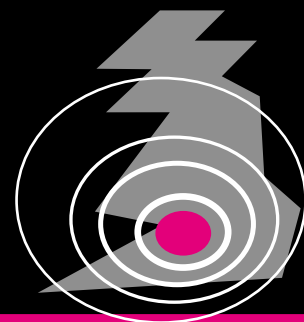


# PRIMARY CARE NETWORK



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ISSUE 29

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## Health and Social Care Bill encourages investment of PCO premises in under-privileged areas

**The Health and Social Care Bill, which had its second reading in the Commons last month, is a ragbag of clauses for legislation that will implement the National Plan. It is also the bill that axes the Medical Practices Committee and changes doctors' contracts, and will at long last free up cash from a central fund for building new, and refurbishing primary care premises.**

The passing of the bill should kick-start 500 one-stop primary care centres to be established by 2004, which may incorporate additional rooms for dentists, opticians, chemists, physiotherapists and others, and will mean building extensions to current GP premises or building from scratch. Also by 2004, 3,000 GP premises should be refurbished or replaced – at the cost of £1 billion.

Through this additional and more centralised funding, the government is seeking to encourage GPs to move into inner cities, as well as to expand practices to take in additional healthcare providers. Where they have outgrown an original surgery in a Victorian house, there is now a fund where they can re-convert it to a house, sell it, and use the proceeds for purpose-built premises.

In the past few years, major problems have arisen with building and re-building practice premises using the cost-rent scheme. Health Authorities devolved building funds to PCGs, and PCGs – possessing a quarter or one eighth of the funds an HA held as a financial cushion, hesitated to throw it all at building one large and glowing new centre a year.

Ironically, the NHS reforms made it much more difficult for doctors to build large premises at the time when public and government were crying out for the addition of such services as physiotherapy, minor surgery etc.

Dr Russell Walshaw, Winteron GP, North Lincolnshire, and chair of the BMA's Rural Practices Premises sub committee said: 'We believe the other reason for less new build is that doctors are slightly less willing to go down the route of building their own premises and owning them.'

But once the bill is passed it should, at least, be much easier to raise money for building. GPs will

be able to get loans to improve primary care premises in England through LIFT: the NHS Local Improvement Finance Trust.

It is an anomaly that primary care is the only part of the NHS where the doctors also own the premises, and on the whole, they are now less willing to invest in the premises in which they practice than they used to be.

'You wouldn't expect a consultant appointed to a hospital to be told "And to work here you've got to buy one two hundredths of the hospital," Dr Walshaw pointed out. But he accepts that a



Dr Russell Walshaw

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## EDITORIAL COMMENT

The Health and Social Care Bill will be instrumental in implementing the National Plan but there is some concern that the abolition of the Medical Practices Committee (the national body which has controlled the distribution of GPs in England and Wales since the start of the NHS) will lead to an uneven distribution of GPs.

'Abolition of the MPC, devolving its functions to individual health authorities, risks exacerbating rather than reducing current inequalities in the distribution of GPs. Decision making about the GP workforce will be devolved to local level in accordance with local rather than national priorities, with no obvious central levers if maldistribution results,' says Dr John Chisholm, chair of the BMA's General Practitioners Committee.

Both the Government and the BMA agree that patients with equal clinical needs must have equal access to primary care services, but will the proposed new system – a financial mechanism for regulating the number of doctors in a Health Authority area, be better able to achieve that aim. The BMA doesn't think so, do you? Please let us have your views.

Views of lay members are given an airing on pages three and four of this issue, from preparing for Trust status to getting other board members to listen. And 'Free fun health checks' is a report from a lay member responsible for an innovative, caring approach to public involvement.

Jenny Sims, Editor

NEWS IN BRIEF

**New Chief Nursing Officer website**

The DoH launched the new CNO website in January to provide information about its Nursing Group, part of the Nursing, Quality and Consumers Directorate headed by the Chief Nursing Officer, Sarah Mullally. She said: 'Over the coming months, we would welcome your comments about what you would like to see included.' Visit it at: [www.doh.gov.uk/cno/index.htm](http://www.doh.gov.uk/cno/index.htm)

**Long-term care resource**

*Caring Matters* provides information about the responsibilities of care providers and receivers. They address: access to information, advance directives, charging policies, care home issues, protecting vulnerable people and their money, what to do when a person dies, sectioning, and many other care issues. Visit [www.caring-matters.org.uk](http://www.caring-matters.org.uk) for up-to-date information about changes in health and social care procedures.

**NHS Alliance annual spring meeting and AGM**

'What a performance' to be held at The Royal Institute of British Architects, Portland Place, London 15 March. For details contact Jean Trainor on 0121 248 3399.

**HIMP, CHD & PCO Awards of Excellence**

PCN and the University of Durham are launching three new Awards of Excellence (AoEs), and simplifying the criteria of the HIMP Award of Excellence.

**Two new CHD AoEs** one each for Scotland and Wales will be awarded for the best developed integrated approach to primary and secondary prevention of Coronary Heart Disease. It is open to Health Authorities and Boards, NHS Trusts and Primary Care Organisations (PCOs). Joint entries from health agencies and local authorities will be especially welcomed.

**The HIMP AoE in England** will this year be more outcome focused and linked to the implementation of the CHD National Service Framework.

The closing date for these three AoEs will be April 27th 2001.

**A New PCO AoE** will be announced shortly, the closing date will be in the summer. As in previous years the Awards are being supported by an educational grant from Merck, Sharp & Dohme and are in association with the NHS Alliance, BAMM, RCN, UKPHA and in Scotland also with the IHM.

Further details contact Clive Johnstone at MMS Tel: 01225 333711.

# Commissioning Children's Services in the Community



By Dr Cliona Ni Bhrolchain, Consultant Community Paediatrician, Northampton

**Primary Care Groups and Trusts will find themselves commissioning, or sometimes managing, services for children in their communities. Children's services have changed since most GPs did their training, although many may have some experience by being parents themselves. What needs to be thought about when considering what to buy for children in your community?**

GPs, health visitors and other nurses will provide care for most common illnesses, child health surveillance and immunisation. For school age children, health surveillance and immunisations are often administered at school. Many young people prefer to have these done with their peers rather than go with their parents to the GP.

Secondary care for children in the community is provided in a number of ways. Children with chronic severe illnesses such as diabetes or cystic fibrosis will often have a community children's nurse, based at the specialist clinic, to monitor and educate them about their condition. For those with a developmental disability, community paediatricians provide treatment and preventive care across a broad range of conditions including cerebral palsy, Down's Syndrome and autism.

**What services must a PCG contract for?**

The law requires the provision of some children's services. These include services for investigation and management of child abuse and assessment of children in need, providing medical advice for children being adopted and fostered ('looked after children'), and the early identification and management of children with special educational needs. A community paediatrician must see any child with identified special educational needs to assess any medical needs they may have.

HA targets in the *NHS Plan* implementation include:

- A health co-ordinator for 'Looked After Children' in each district
- Joint care packages for children with a disability
- Health input to Youth Offending Teams
- Sexual health promotion and the reduction of teenage pregnancy
- Improvements in the antenatal and childhood screening programmes
- Involvement in Surestart programmes
- Improvements in Child Mental Health. In future this may include implementing the recent NICE recommendations on ADHD (see *Primary Care Network Dec 2000*)

**Service models**

Community paediatricians and their allied school nurses and therapists provide these services. Each PCG (population of 100,000 with

about 20,000 children) should aim to have 4.5 WTE community paediatricians, though not all of these will be consultants. However, the range of duties required of community paediatricians means that expertise will have to be shared between PCGs, with particular consultants taking lead roles in primary care and public health, educational medicine, social medicine including child protection, disability services, audiology etc.

School nurses should have a caseload of no more than 2000 pupils per WTE but most nurses now work term time only. Again, small numbers means that PCGs would do well to consider collaboration to ensure the breadth of expertise is maintained in areas such as sexual health, learning disability, asthma management, child protection, enuresis etc.

Therapists work closely together and with schools and paediatricians to manage disabled children in the community setting. In addition, speech and language therapists provide a wide range of advice on language and communication issues relating to autism, learning disabilities and others. Numbers of therapists are small and recruitment difficult. Again differing expertise and the need for peer support suggests that collaboration between PCGs should be considered to maintain standards and morale.

**Service models currently in place include:**

- One PCT managing children's services for a group of Trusts covering say 300,000 to 500,000 population
- A Community Trust managing services for a similar population, often with mental health services included,
- An Acute or Combined Trust managing all children's services (acute, community and mental health) under one management.

**Regional and supra-regional services**

A small number of children will need these services including the treatment of malignant disease, rare muscle disorders like Muscular Dystrophy, difficult epilepsy, cochlear implants and communication aids etc. These are likely to be commissioned at district or regional level.

**Useful resources for commissioners**

**Child Health in the Community: A guide to Good Practice.** DoH 1996

**The Essentials of Effective Community health Services for Children and Young People.** Royal College of Paediatrics and Child Health 1997

**Paediatric Services within the Community for the New Millennium.** Royal College of Paediatrics and Child Health 1999

**Health Services for Children and Young People. A Guide for Commissioners and providers.** Action for Sick Children ISBN 0 904076 26 1



# Free fun health checks:

## An innovative, caring approach to public involvement

In our Bebington and West Wirral locality the geographical area and population is diverse, and along with other publicly funded agencies we have a duty to engage with our communities. It was therefore important to create an innovative and flexible approach to public involvement and build partnerships to share opportunities and outcomes.

I took lead responsibility on behalf of the PCG to develop the informal medium of 'Fun Health Checks' as an opportunity for dialogue with the community. These were held in venues across the locality and targeted:

- families in a disadvantaged area
- young people
- a mental health support group
- elderly people and carers.

Meetings and discussions took place with local statutory and voluntary organisations invited to be partners in the events, each of which was linked to national and local campaigns. Partners provided assistance, advice and services on the day, e.g. the fire service offered HAZ-funded Home Fire Safety Checks. The PCG provided the 'Fun Health Checks' (everyone is interested in their own and families' health). These included: B.M.I., Strength, Suppleness, Blood pressure, Stress and Health Promotion information.

Success can, in part, be measured by the attendance. The evening youth event attracted 170 young people and the elderly lunchtime event over 130 senior citizens and carers. Questionnaires, response flips and forms were used to gather information.

The planning, delivery and subsequent evaluation meeting also created opportunities for the PCG to network, share information and build contacts and relationships across the locality. Promotion and awareness of the PCG was also possible by provision of newsletters, bookmarks and contact slips. The events were visited by the mayor, local MPs and councillors to maximise opportunities for communications and publicity. The PCG was identified as a

caring, open organisation working constructively with partners in the local community.

In conclusion, these events were developed as an opportunity for the PCG to demonstrate its commitment to public involvement and partnership working. Evidence of early successes and achievements are underpinned in the constructive feedback contained in a detailed evaluation report.

What is clear from the overall outcome is:

- people consider holistic determinants of health, e.g. transport, employment, lack of facilities, parenting, stress, environment
- their views of what services are like for them are very important
- a greater focus on preventative healthcare is needed
- the PCG needs to ensure services are commissioned to meet people's needs and are provided in a way people want
- the PCG must be open and accountable
- to promote community, people have expertise in relation to improving their health individually and collectively

The outcomes also create some challenges for the PCG in future in resource and decision-making processes, including:

- service developments
- clinical governance, and
- whole board responsibility to communicate.

If the board wants to build on the outcomes of this project it will be important to invest in the process and ensure public participation and community action planning are built into the PCG agenda.

The project has begun to create respect, enthusiasm and credibility to work in partnership with the PCG. It is important that the PCG demonstrates its commitment to these early successes, building on and investing in future opportunities for share developments. Empowered communities can take greater responsibility for their own health and well being.

**Ruth Mullins** Lay Board Member

Bebington and West Wirral PCG Telephone 0151 651 3979

### Messages for PCGs on moving to Primary Care Trust status



From Shiena Bowen, Lay Member for West Wiltshire PCG, which has applied for a move to Trust status in April 2001

**It's likely that most Groups will change rooms before the 2004 deadline set by the Government. It is never too early and may not be too late to give careful consideration to the model of your Trust's structure, and the messages you want to convey to all working for, involved with, or hoping to benefit from a new look local NHS.**

If you have valued the contribution of the Lay Member, reflect on the 'at a stroke' ending of that role in the move to Trust status. Although Non-Executive Directors will be selected from local applicants, it is the new management responsibilities and strategic planning, not the development of community links and public engagement, that will be their focus. So who will continue to take the lead in developing public and patient involvement?

The recent inaugural meeting of the new National Association for Lay people involved in Primary Care (N.A.L.P.P.C.\*) offered an opportunity to share some of the good things that have happened as a result of having a Lay member on Boards to stimulate and encourage a public voice on health matters, and to develop better ways of listening and responding to patients.

These included:

- the development of consultation guidelines as part of a communications action plan,
- local elders' focus groups,
- homeless people's health needs survey,
- Health Improvement listening exercises in clubs,

All this resulted from including people who are strongly committed to enabling patients to influence the shape of future health services.

Although good communication is the job of every member of a PCG/T, it has often been the Lay member who has taken the lead or acted as a catalyst. All this could be lost unless the baton is picked up in better style than England's relay team managed in Sydney.

How can the evolving Trusts ensure that the momentum is continued? There is an opportunity for PCGs to deliberate and define the sort of Trust they wish to be. A Trust that is seen to have local connections, is accessible, open, approachable,

values the contribution of non-medical people and focuses on creating patient-centred services will send out clear messages.

In preparation for moving to Trust status, a PCG must decide on the configuration of its Executive and Board. The suggested format is laid out in the NHS Executive's guidance. However, the bog standard version has not been the only accepted structure. Consideration will be given at Regional level to a well presented case that is supported in consultation.

The local Health Authority may put pressure on PCGs but it cannot veto the proposals. It may not, however, endorse a structure that looks more expensive. Convincing them will be a necessary part of pre-application discussions.

And if you are really concerned with the reality and not just the rhetoric of encouraging patient and public participation you will surely be giving serious thought to the messages your new Trust will send out. The government, as well as local people, will be watching to see if you are making headway in terms of the new NHS Plan, Chapter 10, Changes for Patients. \*The NALPPC is a new organisation supporting Lay Members and Non-Executive Directors of PCGs and PCTs. Telephone 01225 723638 for more information, or write to: NALPPC, St. James' Medical Centre, St. James' Street, Taunton, Somerset TA1 1JP

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portion of the NHS Plan has been designed directly to address some of the problems GPs have had with premises. And it acknowledges the strength new PCTs will have.

'PCTs do have the power to own premises, therefore there may be a move from PCTs to change the thrust of the provision of primary care general practitioner premises' warns Dr Walshaw. But he also adds. 'It is a new way of funding, and we are supporting any new venture that provides resources for provision of general practice.'

Under the new Act, Partnership UK, which is a government-owned company, will build premises under an arrangement with LIFT, and a huge amount of cash is on offer. So is the BMA in favour of the new scheme?

'It remains to be seen how it works' Dr Walshaw said. 'The mechanics of it are complex to say the least. If it is a new way of providing premises where doctors don't have to be the owner, and provides premises quickly where they are needed, then we sincerely hope that it will work. It is essential that general practice be provided from quality premises.'

Professor Mike Pringle, chair of the Royal College of General Practitioners, said: 'We welcome and support the principles behind the proposals to invest money into the expanding and improving of GP surgeries and premises, particularly if it means investment in under-privileged areas that have previously been under-resourced. However we'd like to see more detailed plans about how NHS LIFT will work before we can comment any further.'

For patients, new and refurbished primary health care premises are going to be the most visited, most visible signs of more money going into the NHS. The government needs to get it right.

Di Latham



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## FROM THE GRASSROOTS

### Reply to a lay members query 'Why won't they listen?'

Dear Editor,

I feel I must reply to the article in the December issue of Primary Care Network in which a Lay Member complained of their uphill struggle and feelings of not being taken seriously.

My own experience could not be more different. I joined my PCG, Leicester City West, quite late and most of the other Board members already knew each other. From the very beginning I was made to feel part of the Board and soon felt confident enough to put my views and opinions across and never once felt that I was not being taken seriously.

Our Nurse Board Members are not just token gestures and their input has been very beneficial to myself and to other Board members alike.

Regarding patient participation, granted I did not choose the same path as my colleague but I have had plenty of help and backing from my PCG Management Team to set up a Public

Involvement Committee and I have visited local Health Forums, Groups and Clubs to access our population. I believe that from the outset I made my presence felt and I would have indeed confronted my Board if I felt like the Lay Member in the article.

I feel that unless Lay Members voice their feelings and opinions things will not change. I consider that in all health matters the patient is paramount and would always remind my Board of this if I felt that they were not of the same mind.

Yours sincerely,

**Anne Glover**  
Lay Representative  
Leicester City West PCG  
16 Fosse Road South  
Leicester LE3 0QD  
Tel: 0116 2552042

*\*Replies please to the editor.*

## PCG TIPS: Books and reports

### *Harnessing Official Statistics*

Edited by Deanna Leadbeter

This is the third title in the Harnessing Health Information series which seeks to make information more understandable and accessible. It is written for the full range of practitioners, managers and support staff. Its aim is to take the threatened mystique out of information and give confidence in how to find, appreciate, and use information as a key resource for those who deliver, plan or manage healthcare. This title highlights issues that need to be considered when accessing and using data, and shows the reader how to transform data into something of practical use.

Radcliffe Medical Press Ltd Tel: 01235 528820  
£17.95

### *Reforming the Mental Health Act*

Part 1 The new legal framework

Part 11 High risk patients

Presented to parliament by the Health Secretary in December, the White Paper can be found on the internet at : [www.doh.gov.uk/mentalhealth](http://www.doh.gov.uk/mentalhealth)  
A summary is available in English, Hindi, Punjabi, Gujarati, Urdu, Bengali, Chinese, Vietnamese, Greek, Turkish, Somali and Arabic. The summary is also available as an English audio cassette tape and in Braille and large print. All summary versions are available free of charge from the DoH, email: [doh@prolog.uk.com](mailto:doh@prolog.uk.com)

Published by The Stationery Office Limited  
Tel: 0870 600 5522 £14.20

### *National Reference Costs 2000*

This report provides information on the cost of several hundred different hospital operations such as hip replacements, as well as a range of other treatments provided by most NHS hospitals and community health services in England. This is the third year they have been published and NHS services around the country are using them to improve cost effectiveness and see more patients.

Published by the DoH, available through the DoH website:

[www.doh.gov.uk/nhsexec/refcosts.htm](http://www.doh.gov.uk/nhsexec/refcosts.htm)

### *What's Gone Wrong with Health Care? Challenges for the new millenium*

Edited by Alison Hill

Shortcomings in the NHS cannot be cured simply by throwing money at it. This book looks beyond the funding issue to critically and constructively view other aspects of providing health care to get people in the service thinking about how they can change things for themselves. Aimed at GPs, practice managers, PCGs, clinicians, academics, HAS, social policy makers, nurses, general public and educators of health professionals.

Published by the King's Fund 0207 307 2400  
ISBN 1 85717 425 9 £14.99

### *General Practice: Demanding Work understanding patterns of work in primary care*

John Waller and Paul Hodgkin

The authors provide insights and practical suggestions on how demand can be met effectively and efficiently. They show how to improve service provision, and guidance is given on how to reduce the stressful working conditions of GPs, nurses and other practice staff. Illustrated with charts and graphs, it provides new and relevant data in an easy to understand and accessible format.

Radcliffe Medical Press Tel: 01235 528820 £17.95