager, NHS Confederation
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PCG TIPS: Books and reports

Factors affecting demand for primary health care services by residents in nursing homes and residential care homes

By Charles Crosby, Keith Edward Evans and Lesley Ann Prendergast

Aimed at health care professionals and managers, the authors investigate the demand for primary care and community nursing services generated by residents in residential, nursing and dual-registered homes.

The Edwin Mellin Press on 01570 423356 £39.95 ISBN 0-7734-7627-X

Target Prostate By Dr Mike Hall

Prostate cancer and benign prostatic hyperplasia (BPH) have attracted much less attention than women's disorders such as breast and cervical cancer, but the situation is changing. This 32 page patient booklet is a well written guide to diagnosis, screening, current treatments and vaccine possibilities for the future. It also has a question and answer section and lists of useful addresses.

An ABPI publication, available free on 020 7930 3477, fax 020 7747 1411.

Spotlight on General Practice: preparing for the demands of clinical governance and revalidation By Sally Irvine and Hilary Haman

This book addresses difficult issues such as power, leadership, interpersonal behaviour, confrontation, accountability and handling conflict. It looks at the dynamics of both groups and individuals, and investigates ways of dealing with them. Practical solutions are given, and questions to help the reader analyse problems and test their performance. Case studies and real examples guide the reader and are drawn from the authors' many years experience in diagnostic management consultancy.

Radcliffe Medical Press Ltd on 01235 528820 £18.95 ISBN 1 85775 496 4

GROUPS: a guide to small group work in healthcare, management, education and research By Glyn Elwyn, Trisha Greenhalgh and Fraser Macfarlane

If you have any form of responsibility for leading or facilitating a group then this book will provide a primer on how to set about the many tasks you will face. It provides a practical guide to when and how to use small group work in educational, organisational and research settings.

Radcliffe Medical Press Ltd on 01235 528820 £25 ISBN1 85775 400 X