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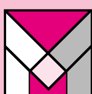

Medical Management Services
Creating Successful Partnerships

Health authorities scrapped in surprise Welsh National Plan

Reactions have been mixed to the news that Health Authorities in Wales are to be scrapped and the 22 Local Health Groups given greater responsibility in a bid to make services simpler and more accountable.

Jane Hutt

The five Welsh HA chief executives only learned of their abolition in a meeting with Health Minister Jane Hutt the day before The NHS Plan for Wales* was published last month.

However, along with their staff, they have been assured of jobs within the expanded Local Health Groups or in the Welsh National Assembly, which is to be supported by a new Health and Well-being Partnership Council chaired by the minister.

The plan, which is radically different from the English NHS Plan, will retain Community Health Councils and extend representation on LHGs to include local government members.

Though bold in some aims, and rich in rhetoric, the plan falls short on specifics such as targets and timetables. As a result, the National Assembly refused to 'rubber stamp' its approval at a plenary session last month. Labour members voted with conservatives to defer the vote on endorsing the document and called for more time for discussion.

But Jane Hutt had started putting the plan into action even before endorsement. An implementation steering group is being set up with the aim of completing structural changes, including the abolition of HAs, by 2003.

The plan, 'made in Wales and designed to meet Welsh needs,' will break down barriers between institutions and organisations to provide integrated services which would be simpler for people to use and understand, said Ms Hutt.

'It presents fresh challenges that demand new approaches. These will be based on dynamic new partnerships between the NHS, local government, the independent sector and the communities they serve. These changes will not take place overnight but we will deliver,' she promised.

'By the end of the decade we will have a set of tools in place that will ensure the continued improvement of the NHS in Wales,' she added.

The plan has been given a cautious welcome by some HA chief executives and LHG general managers, but others have expressed concern that it has been 'rushed out' without being fully thought through.

Peter Ganesh, vice chair of the Welsh Association of Managers in Primary Care and the NHS Alliance lead for Wales, pointed out: 'Some tasks are being devolved down to LHGs, others kept with the Assembly, but there are no firm structures detailed.'

Though many people guessed the number of HAs in Wales might be reduced, perhaps from five to two or even one, few thought they would be scrapped altogether.

'And the direction of the whole document being totally different from England's National Plan has totally surprised people' said Mr Ganesh.

He warned: 'The Assembly must be very careful that re-structured Health Groups don't end up as mini-health authorities with a different name.

'If we are really going to improve health care for the people of Wales, we must retain all the dynamism, enthusiasm and drive that has

continued on page 4

EDITORIAL COMMENT

The decision to abolish Health Authorities and retain community health councils demonstrates clearly that the NHS Plan for Wales is different from the English National Plan, though the underlying aims are the same, to improve people's health. Local Health Groups have welcomed their expanded role, but it is no surprise Welsh Health Minister Jane Hutt came in for criticism from National Assembly members for the plan's lack of detail or promise of more funding for LHGs to deliver the plan. 'Local health groups face a significant challenge to develop the capacity, backup and expertise to deliver their increased role. Significant additional resources must be directed to them and to primary care' said GP and county councillor David Lloyd in the session which refused to endorse the plan. LHG boards agree with him.

The aims of both English and Welsh Plans include reducing inequalities in the delivery of health services and increasing patient education and management of their own health. The Men's Health Forum is pioneering innovative projects to achieve both these aims. Its chairman Ian Banks explains on page three the challenge for PCGs/PCTs and the progress being made in this area.

Jenny Sims, Editor

NEWS IN BRIEF

Out-of-hours implementation

The National Association of GP Co-operatives (NAGPC) and NHS Direct have announced a partnership to help implement the recommendations of the Independent Review of GP Out-Of-Hours services published in October.

The Review recommended that patients can access the service with a single call. Where integrated services with GP Co-ops have already been piloted, nurse triage provided through NHS Direct has demonstrated that GPs' out-of-hours workloads can be reduced by up to 50%.

Part of the initial phase of implementation involves the development of exemplar sites demonstrating the benefits of close working between primary care, other stakeholders and NHS Direct. Within these, best practice will be identified to inform the continued implementation of the Review recommendations.

PCGs/PCTS will be asked to produce by September 2001 implementation plans that deliver the recommendations of the out-of-hours report in their areas.

Recruiting nurse returners

The government's nurse recruitment campaign has moved into a new stage focusing on encouraging trained nurses, midwives and others to return to the NHS. As well as TV, radio and newspaper advertising there will also be local publicity campaigns such as 'job shops' at community health clinics, a London nursing bus and 'We need you' posters and videos in schools, colleges and hospitals.

MIND OUT

'MIND OUT for mental health' is the title of a new publicity campaign to be launched soon by the government and the voluntary sector to reduce discrimination against people with mental health problems and users of mental health services. Health minister John Hutton wants to create a climate of public disapproval towards discrimination.

Mental health law

Mental Health Law and Human Rights: Essential Guidance for understanding the latest law, one day conference, 26 April, at the Scientific Societies Lecture Theatre, London. Organised by IBC UK Conferences Limited. For details visit their website www.ibc-uk.com/LG175

Impotence education

The Impotence Association has launched a new public education campaign to encourage sufferers to seek treatment. Call the helpline number 0870 129 0100. The website is www.impotence.org.uk

PRIMARY CARE TRUSTS

The role of nurse board members

A new wave of PCTs come into force next month. Fiona White, nurse board member for an existing Surrey PCT, explains her role and responsibilities.

Nurses on boards have to be responsive to change and adopt a 'flexible, can do attitude' to meet the demands of the increasing pace of change and evolution outlined in the national plan.

Nursing leadership has seen the shift of power from hierarchical management to the workforce working within much flatter management structures. Leadership and change is the responsibility of all those involved in health care. Everyone has to take responsibility for communication, networking and teamwork. We have to value the relationships we have with our team colleagues and make our patients our allies.

The drivers for change are the public's demand for a service designed and focused around them, which is polite, fast, safe, convenient, with 24-hour access.

Primary care has to be demand led with direct access. It will have to incorporate continuity, longitudinal care in various settings which is reactive, proactive, co-ordinated and comprehensive within a generalist and specialist service that meets the needs of the practice population and PCT's corporate agenda.

Collaboration by GPs, nurses, and PAMs in professional partnership is key in maintaining and changing services and meeting the expectations/demands of government and the public.

The white paper, *Making a Difference*, signposted the future of nursing followed by the *NHS plan* (a plan for investment and reform) involved nurses in the taskforce (modernisation action teams of staff and public to analyse the problems facing the NHS).

The issues affecting nurses include:

- National and international shortages of nurses
- Ageing workforce
- Demand > supply
- Extended roles/delegated tasks increased
- Increased workloads for practice nurses and primary care nurse practitioners due to NSF demands.
- More accountability and responsibility in maintenance/recall for chronic disease management.
- Health visitors role changing to be more public health/community focused (skill mix/new roles)
- Gatekeepers/gate openers for the NHS
- Primary care telephone advice, email advice
- Direct referrals
- Education of nurses.

These have to be balanced with the demands of GPs which include:

- Recruitment & retention
- Changing career aspirations
- Increased salary options
- Early retirement
- Greater GP responsibility/accountability for child protection and clinical governance.

PCTs have to change from a disease service to a health service. Focus on quality, efficiency, and cost effectiveness, understanding the impact on other providers while improving the patient's journey and meeting the demands within a finite budget.

We need all clinicians and managers to be more knowledgeable about the NHS and its health systems. Leadership isn't the same as management.

As PCT board nurses we have to maximise the potential of the whole workforce, understand the corporate and financial workings, constraints and engage with our peers to find local solutions that benefit patients, carers, local stakeholders and employers. We have to be able to know, understand, act on:

- Networking with nurses, GPs, PAMs, managers, Health Authorities especially Public Health/Health Promotion, Social Services, Region and local Stakeholders
- Risk taking and management
- Maintain a patient focus towards positive health outcomes using evidence based nursing/medicine within agreed care pathways, protocols, prescribing and patient group directions
- Human resources – improving working lives
- Student placements, cadet nurses, National Vocational Qualifications, introducing skill mix
- Work force planning and service developments based on needs assessment
- Understand the constraints of an ageing workforce
- Recruitment & retention with opportunities to work in practice, NHS Trust (or both)
- Professional regulations (Prep)
- Role changes - new roles/extended roles/expanded roles with fewer barriers between professionals and organisations (e.g. Nurses undertaking minor surgery and outpatient procedures, resuscitation procedures, prescribing medicines and treatments, running clinics, caseloads, admitting and discharging patients, making and receiving referrals, ordering diagnostic investigations)
- New nurse consultants and GP specialists - empowerment of nurses, midwives, Health Visitors and therapists to undertake clinical tasks
- Morale and support of staff with greater opportunities to develop and use new and current skills in new settings
- Education and training (academic access and personal development)
- Nursing/GP culture
- Local Medical Services (*Red Book* regulations/PMS)
- Finance management
- Staff involvement
- New technologies, clinical competence
- Communication
- Information technology - move to paperless patient held records and systems, triaging patients
- Change management
- Integrated working with consumer involvement
- Private services, social services /local authority.

Policy, strategy and philosophy underpinned by clinical and corporate governance have to be unified, agreed for and by all those working within the PCT.

Fiona White ***(Nurse Practitioner)***
Nelson & West Merton PCT,
Executive Committee member, Health Promotion lead,
PCT Board Nurse Member

Men's Health: A contradiction in terms

Dr Ian Banks, Co. Down GP, and chair of the Men's Forum, takes a look at how PCGs/PCTs can improve men's health.

It is difficult to overstate the gap in health between the sexes especially when compounded by social class. Public Health minister Yvette Cooper addressing a young men's health conference in Birmingham said: 'When it comes to life expectancy there is no greater inequality than that between men and women'. Blaming this on an unequal distribution of resources is a dangerous and divisive temptation, considering that the UK spends less on female health than the whole of the EU. Comparing pittance with pittance is unhelpful. Men's health is poor according to a wide range of measures. These are some of the most significant:

- The average male life expectancy at birth is currently under 75 years.
- The average man can expect to be seriously or chronically ill for 15 years of his life.
- Men who are defined as partly skilled or unskilled have a life expectancy of less than 70 years.
- Heart disease and stroke are, together, the biggest single cause of male deaths. The male death rate from these two diseases is 333 per 100,000 population.
- Cancer is the second most common cause of male deaths with a rate of 273 per 100,000 population.
- Nearly 22,000 men in the UK are newly diagnosed with prostate cancer each year and about 9,500 die; the number of new cases diagnosed is expected to treble over the next 20 years.
- The incidence of testicular cancer has doubled in the past 20 years.
- The suicide rate among men is increasing; the rate has doubled among 15-24 year old men in the past 25 years.
- Depression is a widespread but under-recognised problem in men. The Royal College of Psychiatrists suggests that at least one in five people suffers clinical depression at some point in their lives and that men are as likely as women to be affected.
- Sexual problems are common amongst men: almost one-fifth of men in their 50s experience problems maintaining or achieving an erection.
- Men with diabetes are likely to take longer to diagnose because they are generally reluctant to report symptoms to a health professional or to have a general health check-up.
- 45 per cent of men are overweight and another 17 per cent are obese.
- 28 per cent of men smoke. The average male smoker smokes 111 cigarettes a week.
- 27 per cent of men drink more than the recommended limits. 36 per cent of men aged 16-24 drink excessively.

The challenge for PCG/PCTs

As yet, most health services have been slow to respond to men's health needs. The Government has not addressed men's health issues in any of its major policy statements and plans and few health authorities, except for one notable exception, have developed policies designed to improve men's health. Most primary care services are open at times inconvenient to many men and have done little to encourage more men to attend. Worse still, health promotion materials are rarely produced in a form likely to influence men's attitudes and behaviours. Despite this there are interesting anomalies in the equation. NHS Direct on-line has as many hits from men as women, an interesting statistic considering men attend their GP half as often as women and invariably much later in the course of any given condition.

This could be addressed by:

- The development of services that are more attractive to men (e.g. evening, weekend and drop-in clinics).
- Health services actively seeking out men (e.g. at work, sporting venues, pubs, community organisations).
- The greater use of confidential telephone helplines and Internet-based services.
- Establishing male-specific health promotion initiatives that challenge risk-taking behaviours such as excessive drinking, eating a high-fat diet and dangerous driving.
- Investing in research into neglected clinical areas (e.g. prostate disease) as well as into effective ways of improving health services for men and changing their behaviours.
- The collaborative role of government & health services.

It is not all doom and gloom. There has been an increased awareness in government and the NHS that there is a problem. For example:

The Department of Health has recognised that men's health is a significant problem. The minister for public health, Yvette Cooper MP, has made statements recognising the need for action and has supported several Men's Health Forum initiatives.

The inaugural meeting of the All-Party Parliamentary Group on Men's Health chaired by Howard Stoate took place in January 2001.

Health services are beginning to address men's specific needs (e.g. Worcestershire Health Authority, guided by Meryl Johnson, has drawn up the first men's health improvement programme; the Health Development Agency has appointed an officer, Sally Taylorson, with specific responsibility for men's health).

A major new website, www.malehealth.co.uk, has been launched to offer advice and information to male 'consumers'.

An increasing number of local community and voluntary men's health projects are being developed.

Media interest in men's health continues to grow.

There are signs that men are beginning to take a greater interest in their own health.

The Men's Health Forum is also making its contribution to this developing area of work (see Box 1).

Box 1
About The Men's Health Forum

The Men's Health Forum is an independent charity which aims to improve men's health through the development of innovative and imaginative projects, research, policy development and collaboration with the widest possible range of interested organisations and individuals.

In particular, the Forum:

- Publishes reports on key aspects of men's health (e.g. young men and suicide)
- Runs public education campaigns (e.g. on use of the PHCT)
- Develops new models of health promotion aimed at men (e.g. on sexually transmitted infections)
- Provides health professionals and others interested in men's health with information and networking opportunities (e.g. through the Forum's website)
- Meets regularly with Government and other policy-makers
- Sponsors and contributes to conferences on men's health.

The Forum now has some 200 members drawn from a wide range of health organisations, patient groups, companies and charities.

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characterised the Health Groups over the past couple of years. Too much bureaucracy and top-down decision making would destroy that.'

The plan sets out:

- a vision for care
- health care challenges
- public and patient involvement
- partnerships for health/ working
- the workforce
- investment in infrastructure
- managing the future.

It says:

- All services for CHD must meet the targets set in the NSF Implementation Plan by 2004/5
- An additional £1billion is to be invested over the next three years
- Contractual arrangements for consultants will be modernised
- Guidance on compulsory competitive tendering will be replaced with a 'Best Value' approach
- A £15 million Health Inequalities Fund will be set up and spent over three years, targeting CHD and social disadvantage in the first year.

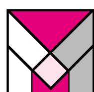
Critics have claimed the plan is premature as the Assembly is to publish a consultative document on the future of primary care and the development role of Local Health Groups in June, a new public health strategy is also awaited and a major resource allocation review is currently being carried out, chaired by Professor Peter Townsend.

**Improving Health in Wales* is available at www.wales.gov.uk

Wales is to follow Scotland's lead on free nursing for older people recommended in the Sutherland report on long term care. Jane Hutt said: 'We propose to make nursing care the responsibility of the NHS and therefore free in all settings.'

She also announced a new initiative in which older people, on discharge from hospital, will be entitled to up to six weeks free home care.

By Jenny Sims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PATIENT INFORMATION

Patients will get access to at-a-glance electronic health records

Alan Milburn

Every adult will be able to access their own at-a-glance electronic health record (EHR) over the next four years, Health Secretary Alan Milburn has announced.

A & E departments, walk in centres and ambulance services could offer gateways into patients' records, but 'full blown' access will still be through GPs, according to Paul Jenkins, NHS Direct project manager.

The initiative, to help redesign the NHS around the needs of patients, is the centrepiece of a rolling programme of investment worth £700m over the next three years to overhaul NHS information technology under the NHS Plan.

The EHR will hold summarised key data about patients, such as name, address, NHS number, registered GP and contact details, previous treatments, ongoing conditions, current medication, allergies and the date of any next appointments. The EHR will be securely protected, created with patient consent, with individual changes made only by authorised staff.

By 2003, five million people are expected to have their own lifelong EHR, this will rise to 25 million by 2004 and by March 2005 every person in the country will have their own record.

Pilot studies are underway to find the best way of allowing patients access to their EHR. Options include on-line access via NHS Direct and smart cards for use in information points in GP surgeries, hospitals and walk-in centres.

Mr Milburn said: 'The Electronic Health Record will help put patients in control. The sustained investment we are making in NHS IT will help redesign the health service around the needs of its patients. In future, every patient will have easier access to their own health records.'

Pilot projects include South Staffordshire HA where an operational EHR provides 24 hour support involving ambulance staff, out-of-hours services, community psychiatric nurses, A&E staff and social services trialling the EHR prototype and developing a production version.

PCG TIPS: Books and reports

Healthcare funding review

Public support for the principles of the NHS is still strong, but confidence in its delivery is slipping, says this major report published by a wide-ranging group of patients, health professionals and others involved in healthcare. It is the result of a year-long review of the future of health care funding by a steering group headed by Dr Ian Bogle, BMA chairman.

The report says that the concept of the NHS as a comprehensive service may have outlived its usefulness and that it will be increasingly commonplace to see treatments excluded from the NHS if they are judged to be of limited clinical effectiveness.

The report's findings are based on opinion polls, written evidence and surveys.

Written and produced by the BMA Health Policy & Economic Research Unit
Available at www.bma.org.uk

The Toolbox for Portfolio Development a practical guide for the primary healthcare team By Roger Pietroni

According to Sir Donald Irvine in the foreword it is an 'excellent' book and one of the most important training texts to come out of primary care in recent years. He says: 'Portfolios will form a key piece of the evidence of continuing fitness to practise required to revalidate in future with the General Medical Council.' It provides a flexible guide to portfolio development, and is not just for doctors but for all those involved in primary healthcare teams.

Radcliffe Medical Press Tel: 01235 528820 £19.95
ISBN 1 85775 444 1

The Cancer Services Collaborative Twelve Months On

This is the title of the National Patients Access Team report describing progress made by the government-funded Cancer Services Collaborative during its first 12 months. Nine cancer networks, designed to reduce delays and cut bureaucracy, cover a population of 15 million and form the first phase of the Cancer Services Collaborative which started in September 1999 and is due to finish in March 2001.

Copies are available on the internet at: www.nhs.uk/npat

Alcohol - can the NHS afford it? Recommendations for a coherent alcohol strategy for hospitals

The widespread consequences of alcohol misuse should be given a higher profile according to this report by a Royal College of Physicians working party which calls for a National Alcohol Strategy. It describes the burden of alcohol misuse on general hospital services and makes recommendations for trusts and purchasers.

Published by the Royal College of Physicians
ISBN 1 86016 146 4
Details on website www.rcplondon.ac.uk

Why Care About Health Inequality?
By Adam Oliver

In this monograph Oliver looks at health inequalities in the UK from a health economics perspective. He presents evidence on health inequalities in the UK and outlines the main arguments that have been put forward to explain the differences in health across social class. He goes on to explain why health inequality should be seen as a problem by everyone in society, not just those who have the worst health. He also gives a critical appraisal of the Acheson Report.

Published by the Office of Health Economics
Website www.ohe.org