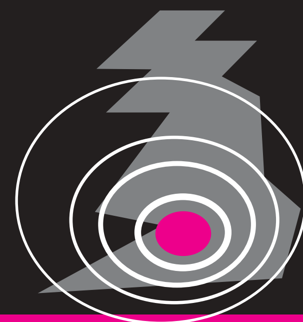
# PRIMARY CARE NETWORK



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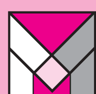


Medical Management Services
Creating Successful Partnerships


# Abolition of NHS watchdog criticised
## but patients promised greater role in NHS

**Reactions to the government's NHS Reform and Health Care Professions Bill has been mixed. There has been widespread criticism of the proposal to abolish Community Health Councils but other proposals to give patients a greater role in shaping local NHS services have been welcomed.**

*Involving Patients and the Public in Health Care: Response to the Listening Exercise* form part of the bill published on November 9 and were developed following a six-week listening exercise involving the public, patient representatives, voluntary organisations, local authorities and NHS staff about how they think the public can best become involved in the NHS.

However, suggestions from the College of Health, Tory and Liberal MPs, and others that CHCs should be reformed rather than abolished have been ignored.

Angelina Burke, Senior Policy Officer at the ACHCW said: 'The proposed alternatives to CHCs, as set out in the bill, fall far short of meeting the widespread concerns about the independence of the new bodies and their lack of integration. We are particularly disappointed to find that the government has turned its back on the idea of patients' Councils with statutory powers, an idea put forward by David Hinchcliffe, Chair of the Health Select Committee.'

It is proposed that Patient Advice and Liaison Service (PALS) are set up in every NHS Trust and Primary Care Trust (PCT). These will act as a 'one-stop-shop' for patients, helping to guide them through the system and resolve any immediate problems and complaints straight away.

A new nationwide Independent Complaints Advocacy Service (ICAS) will be established to help patients pursue formal complaints through the NHS complaints procedure.

A Patients' Forum will be set up in every NHS and Primary Care Trust which will monitor and review the services provided by the trust and feed back local people's views to the trust. They will:

- play a real role in the day-to-day management of local health services representing local people's views in how services are delivered
- have the power to inspect any premises where patients receive NHS services
- produce an annual report which will be submitted to their local trust, the Secretary of State and the Commission for Patient and Public Involvement in Health amongst others
- be able to elect a Non-Executive Director to sit on their local NHS Trust board
- monitor the effectiveness of the PALS and ICAS in their area.

*Hazel Blears*

The Commission for Patient and Public Involvement in Health ('The Commission'), a national body backed by a local network which will co-ordinate and oversee the new structures, will be set up and:

- support and co-ordinate Patients' Forums and commission local ICAS
- have a key role as a resource for local citizens, helping and supporting community groups and promoting public involvement health through outreach teams, working from local, community-based premises, alongside local community partners
- aggregate and promote the information picked up by its local networks and from Patients' Forums and PALS.

Health minister Hazel Blears said: ''We have recently announced that over 75% of the NHS

**continued on back page**

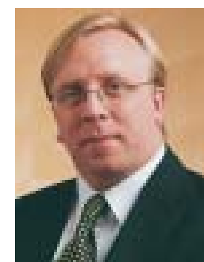
EDITORIAL LETTER

## Re Primary Care Network October 2001, Issue 37

The lead article ''Think big focus small: PCTs urged to concern local partnerships in improving health'' is helpful and realistic. It reminded me of the old World Health Organisation's phrase ''Think globally, act locally''. This was around in the 1980s and 1990s and summarised the importance of local bottom up action within a wider context.

Yours sincerely,
**Dr Graham Bickler**
Director of Public Health
East Sussex, Brighton and Hove Health Authority

# Unhappy doctors – what are the causes and what can be done?



**The problem of unhappiness among doctors is an international phenomenon. While workload and pay are often cited as the main reasons, they are not the only important ones. The NHS Confederation and the British Medical Journal came together with leading figures in the medical profession in the UK to examine this issue and discuss some of the solutions.**

The key issue is that the psychological contact between the medical profession, society, patients and employers has changed; but without any explicit negotiation. Many doctors now find themselves doing a job which is quite different from that which they signed up for. The original contact offered the profession much more autonomy, deference and status than now seems to be available. The expectations of the public have grown enormously and the scale of knowledge that an individual doctor needs to know is becoming almost impossible to encompass. In addition there are aspects of the profession itself which makes this change harder to cope with. This includes the type of people who choose to enter medicine, their training, socialisation and the ways of interacting with each other. The result of this is that doctors have not been well prepared for the change and often do not have a culture of providing mutual support or acting collectively.

An NHS Confederation report to be published in January reflects on the position of the medical profession, but many of these issues are also experienced by other professionals in health care.

The report calls for a new contract between doctors, patients, employers and the government to be developed that recognises changes in both society and the medical profession and which offers doctors a more reasonable relationship between what they are asked to give and what they receive in return. It also calls for changes both in the selection, training and development of doctors and in medical career paths, to allow more diversity and to better equip doctors to engage with the organisations in which they work. This means developing leadership, management and team membership skills and providing doctors with the time and space to take control of their working lives.

**Nigel Edwards**
*Policy Director, NHS Confederation*

(For a copy of *The Problem of Unhappy Doctors - what can be done* call Joanne McManus on 0870 444 5841).

# When things go wrong in primary care

Guidance on managing a crisis, confidentiality and a range of complex issues concerning the performance of doctors are contained in *When Things Go Wrong in Primary Care: Practical steps for dealing with the problem doctor*, a new publication from The British Association of Medical Managers (BAMM).

Written by BAMM's primary care subgroup, Medical Managers in Primary Care (MMPC), the loose-leaf publication has been designed so that it can be easily updated. It currently includes sections on 'Responses to problems, ScHARR and the Panel,' provides information about the essential elements of an investigation and the GMC's fitness to practice procedures.

MMPC chair, Dr David Carson, said: 'This guide is an easily accessible tool to help medical leads in a PCT or PCG make sensible decisions about colleagues who are experiencing problems.'

Problems include disciplinary, health and professional areas and combinations of all three.

It says causes of under-performance include:

- Poor preparation for general practice
- Isolation from both professional colleagues and management
- Lack of continuing education
- Problems of physical health
- Mental health problems, including alcohol abuse or addiction
- Stress related to work or domestic circumstances
- Low morale
- Poor practice infrastructure and insufficient resources
- Excessive workload
- Poor relationships within a practice (turf war or tribalism)
- Inappropriate or complex relationships with patients
- Tragic or upsetting patient experiences
- An unsupportive or inappropriate attitude on the part of the HA
- Attitudinal problems on the part of the GP.

**For more information call BAMM on 0161 474 1141.**

## NEWS IN BRIEF

**Series of FREE Workshops on "How will YOU and Your PCOs Deliver the NSFs, Health Improvement and Build Capacity? – Learning from Local Initiatives"**
MMS are organising the above series of 17 free workshops across the UK between Jan & June 2002 in association with the DoH, NHS Alliance, UKPHA, BAMM and HDA. They will feature the winner of this year's PCN & University of Durham HImP Award of Excellence (Sheffield HA) and other examples from PCOs on delivering the CHD NSF and HAZ's. The worshops and reports are being supported by an educational grant from Roche Products Ltd. Please call 01225 333711 for more details.

**NHS Reform Bill published**
The NHS Reform and Health Care Professions Bill designed to decentralise the NHS, provide more power to front-line staff, a more powerful voice for patients and a new council to oversee the activities of health care professionals was published last month. It allows for the abolition of two thirds of health authorities by July 2003.

**New chief executive**
Dr Gillian Morgan has been appointed new chief executive of the NHS Confederation from 1 Feb. She is currently chief executive of N & E Devon HA.

Dianne Jeffrey, Confederation chair, said: 'Fresh from the frontline she brings strong acknowledged leadership skills, vision and in-depth experience of the NHS. She is ideally placed to lead the Confederation and develop the organisation as the NHS itself changes.'

**£55million for NHS LIFT**
NHS LIFT, the new public private partnership, will get a £55million package to improve and replace primary care premises in deprived parts of the country. It will be shared between around 2000 GPs in 600 surgeries over the next two years.

The new company, Partnerships for Health, made up of the DoH and Partnerships UK will own 50% each. It will build and refurbish primary care premises and lease them to GPs, pharmacists and dentists.

**Occupational health**
Launching NHS Plus, a new NHS network that sells occupational health services to the private sector, health minister Hazel Blears singled out Oldham NHS Trust and Parkside NHS Trust for providing 'exceptionally good occupational services'. www.nhsplus.nhs.uk

# Award of Excellence in CHD for Scotland

**Five projects within a Borders "Healthy Hearts Initiative" have together won the Primary Care Network (PCN) and University of Durham Award of Excellence in CHD for Scotland.**

Malcolm Chisholm, deputy minister of health and community care, joined Tony Taylor, Chairman, NHS Borders, Drew Tulley, Leader, Scottish Borders Council and Professor David Hunter, Professor of Health Policy and Management and chair of the Award of Excellence Panel of Judges to present the award at the launch of *In Fine Fettle* - one of the five projects.

Mr Chisholm said: 'Improving the health of the nation lies at the heart of the Executive's priorities and I welcome the fact that *In Fine Fettle* will continue this work. Good health will build a confident and healthy Scotland. Coronary Heart Disease, stroke and cancer are the three largest killers in Scotland but are largely preventable.

'This project will look at practical ways of achieving this, such as educating people about better diet and providing access to a wider range of foods at reasonable cost. It will also encourage more people to take up physical exercise and quit smoking. These efforts alone will go a long way to improving people's health and prove a good example to the rest of the country.'

He added: 'This award shows how joint working can have lasting and real effects for the community. All the entrants should be congratulated for their work in tackling heart disease. All these efforts will have real and lasting benefits. The work in the Borders shows what can be achieved when agencies work together. Tackling the root causes of heart disease will have the welcome effect of lowering the number of those dying from this illness and improving the health of the country as a whole".

Professor Hunter said: 'The CHD Award of Excellence in Scotland is an important initiative because it focuses attention on the importance of developing an integrated approach to primary and secondary prevention of Coronary Heart Disease. The *In Fine Fettle* project and its sister projects are excellent examples of partnership working across the different agencies and based on sound clinical evidence and have agreed targets and milestones.'

The judges unanimously decided NHS Borders and Scottish Borders Council should win because their entry:

- Was very clear and well presented
- Had evidence of strong and real partnership working in their primary and secondary prevention programme
- Had clear measurable targets

Tony Taylor, Chairman, NHS Borders said: 'I am delighted that the excellence of our local services for heart disease has been recognised through this award. We will be working hard to improve them even further over the next few years.

John Hughes, Health Care Development Manager, Merck Sharp & Dohme which sponsored the award said: 'We at MSD recognise if the NHS in Scotland is to achieve its challenging target of 50% fewer deaths from CHD by 2010 then primary and secondary prevention are vital. The local services in Scottish Borders address both. We congratulate everyone involved in this important work.'

The panel of judges included the PCN Editorial Board; Professor David Hunter, Chair of the Panel, Professor of Health Policy and Management, University of Durham and Council Member of the UKPHA; Professor Ross Lorimer, Chair of CHD Task Force in Scotland; Dr Trish Donald, GP and RCGP, Scotland and Mr Tom Divers, Chief Executive, Lanarkshire Health Board.

*For more information call the programme co-ordinator on 01896 825522 or email Fiona.day@borders.scot.nhs.uk*

# Managing risk in PCTs

With all NHS organisations required to have in place a robust system of internal control (fundamental for effective corporate governance), risk management has assumed an increasingly central role across the NHS (HSC 2000/005; 1999/123; 1999/065). The past year has witnessed a rapid expansion in the number of PCTs and the challenges posed by re-structuring and the modernisation agenda are considerable. It is vital that PCGs and PCTs draw on collective experience, so that best governance practice can be shared and common approaches to specific risk management issues developed. Using information from the PCT governance training programme run by the Controls Assurance Support Unit (www.casu.org.uk) this article outlines some of the key risks facing PCTs.

- For many PCTs, one of the major issues in embedding risk management within the organisation involves setting an appropriate context (culture) whereby risks can be continually identified, managed and information concerning significant risks passed up the organisation to the Board. This requires appropriate training to be provided to all individuals (from front line staff to Board members) and needs strong commitment and leadership at a senior management level. Equally, systems need to be in place to support this process so that the organisation can demonstrate that it has done its 'reasonable best' to protect patients, staff and other stakeholders against 'risks of all kinds'. Establishing such systems and developing potentially different patterns of work within a new organisation takes time and presents many challenges.
- Following any major re-organisation it is necessary to ensure that accountabilities concerning risk management are clearly defined and that all staff are clear as to their responsibilities.
- During re-configuration, it is important that organisations communicate key risks where appropriate and that responsibilities for risk management are defined within the change management process. Clear and accurate information needs to be passed from one organisation to another to ensure continuity in the management of risk.
- PCTs commonly have a number of services/functions provided through Shared Service Agreements (i.e.; finance; human resources; estates). Such arrangements may pose a risk to PCTs, especially in terms of accountabilities and business continuity. To provide an assurance to the Board that the PCT is not being exposed to increased risk through such arrangements, PCTs should determine that the provider(s) of such services have in place robust internal control systems. It is also important for the PCT to ensure that they are aware of their own accountabilities under such arrangements. Where PCTs work with other public sector bodies (i.e.; Local Authorities), the governance arrangements should be clearly documented.
- For risk management to be effective it is vital that all organisations within a local health economy work together to identify, communicate and manage risk. Whilst independent general practitioners (and practices) are not subject to the same DoH reporting requirements as PCTs regarding corporate governance, they are subject to a raft of legislation (Health and Safety, Fire etc) and are required to undertake regular risk assessments. Developing mechanisms to involve and support practices in risk management activities has been one way PCTs have sought to advance a primary care wide approach to risk management.

Effective risk management enables organisations to identify and analyse a wide range of factors which may impact on the achievement of organisational objectives. It also provides a systematic way to make informed decisions and gives an assurance to patients, staff and other stakeholders that the organisation is maximising opportunities and managing risk.

*Katherine Birch & Kim Donovan, research fellows at the Controls Assurance Support Unit (CASU)*

continued from page 1

budget will be put in the hands of front-line NHS staff – it is only right that local people also have a say in how that money is spent and what services it provides.

'Patients' Forums will give citizens a real stake in their own local health services by ensuring that the voices of local people are heard by GPs and trusts who will control 75% of the NHS budget and have the power to instigate real change at a local level.

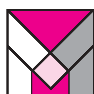
'These new structures have been further developed in the light of what we have learned from the listening exercise. I believe that these new structures will address the concerns and reflect some of the good ideas raised during the listening exercise. Local people will now, more than ever, have a real opportunity to get involved in the NHS and help to implement change at a local level. The NHS is a patient centred service and we intend to put the patient back where they belong – at the centre.'

The NHS Alliance said it planned to do everything in its power to ensure the document was turned into reality, and would be organising research and seminars over the next few months to see how the policy could best be organised on the ground.

It is also to support pilot projects in selected areas. Dr Michael Dixon, Alliance chair, said: 'The policy is good. Everything now depends on its implementation.'

Jackie Glatter, Senior Public Affairs Officer at the Consumers Association, welcoming the new structures, said: 'We are delighted that the government has responded to our calls for the setting up of a national patient organisation. This at last gives patients and the public a seat at the table of decision-making in the NHS.'

** The document is available at www.doh.gov.uk/involvingpatients/index.htm*



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# How to keep up the momentum for improvements in diabetes services

*Despite the delay of the Diabetes National Service Framework, PCOs must be encouraged to establish building blocks now for the long-term success of services says Paul Streets, Chief Executive of the charity Diabetes UK.*

*Paul Streets*

**The government announcement on October 16 by health minister Jacqui Smith of a delay in the implementation of the Diabetes National Service Framework (NSF) has dealt a serious blow to people with diabetes.**

Since the end of 1999 healthcare professionals and people with diabetes have been looking to the NSF to provide a lead in resolving the terrible variability of care which people receive in the UK. People with diabetes need early and effective treatment to reduce the risk of the complications such as heart disease which impose a massive cost on the individual and the NHS. This needs to be addressed sooner rather than later.

Faced with this setback it is now important that we do not lose the momentum which has been building towards improving diabetes care. The government is still committed to publishing the standards document this year. In order to ensure that when the delivery strategy is published next summer we are ready to act, it is important that everyone involved continues to work towards establishing the building blocks vital for long-term success, including:

- Establishing Local Diabetes Service Advisory Groups (LDSAGs) bringing together all the members of the diabetes care team including people with diabetes. These will play a key role in local implementation of the framework.
- Identifying local people to take the lead on implementation.
- Developing information technology locally to identify people with diabetes and ensure they are getting the care they need.

The Department of Health was concerned that the health service and particularly those in primary care were not yet in a position to deliver a Diabetes National Service Framework. This is a legitimate concern and it is why Diabetes UK has been calling on the government to ensure that the framework is properly resourced. Implementation will fail unless there are enough people on the ground with sufficient training, time and resources to provide individual care.

The delay in implementation has been a blow but it is one from which we must recover. Expectations are now higher than ever that a well planned, well resourced NSF which addresses the needs of people with diabetes will be delivered as early as possible. We must all now redouble our efforts to ensure that the framework is one that can make a real difference in diabetes care for everyone and that we are ready to act upon it as soon as possible. It is time for patients, health care professionals and the government to work together to achieve this.

## PCG TIPS: Books and reports

***Ethics. management and mythology rational decision making for health service professionals*** **By Michael Loughlin**

'This book will be a catalyst for change. Michael Loughlin's incisive, humane and at times outraged analysis of health management is an oasis of reason in an intellectual desert. It is essential reading for all health managers and policy-makers' says David Seedhouse in the foreword.

**Radcliffe Medical Press Ltd Tel 01235 528820**
**ISBN 1-85775-574-X Price £19.95**

***Leading edge - Rethinking performance management***

*'Why won't the NHS do as it is told - and what might we do about it?'* is the first of a series of three briefings published by the NHS Confederation. Only eight pages, it examines some fundamental problems with perceiving the organisation of the NHS as a machine. The second, *'Aligning what we say and how we behave'*, six pages, examines some striking contradictions between what is known about managing performance and how the system has been set up. The third, *'Rethinking the System'* is eight pages.

**Available from: NHS Confederation publications, DSI NE, Enterprise House, Rolling Mill Road, Jarrow, South Tyneside NE32 3DP Tel: 0870 4445841 Fax: 0870 4445842**

***Building an Electronic Disease Register***
**By Alan Gillies, Bev Ellis and Nick Lowe**

This clear, straightforward and practical book uses the example of a disease register to show how computers can work for you and not the other way around. It describes how to computerise patient records, implement systems to process them in accordance with best practice and available evidence and considers future developments, including the impact of the CHD National Service Framework.

**Radcliffe Medical Press Ltd on 01235 528820**
**£19.95**

***Key principles for the new GP contract***
**By Dr David Jenner**

There should be a single national contract, subsuming the current GMS and PMS arrangements and drawing them together under one umbrella says Dr Jenner in this set of key principles published by the NHS Alliance. It also suggests the new contract should be accompanied by a national public information campaign to educate patients about their own responsibilities as well as rights.

**Tel: 01777-869080 or at www.nhsalliance.org.uk**