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Support needed to stop resignations of clinical governance leads

Clinical governance leads in Primary Care Groups and Trusts are resigning because of workload, lack of resources, pressure from partners and other factors according to two new surveys.

In the South West Region, 11 out of 49 CG leads have already resigned and more are likely unless supportive action is taken, said a survey from the University of Exeter.

Funded by the NHS Executive South West as a joint venture between the departments of Public Health and Research & Development, the 'resigned lead study' is part of a larger study into the development of clinical governance and the results are tentative at this stage.

However, Dr Grace Sweeney, Research Fellow in Clinical Governance at Exeter, who is carrying out the study said: 'Our early findings suggest that an accumulation of factors over a period of time influenced decisions to resign, including the speed of implementation, the move to Trust status, the volume of work, the lack of guidelines on non-clinical aspects of the framework, and the paucity of earmarked and adequate funding.

'The greatest tension revolves around the "unprofessional" nature of the role (absence of a "job description," absence of clear lines of accountability, lack of permanency, weak infrastructures, absence of a base, inadequate funding and the peripatetic clinical governance team) coupled with the potential implications of "failure".'

She said: 'Leads can also identify some negative consequences for themselves and their surgeries, including increased paperwork, over-reliance on locum cover, neglect of their own professional development and strained relationships with colleagues, patients, spouses and children.'

She added: 'As a result of resignation, valuable experience and skills gained over the first two years of clinical governance may be lost to the PCG/T, the process and implementation may become fragmented and practitioners and managers may become disillusioned. Clinical governance leads need to be supported in the job.' They suggest the following:

- Clear job descriptions, ongoing support and membership
- Ongoing training, as well as technical and administrative assistance
- A multidisciplinary clinical governance team approach with adequate financial and administrative resources

■ A systematic approach to 'hand-over' and election to ease the way for successors, and to capture the experiences and harness the achievements of resigning leads.

'CG leads have accumulated a wealth of experience and knowledge about improving patient care. This is far too valuable to be lost just as organisations are moving to Trust status. It is therefore critical that robust structures are in place to support these people' said Dr Sweeney.

The Exeter findings were mirrored in a national survey carried out by the NHS Alliance. Dr Graham Archard, clinical governance lead for the Alliance said he had received lots of letters following their survey and had been surprised and concerned by the extent of 'distress, disillusionment and hopelessness' expressed by colleagues.

He said he did not believe the government had deliberately under-resourced CG leads, but had failed to understand the enormity of the task and the resulting pressures on individuals and practices.

As a result, the NHS Alliance was lobbying ministers to get more support and consider new ways of addressing clinical governance.



Grace Sweeney

EDITORIAL COMMENT

Rumours about resignations of clinical governance leads have been confirmed by the two surveys described in our lead story. The numbers may still be a trickle but a raft of actions need to be taken, urgently, before they become a flood.

Health minister John Denham speaking at the NHS Alliance's conference (see page three) said he recognised 'the huge strides that have been made in developing clinical governance and clinical audit in primary care groups and primary care trusts.' And he acknowledged the 'huge individual commitment that many people, particularly clinical governance leads, made to the development of that work.'

Clinical governance was an activity 'absolutely integral to good patient care,' he said, and warned that it was not a 'bolt-on'. Hopefully the minister will now heed the warnings of the surveys that clinical governance leads need support not sympathy.

Jenny Sims, Editor

NEWS IN BRIEF

NICE on Type 2 Diabetes

NICE has issued guidance on the use of pioglitazone for Type 2 diabetes to all GPs and consultant grade diabetologists and endocrinologists in England and Wales. It has advised that patients should be offered pioglitazone combination therapy (as an alternative to injected insulin) if:

- they are unable to take metformin and sulphonylurea (medicines that lower blood glucose levels) as a combination therapy, or
- their blood glucose levels remain high despite adequate trial of this combination treatment.

The Royal College of General Practitioners is currently leading the development of guidelines on the management of Type 2 diabetes in collaboration with other royal colleges and Diabetes UK, as part of the NICE guidelines programme. The guideline on control of blood glucose levels is due to be published in mid 2001. Copies of the full guidance and supporting documentation is available on the NICE web site www.nice.org.uk

NHS Confederation forum

Kathy Doran, DoH Head of Primary Care and Health Secretary Alan Milburn are among speakers at the NHS Confederation's one-day national forum, Primary Care Trusts 2001: Connecting to Success, 23 May. For more details call Robin Saklatvala at 020 7959 7260 or email: robin.saklatvala@nhsconfed.co.uk

BAMM conference

Health Secretary Alan Milburn will open *Modernisation for Real*, the British Association of Medical Managers' annual conference and summer school in Liverpool, 13-15 June. For details call 0161 474 1141 or email: bamm@bamm.co.uk

Older People NSF Workshop

A pilot workshop entitled 'How to Implement the NSF for Older People & Improve Care Services' will be held in Gloucestershire at the Cheltenham Racecourse on Wed. 25th April 2001. You can see details and register online at www.medman.co.uk or telephone 01225 333711 for a registration form.

NHS number tracing on-line

A ground-breaking service that gives NHS organisations instant access to a definitive national database of patients' NHS numbers is now live. On-line searching is the latest addition to the NHS Strategic Tracing Service (NSTS), which was first rolled-out to the NHS in March 2000. Information about NSTS is available from www.nhsia.nhs.uk/nsts

Implementing *Information for Health* in the Dales PCG

The implementation of the *Information for Health strategy is key to the efficient delivery of clinical services in Primary Care and within acute Trusts. It also enables the monitoring of such services at PCG/PCT level. It is therefore imperative that PCOs hit the targets set out in the plan by or preferably before their due date.**

In the Dales PCG we have invested heavily in Primary Care IT over the last two years. Our first step was to encourage all practices with the offer of 100% funding to move to a common system. The majority already had EMIS and all GPs converted to this system within our first year.

Most GPs are of course now computerised but many do not use their systems to their full potential. In the Dales we set out to encourage all GPs and their staff to abandon paper records. We did this by setting Clinical Governance standards that relied heavily on common computer templates and common audits. This made life very difficult unless GPs converted to paperless consultations. The majority of GPs in the Dales have now converted and most found the change relatively easy to make.

In order to encourage GPs further we have developed Electronic Patient Record (EPR) levels for Primary Care. This sets out four EPR levels depending on how much GPs use their systems and rewards them accordingly. We hope to make incentive payments to our practices before the end of this financial year.

In addition we have installed an EMIS system in our Out of Hours Co-operative and overnight dispenser with all paper records there. The next step is to pilot the transfer of clinical data between the practices and the Urgent Care Centre which we hope to set this up over the coming year. We have an EMIS system in the PCG office to enable us to write templates and protocols and hope to extend this to provide a training room for all Primary Care staff.

All GPs in the Dales have desktop access to the Internet and to e-mail and we have started routinely sending out information electronically rather than by paper. Our local general hospital in Bishop Auckland has been sending out pathology and radiology results to the majority of GPs for many years and many practices no longer receive any paper results.

One of the targets we will have to hit over the coming years is the development of integrated primary and community records. The 100% deadline for this is not until March 2005 but I believe district nurses and health visitors are ready now to begin the conversion to electronic records. They are in fact far more

ready than our colleagues in secondary care who are a long way from being able to use a 'Clinical System'. Some of our attached staff already access and input data on the GP system but their access to computers, to e-mail and to the Internet is limited.

Now is the time for community trusts to invest a great deal more money in community IT.

In the Dales area we are currently running a pilot whereby the district nurses and health visitors use hand held devices to record information in patients homes. The data is then synchronised with the practice system on their return to the surgery. If this is successful at the end of our six month pilot, we would like to roll the system out to all our practices.

Of course change is always difficult, and some GPs have had to overcome their fear of, and their reluctance, to use their computers. In addition there are still training issues with regard to the use of the clinical system, read codes and 'office' applications. Templates and audits take a lot of time to develop and it is a great pity that the NSFs were not published with a set of standard templates and audits for the common GP systems.

Communication with other health professionals and with the public is now possible using the internet and I think it is essential that PCOs develop their own web site. We have done this in the Dales and hope to make it a site that is both informative and interesting. We hope that by doing so we can get our health message out to a wider audience efficiently and cost effectively. You are all welcome to view our web site, even though it is still at an early stage of development at www.dalespcg.co.uk

It is possible to progress rapidly, but it requires a willingness to change on the part of clinicians. It also requires considerable investment and PCOs will have to be prepared to use incentives, clinical governance standards and 100% funding of systems and maintenance charges. Only then will they be able to persuade their Practices to abandon their antiquated Lloyd George cardboard notes!

* *An Information Strategy for the Modern NHS 1998-2005 A national strategy for local Implementation* at www.nhsia.nhs.uk



Dr Stewart Findlay

Dr Stewart Findlay

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Results of the NHS Alliance national survey on 'Getting the balance right'

Many GPs are finding it difficult or impossible to cope with membership of PCG and PCT boards or committees as well as their practices, an NHS Alliance national survey has shown.

Around 55% of GP, chief executive and senior manager respondents said they knew of resignations from boards because practices were so overstretched people did not have the additional time needed to undertake board work. And another 57% said they knew of GPs who were considering resigning.

But the survey/questionnaire also uncovered a range of other problems and concerns from workload and lack of resources to prescribing. For example:

- 87% of the doctors, nurses and managers who responded to the survey thought restrictions on medical treatments were 'likely' or 'possible' (59% 'likely', 28% 'possible') because of the cost of implementing decisions by NICE and National Service Frameworks
- 76% of GPs said they would not prescribe relenza despite the NICE decision.
- 92% complained about 'undue or inappropriate pressure' from at least one of a list of national and local bodies, 80% said decision making was too 'top down' and four out of five doctors and nurses believe their individual clinical judgement could be affected by corporate decisions.

Dr Michael Dixon, Alliance chair, said: 'Our

survey reveals the depth of anxiety and frustration at the frontline of the NHS. The problems are essentially about priorities.

'No-one is looking at the overall cost effectiveness of everything we do. National priorities have been all about new drugs and new technologies. NICE, for example, has a limited remit. It looks at the cost effectiveness of individual drugs and treatments but not at whether a drug is more or less cost effective than an extra district nurse. We are not looking at consultation time, or services like community nursing.'

More people, time and money were needed in primary care, said Dr Dixon, speaking after the Prime Minister's announcement of £100 million for primary care organisations (see back page) and the Alliance's conference attended by health minister John Denham (see below)

Mr Denham said the government did not expect GPs to work harder, but wanted them to explore new ways of working. And he promised more incentives to recruit and retain GPs.

* The survey was distributed to around 300 PCGs and PCTs, and to individual NHS Alliance members active in primary care organisations; 116 responses were received.



Mike Dixon

Call for national debate on NHS priorities

Launching its own election manifesto at the conference the NHS Alliance called for a national debate on what the NHS can and cannot provide.

'A health service with limited resources cannot provide unlimited care. The health professions, NHS management and the new government should combine together to initiate a national public debate,' said Alliance chair, Dr Michael Dixon.

'That means a grown-up debate about choices, costs and consequences. It is a debate the nation has never had. But it is necessary now,' he said.

Initiatives such as NICE to end postcode rationing have not worked as successfully as hoped, the Alliance claims. And after a national debate the government should take responsibility for stating in broad terms what the NHS can provide, the manifesto says.

Learning in primary care

Not sure what is meant by primary care having to become 'knowledge based' and 'learning organisations,' especially in terms of commitment and cultural change?

Then a short paper, *Primary Care Trusts as Learning Organisations – the NHS Alliance View* will give you the answers.

The report's author, Professor Ruth Chambers, the NHS Alliance education lead, explains:

'It's about ability and capability within the organisation as well as individuals. The culture has to be positive and facilitate learning for everyone. It needs strong leadership from the top.'

Multi-disciplinary team-based learning is the best way to enhance patient care, the paper says. That is quite different from the traditional education of health professionals and managers, who normally learn in isolation from one another. At the same time, the importance of tacit (existing or implied) knowledge is being increasingly recognised. PCTs need to harness this tacit knowledge, which resides at both individual and collective levels.

* *Primary Care Trusts as Learning Organisations* is available free of charge from the NHS Alliance, Retford Hospital, North Road, Retford, Notts DN 22 7XJ, tel 01777 869080 or fax 01777 869081.

Hand over the reigns health minister tells HAs

Health authorities must hand over the reigns on commissioning to Primary Care Groups and Trusts, health minister John Denham said at the NHS Alliance Spring Conference.



John Denham

He said that as of this month (April) just under half of the population of England would have their health services provided by, and commissioned by, PCTs. And if signs were right, by next year the majority of PCGs would

have moved to PCT status. By 2004 PCTs would be responsible for the control of around three quarters of total NHS expenditure.

He told delegates they shouldn't underestimate how control of that level of expenditure would put them in charge, give them influence and allow them to drive decision making locally. However, a great deal had to happen to make that a reality. Health Authorities in particular had to ensure it happened.

'That means they must hand over the reins on commissioning, they must transfer significant

management resources to PCTs and cannot expect new organisations to exercise real influence over that level of resources without the management support and capacity to do it effectively.'

He said it was essential that HAs support and enhance development of PCTs and PCGs ensuring they didn't just survive but thrive.

'Health authorities that persist in seeing primary care as part of the problem and not part of the solution are determining their own futures,' he warned.

He said the DoH with the Alliance would be holding eight regional workshops around commissioning*. 'These will challenge professionals to identify and attack the blockages in their systems that cause unnecessary delay and prevent patients being treated in the most appropriate way.'

Mr Denham said he had been long enough in the job to see that PCGs were already delivering better services for patients and their communities. But he recognised an expansion of primary care staffing was needed.

* (These start in early May and will be organised by Medical Management Services, for further details tel 01225 333711).

£100m for PCOs

Primary care organisations (PCOs) have welcomed the Prime Minister's announcement that they are to get £100 million a year – an average of £10,000 per GP practice – to promote new ways of working and reward ideas that improve services.

The money, including £45 million from extra investment announced in the Budget will be allocated as follows:

- A lump sum of around £5,000 will be paid up-front to help practices provide improved services. PCOs will draw up with practices their own incentive schemes which will deliver local improvements to reflect NHS priorities.
- The second tranche of cash will be paid out at the end of the financial year provided that the practice hits its local incentive targets. Practices hitting the targets will have complete freedom to spend the subsequent bonus. GPs can take it as a cash sum for themselves, reward practice staff or put the money back into patient services. Other key initiatives announced by the Prime Minister include:
- The creation of a National Director for Primary Care Services. Runcorn GP, Dr David Colin-Thomé has been appointed.
- £25 million over three years to set up a series of Teaching Primary Care Trusts. The first will start on 1 April in Salford, Bradford and Sunderland.
- All PCGs and PCTs to receive £5000 this month (April) to improve cancer services.

'The Prime Minister has left us in no doubt he understands the pressures facing primary care. This could be a major force for improving primary care as well as bringing GP practices and PCTs together' said Dr Mike Dixon, NHS Alliance chair.

But Stephen Thornton, NHS Confederation chief executive, warned: 'If we are going to get the best out of this initiative, we will need to make sure that the new PCTs have the resources to be able to design and run a large number of individual practice-based incentive schemes. This would be a tall order for them given their present management allowances.'



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Bigger may not be better for Primary Care Groups and Trusts

Rapid moves to merge by many Primary Care Groups (PCGs) may be a mistake, suggest independent researchers in a new report published by the National Primary Care Research and Development Centre.

Two thirds of PCGs were considering mergers with neighbouring PCGs within a year of being established. If all of these mergers were to go ahead, it could lead to the average size of PCGs doubling, from the 100,000 population initially recommended by the Department of Health, to nearly 200,000.

The authors of the report have carried out a comprehensive review of the international and UK research literature on the relationship between performance and size in health care organisations. They found that:

- In terms of overall performance, there is no evidence that increasing the size of Primary Care Groups and Trusts beyond 100,000 will produce improvement or significant cost savings
- Optimal size will vary for different functions of primary care groups and trusts (commissioning hospital services, commissioning community health services, developing clinical governance, providing primary care services, etc.)
- Delegation within PCGs and Trusts and alliances between them can be used to achieve the different optimal sizes for different functions
- Optimal organisation of Primary Care Group/Trusts is at least as important as overall size

- Mergers often fail to deliver the anticipated benefits and require active management of change to avoid damaging effects on staff morale.

Professor David Wilkin of the National Primary Care Research and Development Centre, one of the report's authors, said: 'Our review of published research found no evidence to support the argument that bigger Primary Care Groups and Trusts will do better.'



Professor David Wilkin

'In my opinion, the widespread interest in mergers seems to be driven by a lack of management resource. Mergers are unlikely to solve this problem. The evidence suggests that any benefits from mergers take a long time to be realised and that there are costs which are often overlooked until after the event.'

'Primary Care Groups and Trusts should think very carefully about the costs and benefits of mergers before making any decisions.'

* *Is Bigger Better for Primary Care Groups and Trusts*, published by the National Primary Care Research and Development Centre, is available from the Communications Unit, NPCRDC Tel: 0161 275 7126 or on the website: <http://www.npcrdc.man.ac.uk> (NPCRDC is a collaboration of the Universities of Manchester and York. It receives long term funding from the DoH and also holds grants from a wide range of bodies.)

PCG TIPS: Books and reports

NHS Beacons Learning Handbook Spreading good practice across the NHS 2001/2002 Vol 2

An invaluable tool aimed at helping health care professionals implement the NHS Plan, it contains details of the 68 new Beacons. Each demonstrates good practice in a key area of targeted improvement for the service. The NHS Beacon Programme is to become part of the new Modernisation Agency.

For more information call the Beacon Learning Advisers on 01730 235038 or visit the website: www.nhs.uk/beacons

Integrated Healthcare: A Guide to Good Practice

By Hazel Russo

Increasing numbers of people are seeking to combine the best of orthodox and complementary healthcare. This book, based on the entries to the 1999 Guild of Health Writers' Awards for Good Practice in Integrated Healthcare, highlights good practice and guides health professionals through the process of setting up and running new integrated services.

The Foundation for Integrated Medicine
Tel: 020 7688 1881 ISBN 0-9539453-0-8 £7.99

Health Promotion Professional Perspectives 2nd edition

Edited by Angela Scriven and Judy Orme
Completely revised and updated to take into account the role of PCGs/PCTs and new policy, this second edition aims to increase understanding and facilitate joint working between professionals drawn from different backgrounds, cultures and ideologies.

Palgrave/The Open University £15.99
www.palgrave.com/catalogue ISBN 0-333-94834-3

How To Be A Good Enough GP: surviving and thriving in the new primary care organisations

Gerhard Wilke with Simon Freeman
This book analyses the various reforms of the past decade and examines politeness, conflict avoidance and rivalry for power to reveal how at the core of reform is the struggle for each GP to construct a new professional identity which integrates medicine, management and politics. It proposes ways in which GPs can use their own experiences to become equipped with the necessary competencies to be active members or dynamic leaders in their locality.

Radcliffe Medical Press Ltd Tel: 01235 528820
ISBN 1-85775-358-5 £19.95