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for PCGs/Ts will be many fold. They are starting to deliver service improvements in primary and community care. It is not too fanciful to talk of a changing culture in primary care. Clinical governance leads report wide-spread sharing of clinical data between practices to an extent unimaginable just a few years ago. Whether PCTs can develop as effective commissioners is unclear. They are beginning to vire money across previously impermeable boundaries but lack the management capacity and information to drive efficiency gains in the secondary sector as things stand. Likewise, persistence will be required if addressing inequalities and population health is to remain a focus for PCG/T boards. And they need greater autonomy to deliver local priorities in the face of overwhelming central directives.

You don't have to be an incorrigible optimist to see plenty of opportunities for resourceful leaders in the new primary care organisations. We can anticipate new investment in new models of care many led by non-doctors. The major transformations are ever difficult to comprehend, such as, the explosion of practice nursing and changes in out-of-hours services. We will look back on the days of the corner shop, pre-collectivisation – and wonder. If PCTs can help deliver improved working conditions and greater investment in training and support for staff, they may just be able to convince those at the frontline. Happier doctors and nurses will mean happier patients. That, after all, remains Labour's biggest challenge.

(Stephen Gillam is editor of *What has New Labour Done for Primary Care A balance sheet published by the King's Fund*).

Medical Management Services
Creating Successful Partnerships

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Making health and social services partnerships work

by Julia Ross, Joint Social Services Director of Barking and Havering Local Authority, London and Chief Executive of Barking and Havering PCT



We all know why the government has been so determined to make health and social care work more closely together. We know it makes sense and we also know how difficult it can be. In Barking and

Havering we've had all sorts of flourishing partnerships. We've had a Health Liaison Team for some time and we have just set up an Integrated Care Co-ordination Team for arranging early hospital discharge. Both teams have nurses and social workers working side by side. We're also on the brink of using the Health Act's Flexibility for the Learning Disability Team which is now managed by social services. Who does what is becoming less and less important as long as we deliver what's needed.

Our approach towards Care Trusts as the delivery body of the much desired partnerships is to say that we think we can do it anyway. I have considerable sympathy with the government's growing urgency about community-based health and social care services getting their act together to provide seamless services and one point of entry for service users. My mother believed implicitly that her local home care service in Kent was organised and managed by her

local GP, and why not? She had confidence in her GP with good reasons. She didn't know or understand who the Elderly Persons Disability Team was and she certainly didn't want to be labelled as an 'elderly person in need'.

Besides all the usual reasons why working in partnership must be a good thing, I have a sneaking suspicion that there must be others who believe as I do that the almost permanent state of stigmatising of social services, amply assisted by the media, is best put behind us. If the easiest way of doing this is to join up with a much respected local GP service well then why not? I have also nurtured a desire to build such an alliance across primary and community based services that people needing health services will no longer believe that the answer is to get into hospital as fast as possible but to help themselves get sorted out at home. I was delighted when I read of the ministerial announcement that people will be encouraged to think in just that way. This will mean very soon that hospitals will become places where people are 'fixed' and the community places where people are treated.

So when the opportunity came to apply for the new post as Chief Executive of the Barking and Dagenham PCT, I went for it. The Health Authority was keen to see closer partnerships and had a clear vision of what we could deliver together. Their vision helped a lot as did the council's determination to modernise, making it clear that what mattered was what worked. So as joint Director of Social Services and Chief Executive of the PCT, we have a partnership with all the benefits of a Care Trust and none of the potential problems. I am dually accountable to the council and to the health service and we are considering setting up a joint governance partnership. We are singly accountable to the users of our services. We hope we can make this work and work well for all users. Time will tell.

PCG TIPS: Books and reports

Racism in Medicine: An agenda for change Edited by Naaz Coker

Racism is still rife in the NHS according to this book which shows that black and minority ethnic doctors are still being sidelined within the medical profession. The book includes guidance on good practice in tackling racism in medicine and calls on the profession's leaders to take action. NHS chief executives and personnel managers should play a bigger role in the recruitment of doctors, it says. **Available from the King's Fund Bookshop on 020 7307 2591 £15.99**

The Peer Appraisal Handbook for General Practitioners

By Hilary Haman, Sally Irvine and Di Jelley
In clear and simple stages it takes the reader through the 10 steps to develop and implement a system that is right for both the practice and individual doctor. It provides a basis for doctors' external appraisal and revalidation and offers a structure to give insights into both clinical and non-clinical aspects of a doctor's work. **Radcliffe Medical Press on 01235 528820 £19.95**

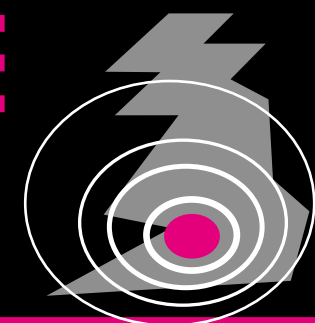
Making Sense of Statistics in Healthcare By Anna Hart

Written for people who want to be able to make sense of published studies or embark on their own studies without getting bogged down by the details of how to use specific methods, it gives insight into how statisticians view data and research and what they do. Packed with ideas and examples it shows how to combine formal results with common and clinical sense. **Radcliffe Medical Press on 01235 528820 £12.95**

Care Services for Later Life Transformations and Critiques Edited by Tony Warnes, Lorna Warren and Mike Nolan

This book provides a comprehensive and practical overview of the provision of services for older people and will be a valuable and thought-provoking resource for anyone involved in caring for and supporting them. **Jessica Kingsley Publishers on 020 7833 2307 ISBN 1 85302 852 5 £17.95**

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JULY 2001
ISSUE 34

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Supported by an educational grant from



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Medical Management Services

Creating Successful Partnerships

Four more years – so what now?

Steve Gillam, Director of the Primary Care Programme at the King's Fund, looks at the challenges on health Labour face in their second term.

When Gisela Stuart held the one time Tory flagship of Birmingham Edgbaston, we knew another landslide was on. This had been the scene of Tony Blair's most uncomfortable moment of the campaign – accosted by Sharron Storer on the steps of the QEH. Jennifer's ear 2001. The clearest messages coming through this election have direct consequences for the NHS. The electorate perceive the state of public services to be parlous. While they were forgiving this time round, Labour's future fortunes depend upon how successfully they turn those perceptions around. Anyone who thinks that recent talk of consolidation and local discretion for the frontline professional means freedom from ministerial interference is likely to be disappointed. What can we expect in primary care?



Stephen Gillam

Labour's manifesto pledges ought to make reassuring reading – in particular, the commitment to increase health spending by an average of 6% in real terms each year for the next three years. The King's Fund continues to press the government on the exact meaning of its commitment to bringing NHS funding up to the level of European averages. For the increases pledged may nonetheless leave cash-strapped PCTs seeking alternative sources of funding. Hence the interest in that other leitmotif for the campaign: greater use of the private sector. The proposals so far are typically Blur. It is not clear that the government knows what the problem is let alone how the private sector will provide a 'solution'. Greater plurality of service provision may be electorally acceptable but this is a zero-sum game. Increasing private sector provision comes at an increasing staff cost for the NHS. Private sector personnel are trained in the NHS and come from a common pool. Or is it more private sector expertise in management that is going to be beneficial? The Prime Minister may be convinced but where is the evidence to support this? As the government starts to fall short on targets laid down in the NHS Plan, watch this space.

The other big issue is, of course, the

workforce. Another 20,000 nurses and 10,000 doctors would make all our lives easier. But are these targets achievable? Cutting waiting times, reforming appointments systems, large scale investment in hospitals and in primary care facilities; all of these should ease the burden of containment in primary care but the government will expect something in return. Battle lines have been drawn

in preparation for early negotiations over a new GP contract. The BMA has been getting its retaliation in first but has appeared tactically crude. Guttural trades union dinosaurs have won few new friends. The government may not want a miners-style confrontation but, if they are ever going to take the medico-political power blocks on, the time is surely now. Expect compromises, but a quiet life? No. New imperatives will start to impact on GPs' working lives: revalidation, performance to targets, more data collection, greater accountability. The outlines of a new post-PMS contract are not too difficult to discern.

Against this turbulent backdrop, the challenges

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EDITORIAL COMMENT

The NHS Reform Bill announced in the Queen's Speech will decentralise power down to frontline NHS staff, support the next stage in reforming professional self-regulation and modernising the NHS and build on the provisions of the Health & Social Care Act 2001. The NHS Alliance and the NHS Confederation have welcomed the proposed Bill, but with understandable reservations. The Confederation warns that a significant investment in management resources in Primary Care Trusts will be needed if 75 per cent of the NHS budget is to be handed over to primary care. And the Alliance warns that to ensure genuine public involvement on PCT boards the appointments system must be re-examined. Both say that otherwise reform won't work. Hopefully the government will heed both warnings.

Jenny Sims, Editor

NEWS IN BRIEF

O.B.E. award

Primary Care Network wishes to congratulate our board member, Dr Michael Dixon, chair of the NHS Alliance, who has been awarded the O.B.E. in the Queen's Birthday Honours List.

The award is believed to be in recognition of the Alliance's role in creating the concepts on which modern primary care is based, especially its commissioning function and putting decision making in the hands of local doctors and nurses.

Dr Dixon has been a GP principal for 17 years in a semi-rural eight-partner practice in Devon and chair of the Alliance since 1998. He said: 'This honour is a great privilege. But it isn't for me, it is for the NHS Alliance and all its members who have worked so hard to achieve a fair and effective NHS.'

Budget switch

Health Secretary Alan Milburn in his first speech following the General Election told the British Association of Medical Managers conference that a key priority will be to decentralise control of the NHS budget to frontline staff.

Within the next two years funding will go directly to PCTs rather than through health authorities. By 2004 PCTs will control 75% of the NHS budget.

Ministerial changes

Jacqui Smith and Hazel Blears have joined the health ministerial team. Mrs Smith, former School Standards minister, has been appointed Minister of State at the Department of Health. Hazel Blears. John Hutton has moved to the Home Office. Hazel Blears, MP for Salford, former PPS to Alan Milburn, has been appointed health minister.

Review of GP systems

A fact-finding market review to help primary care organisations decide which clinical IT system is right for them is being undertaken by the NHS Information Authority as part of its Project Connect Programme. The findings will be used to help patients manage the changes associated with the introduction of Electronic Health Records and the move to Primary Care Trust status.

Poor patient information

Information about the potential for serious birth defects if antiepileptic drugs are taken during pregnancy is not being given to women according to a report in *Health Which?* The June issue highlights instances where patient information leaflets are missing crucial information which is included in the summary of product characteristics. Tel: Which on 0845 924 5000.

Will Strategic Health Authorities shift the power balance in the NHS?

Three PCN board members offer their views.

Ken Jarrold, CBE, Chief Executive, Co. Durham Health Authority, writes:



Ken Jarrold

On 25 April the Secretary of State set out the need for three fundamental shifts in the balance of power in the NHS. Power must shift decisively:

- in favour of the patient
- from Whitehall to the NHS frontline organisations
- within frontline organisations to clinicians and other frontline staff.

The 30 or so Strategic Health Authorities (SHAs) will be a key mechanism in the second shift of power – from Whitehall to frontline organisations, and will be responsible for performance managing the first and third shifts – in favour of the patient and within frontline organisations.

They will be the bridge between the Department of Health and the local NHS and will have responsibility for:

- performance managing the local health care system – holding local health services to account.
- brokering solutions to local problems.
- encouraging greater autonomy for NHS Trusts and PCTs.

Both NHS Trusts and PCTs will be accountable to the new strategic health authorities. Roles and relationships will be crucial. It is suggested that authorities should carry out their role through three aspects of performance:

- policy
 - performance management, and
 - development.
- A clear national policy framework has been

established and is being further developed. The new SHAs will have to interpret this framework in the local context and ensure that it is delivered. In order to achieve these objectives authorities will need a detailed understanding of the health status of the population. This will be the foundation of everything that the authority does. The authorities will also need a detailed understanding of local health services and their contribution to the implementation of key policy areas.

The second aspect of performance will be performance management, including finance, the Service and Financial Framework, the performance agreement with the Regional Director of Health and Social Care and the accountability agreements with NHS Trusts and Primary Care Trusts.

The third aspect of performance will be development. The authority's own personal and organisational development needs, and working with local health services to ensure that the development capability is available to frontline organisations to ensure that power is shifted decisively in favour of the patient and to clinicians and other frontline staff.

The role of the new authorities will be important. However their relationships and the way in which the authorities do their job, both externally and internally will be crucial.

In external relationships the key will be simultaneous loose/tight – the co-existence of firm central direction and maximum individual autonomy. The authorities will need to know when to be loose and when to be tight. A loose approach to performance management will not be allowed. An over-bearing approach to non-core delivery issues will be strongly opposed by NHS frontline organisations. The key to success will be flexibility of style and clarity about which issues require firm central direction and which can be left to local discretion. Knowing whether and how to be

involved will be a vital judgement

In internal relationships the key will be what Bob Dearden has described as a professional service organisation – fluid, flexible and focused.

The new authorities need to be good places to work, utilising the full potential of staff in a purposeful, open and developmental work environment. The authorities need to earn the respect of frontline organisations and staff becoming valued for their contribution to improving health and health services. The new strategic health authorities will serve and lead local health services decisively shifting the balance of power in the NHS.

Nigel Edwards, Policy Director, NHS Confederation, writes:



Nigel Edwards

I have selected four of them.

Firstly, the growth in government's ambitions for the PCTs and in expectations of what they are expected to achieve has grown enormously. The management resource to meet these challenges has grown less quickly. Devolution of power needs to be matched by a corresponding increase in capacity and it is far from clear that the resources released from changes in Health Authorities will be enough.

Secondly, it is time to revisit commissioning, an idea that has often been squeezed out by the use of targets to drive

change. Keeping front line clinicians on board will require commissioning to be more of a clinical dialogue about approaches to patient management that are real areas of concern or where there are opportunities for change. Strategic Health Authorities (SHAs) need to develop frameworks that allow resources to shift between sectors over time to support this.

Thirdly, the changes offer an opportunity to redefine performance management. Targets are effective and do get results but only when there are a relatively small number and there is absolute clarity about priorities. Beyond the absolute 'must do' targets performance management needs to change; to recognise different starting points and create a challenging environment that encourages organisations to set their own timetables and priorities rather than imposing many conflicting targets from above.

The fourth area of interest is the future of the HImP and the health improvement agenda. The emerging map of the new SHAs makes them too large for a single HImP to be appropriate. Initially this means yet another addition to the PCTs tasks and an even more pressing need to develop capacity. PCTs may need to find imaginative solutions for sharing scarce expertise without the disruption of further structural change.

Dr Michael Dixon, OBE, Chair, NHS Alliance, writes:

The new 'Super' Health Authorities should primarily support their local Primary Care Trusts and help to integrate their activity. Also to ensure that Primary Care Trusts deliver. As the latter become increasingly independent, Health Authorities will be required to 'hold the ring' and broker the balance between an NHS that is both a



Dr Michael Dixon

National Health Service but also locally sensitive.

In Wales they have got rid of the 'middle man'. It is questionable how long these 'Super' Health Authorities will themselves survive. Primary Care Trusts

may in time group together and take on many of the functions that might be expected of a Health Authority. For instance, our own PCT is forming a 'Commissioning College' of local PCTs, which should in time be able to take on issues of District and even Regional commissioning as well as commissioning within the PCT. A natural game plan would be for regional NHSE to give way to regional government allowing a one to one relationship with developing Care Trusts, which would make District Health Authorities of any size superfluous.

All this will take a while. It must if we are to get proper ownership of PCTs by local people and professionals, which is essential to their success. District Health Authorities should start discussing future plans not only with themselves and Regional NHSE but also fully involve local Primary Care Groups and Trusts. Unfortunately in some Regions Machiavellian plans are being laid on high and the future of 'Super' District Health Authorities is being stitched up without the local involvement of Primary Care Groups or Trusts. The more that they do this, the more Health Authorities will be signing their own death warrant. But there is no need for acrimony. Just as health professionals are learning to meet the demands of their patients on communication and access, so too must Health Authorities (and the best ones do) nurture, respect and fully involve Primary Care Groups and Trusts, which are their natural heirs.

Integrating diabetes services ■ Integrating diabetes services ■ Integrating diabetes services

The government's National Service Framework for Diabetes, due to be published soon, is likely to focus on changing and improving systems of delivery rather than extending boundaries of care, according to Professor Sir George Alberti, president of the Royal College of Physicians.

Standards of care are 'excellent' in some parts of the country but poor in others. Care in every area needs to be brought up to the levels of the best, said Prof. Alberti speaking at the launch of a feedback report from a series of workshops on integrating diabetes services organised by Medical Management Services.

Professor Mike Pringle, Co Chair of the Diabetes NSF Expert Reference Group, in a keynote speech suggested better education of patients was needed to empower them to take control of the management of their condition.

He pointed out the NSF will be a ten-year plan and that implementation of the guidelines will need to be monitored. If ministers accept the recommendations of the 17-strong multidisciplinary Expert Reference Group, there is likely to be emphasis on prevention, early detection of diabetes and better screening, he said.

Rhys Williams, Professor of Epidemiology & Public Health and a member of the ERG, quoting

from the workshop feedback report, said: 'There are no mysteries about what good diabetes care is.' It's just a question of getting it done in practice, he added.

The report said key issues for people living with diabetes were:

- diabetes specialist nurses are highly valued
- there is awareness of the pressures under which these and other health professionals work
- dietetic advice is important, often difficult to obtain from dieticians and sometimes misleading from doctors
- integration of care is often lacking both

between primary and secondary care and between specialist teams also

- people with diabetes wish to be treated as individuals not as those with 'a condition'.
- Key issues for health professionals were:
 - the importance of the relationship between the person with diabetes and the professional team
 - the importance of education for the person with diabetes and the health professional
 - the clear evidence base for many aspects of diabetes care with the likely future

need for more insulin therapy

- the pivotal roles to be played by PCOs and teams in managing diabetes
- the need to underpin the recommendations of the NSF with adequate resource, and
- the need for a strong contribution by people with diabetes in the planning and monitoring of services.

**Integrating Diabetes Services - time to respond*
By Rhys Williams, Mark Airey and Gill Gilworth
Copies available on www.heretohelp.org.uk or from Novo Nordisk Pharmaceuticals Ltd on 01293 613555.