

Primary Care Partnerships

JAN 2003 • ISSUE 6

Making YOUR Health Communities Work • www.primarycarepartnerships.co.uk

EDITORIAL BOARD

Shiena Bowen - Lay Advisers Lead on the NHS Alliance

Jeni Bremner - Programme Manager for Education & Social Policy, Local Government Association

Sue Carter - Chair, Primary Care Pharmacists' Association

Professor David Colin-Thomé - National Clinical Director of Primary Care, Department of Health

Donna Covey - Chief Executive, National Asthma Campaign

Dr Michael Dixon OBE - Chairman, NHS Alliance

Shirley Goodwin - UKPHA Council Member

Dr Barbara Hakin - Programme Lead, NatPaCT

Professor David Hunter - Professor of Health Policy & Management, University of Durham

Ken Jarrold CBE - Chief Executive, County Durham and Tees Valley Strategic Health Authority

Navin Joshi - Customer Marketing Manager, Merck Sharp & Dohme

Andy Murdock - Pharmacy Director and Superintendent Pharmacist, Lloyds Pharmacy Ltd

Dr John Oldham OBE - GP & Head of National Primary Care Development Team

Dr Stephen Wright - Consultant in Primary Care Medicine, British Association of Medical Managers

Lynn Young - Primary Health Care Adviser, RCN

EDITOR Jenny Sims

PUBLISHER Clive Johnstone

IN ASSOCIATION WITH: 

Modernisation Agency
The National Primary & Care
Trust Development Programme

nhsalliance



British Association
of Medical Managers



Royal College
of Nursing

Local Government Association

SUPPORTED BY EDUCATIONAL
GRANTS FROM:

Lloydspharmacy



MSD



Schering-Plough Ltd

PCT allocations devolve power and resources to the NHS frontline



John Flook

Unveiling the £148 billion three-year NHS programme, Health Secretary Alan Milburn set in motion the most radical changes to NHS funding and financial flows since the establishment of the NHS. John Flook, chair of the Health Services Management Association, comments on them.

Record increases in funding are accompanied by major changes to the allocation process. From April 2003 allocations go direct to the 304 Primary Care Trusts, bypassing the 28 Strategic Health Authorities. A new needs-based funding formula has been introduced and the allocations cover a three-year period to March 2006.

Announcing the changes to the House of Commons, Alan Milburn said 'For the first time locally run PCTs will receive funding direct from central government. This is about devolving power and resources direct to the NHS frontline. Short-term funding has hindered long-term planning for too long. This will give PCTs the power to plan with confidence and certainty for the longer term.'

There are significant changes to the formula used to calculate PCT target allocations (equitable share of available resources). Better measures of deprivation have been introduced and for the first time the formula addresses 'unmet needs' by comparing actual utilisation rates to standardised expected utilisation rates. The market forces factor has been changed to more accurately reflect geographical pay differentials and data from the 2001 Census has been used.

The impact of these changes on individual PCTs is not yet known but it is clear that the range between the most under target to

most over target PCTs is wider than under the previous formula.

Total NHS spending will rise from £56bn in 2002/03 to £74bn in 2005/06. Over the next three years PCTs in England will receive an additional £12.7bn, a cash increase of 30.8%. The increases for each year are £3.8bn in 2003/04, £4.3bn in 2004/05 and £4.6bn in 2005/06. In 2002/03 the average cash increase is 9.2%, ranging from 8.3% in a number of over target PCTs (including the Secretary of State's own constituency of Darlington) to 12.6% in Barking and Dagenham PCT. Over the three years the cash increases range from 28.08% to an unprecedented 42.61% in Tower Hamlets PCT.

The relatively high 'floor' increase of 8.3% provides 'real' growth to all PCTs whilst leaving scope for material levels of additional 'real' growth to under target PCTs. The Department of health claims that by 2006 the differential distribution of additional funding will ensure that only four PCTs will be more than 10% under target.

In 2003/04, £200m has been targeted to address capacity issues in a number of PCTs with particular problems meeting access targets. In the following two years £165m will be targeted at those PCTs with high labour costs.

Continued on Page 4

Editorial

Long campaigned for, long awaited and finally primary care gets the long-term funding it needs to improve planning and implementation of the local health services it wants (see John Flook above).

On the partnership front, there is a new spirit of co-operation between local government and the NHS, particularly on tackling health inequalities and 'prevention rather than cure.' Read Public Health Minister Hazel Blear's comments on page 2.

Also, on the partnership front, I would like to welcome two new co-sponsors of PCP; Merck Sharp & Dohme and Schering-Plough who join existing sponsors Lloyds Pharmacy.

This month sees the long awaited publication of the National Service Framework for Diabetes. If you have any more good news to share with PCP readers at the start of 2003, let's hear it!

Happy New Year

Jenny Sims, Editor

Zero Star Trusts

The DoH has published a Register of Experts to turn around poor management of zero star NHS Trusts. It includes more than 70 expert organisations from inside and outside the NHS able to tender to win the franchises to take over the management of poorly performing trusts. Health Secretary Alan Milburn said: 'No NHS hospital should be left to sink or swim. No NHS hospital should be denied the best management expertise available if than can improve the standards of care NHS patients receive.'

More information at

www.doh.gov.uk/nhsfranchising and
www.doh.gov.uk/performance/2002

Measuring PCT Star Ratings

New targets have been created for Primary Care Trusts which will be given star ratings for the first time this year by the Commission for Health Improvement (CHI). However, NHS Alliance Chair, Dr Michael Dixon has warned that PCTs will still be measured on areas beyond their control, the nature of the population and the quality of the organisations which preceded them. Instead, the ratings should measure clinical governance, engagement of clinicians and how care was being brought closer to the community, he said.

Mental Health Promotion

Greater prioritisation of mental health promotion is needed, backed up with real commitment and dedicated resources says a King's Fund report, *Promoting Health, Preventing Illness – Public Health Perspectives on London's Mental Health*.

It says the NHS needs to realise the cost-effectiveness of promoting health and well-being. By giving greater focus to the preventative agenda the NHS would be saving hard cash in the physical and mental health services.

Free at www.kingsfund.org.uk

Healthy Start Scheme

In response to the government's Healthy Start consultation on relaunching the Welfare Foods scheme for mothers and young children, the NHS Alliance has called for training for lay health workers as community nutrition assistants and health link workers. The Alliance has recommended that PCTs and Local Authorities be set joint targets for the creation of such posts as part of the priorities and planning framework. See the government proposals at www.doh.gov.uk/healthystart

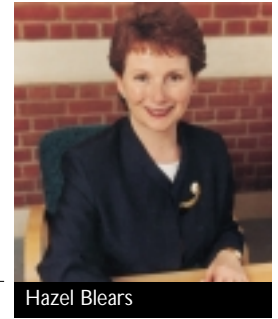
South/North Divide in the NHS

Trusts in the north and midlands have fewer areas of concern and stronger overall clinical governance assessment scores than those in the south and London, according to an analysis by the Commission for Health Improvement. Details at www.chi.nhs.uk

Partnerships in Public Health

Prevention is better than cure

The time is right for working together on tackling health inequalities says Public Health Minister, Hazel Blears.



Hazel Blears

Speaking at the *Prevention is Better than Cure* conference organised by the Local Government Association, the NHS Confederation and Faculty of Public Health Medicine, Ms Blears, a city councillor for eight years before she became an MP, said 'I feel really proud that local government and the NHS are now really beginning to work together on what I think is the most important agenda for our local communities.'

She added 'We are now at a point we can mainstream the whole public health agenda.'

John Ransford, Director of Education and Social Policy at the LGA, agreed that health inequalities are high on everyone's agenda and that public health was now a shared priority between central and local government.

Health inequalities transgress the boundaries between the NHS and Local Government and cannot be tackled by one organisation alone, which was why the NHS and Local Government should work together. There were potential barriers including:

- **Reorganisation fatigue**
- **Fragmented health/social services**
- **Struggle to compete with other priorities**

- **Recruitment and retention of staff**
- **Insufficient funding of health/social care**
- **Overcoming entrenched attitudes**

However, he argued there was no need to reorganise structures to work together, 'unless the purpose is helped by reorganisation.'

Joint working could be helped in the future by greater expenditure of inequalities, more inequalities performance measured and more joint training, appointments and capacity-building.

Dr Gillian Morgan, Chief Executive, NHS Confederation said the health of the public was the business of PCTs and local government. What made for fruitful partnerships between them was:

- Shared values
- Clear vision and objectives
- Trust, including willingness to share knowledge and information
- Realistic plans and timetables and
- Finding some quick wins to celebrate

Her message to delegates was 'Health is everybody's business but one size does not fit all in the inequalities agenda.'

Award of Excellence in CHD with Diabetes for Scotland

The North East Edinburgh LHCC 'Khush Dil' Happy Heart Project won this years MSD & Primary Care Partnerships Award of Excellence in CHD with Diabetes.

Malcolm Chisholm, Minister for Health & Community Care joined Mary Douglas, Development Manager at North East Edinburgh LHCC, colleagues from the Khush Dil Project and Professor David Hunter, Professor of Health Policy & Management and Chair of the Award of Excellence Panel of Judges to present the Award at a special luncheon in Edinburgh on 18th December 2002

Mr Chisholm said: 'I congratulate the University of Durham, Primary Care Partnerships and Merck Sharp & Dohme for extending this award north of the border. It covers a range of issues to which the Executive attaches great priority - the development of services which are culturally competent; closing the inequalities gap; creating a healthier nation by preventing disease; tackling Coronary Heart Disease, one of NHS Scotland's clinical priorities; and taking forward the work of

our Scottish Diabetes Framework.

'I know the project has involved the creation of many partnerships at local and national level but the North East Edinburgh LHCC has acted as the focal point. This is exactly the sort of role which we want to see LHCCs undertaking. It therefore gives me great pleasure to present Mary Douglas with this award on behalf of the North East Edinburgh LHCC.'

Continued on Page 3



Why has progress been slow on the development of Care Trusts?

Ray Jones, Director of Adult and Community Services, Wiltshire County Council, offers some answers.



Ray Jones

When the possibility was introduced in August 2001 (through the NHS Plan 2001) of introducing Care Trusts, responses ranged from seeing this as a considerable opportunity to create the framework for the delivery of integrated health and social care services to seeing it as a major threat to existing organisational and professional interest. Whichever response was elicited, it was understood that this was a major government commitment and it was the direction in which many of us felt that we would be moving.

For some of us within social care, it was felt to be important to get in early on the development of these new integrated health and social care organisations. This was seen as best ensuring that social care perspectives, principles and practice were fully considered and taken into account within what would become Care Trusts rather than Care Trusts essentially being a health-led organisation with social care added somewhat later as a marginalised and minority after-thought. We recognised that the then to be established Primary Care Trusts would be a major vehicle and platform for the establishment of Care Trusts, with the government having made it clear that Care Trusts would be NHS organisations.

The value of moving towards integrated health and social care services has been stated for some time. The research supporting the statements is somewhat more limited. However, within Wiltshire for example, a major study undertaken by the Wiltshire County Council/University of Bath Research Partnership (Brown, 2002), found statistically significant differences in favour of integrated health and social care services with improved access to services, (as defined by more self and family referrals) and a quicker response out to service users than was received from separate health and social care teams.

So, why has less progress been made than might have been anticipated in the development of Care Trusts?

Firstly, the government itself has become less of a clear champion for Care Trusts. Ministerial changes and the somewhat timid government response to what might be seen as vested interest opposition to Care Trusts, has meant that the government's statements about Care Trusts have become somewhat equivocal. Care Trusts are now seen as one of a range of options to move towards more integrated health and social care services. Sometimes it seems that the Secretary of State does want to promote a major push on Care Trusts. On other occasions Care Trusts appear to have slipped on the political agenda.

Secondly, there are outstanding issues with regard to what a Care Trust would actually be. There is continuing lack of clarity about the governance arrangements for a Care Trust with Department of Health guidelines leaving this essentially to local resolution about the extent of Local Government participation and representation within Care Trust Boards.

There is also a continuing lack of clarity and practical guidance about the accountabilities for Care Trusts. With regard to Local Government, for example, how are Care Trusts to be held to account for the delivery of the performance indicators against which local authorities are currently themselves rated within a national star system, both for social services and now for the local authority overall through the comprehensive performance assessment of the local authority? How also is it to be ensured that there are strong enough financial accountability mechanisms to support the transfer of considerable sums of local authority funding (including funding generated through the council tax) to NHS Care Trusts?

Thirdly, there has been considerable instability within, in particular, the NHS since 2001. The very sudden demise of Health Authorities

and the replacement by Strategic Health Authorities, the merger of NHS Trusts and the change from Primary Care Groups to Primary Care Trusts, have all led to considerable change, in organisational structures and in key personnel, at a time when a more solid platform would have benefited the development of Care Trusts. In addition, in many areas there is the destabilising influence of deficit funding for local health services, with the message now coming through that a priority for local NHS managers is to bring expenditure back within budget. Social Services nationally have also, in many areas, been experiencing overspends and have been making more and more demands on local authority overall budgets.

There is, therefore, the very real possibility that because of lack of central drive and guidance, the opportunity to create a new framework for integrated health and social care services may be lost. The government needs to face up to the scenario that an agenda it set may now, because of its own lack of attention and promotion, lose impetus and impact.

In the meantime, those of us who are committed to the development and delivery of integrated health and social care services will continue to make progress to bring operational and strategic services together but whether this will lead to the roll out across England of a major programme of Care Trusts will depend on the government's vision and commitment.

Reference

Brown, L., Tucker, C., and Domokos, T. (2002) *The Impact of Integrated Health and Social Care Teams on Older People Living in the Community*, University of Bath/Wiltshire Social Services Research and Development Partnership.

Award of Excellence in CHD with Diabetes for Scotland (cont'd) from Page 2

Introducing the Awards, Professor David Hunter said: 'The Award of Excellence in CHD with Diabetes for Scotland, now in its second year, remains an important event because it celebrates and raises the profile of valuable and often innovative, efforts to develop integrated preventive approaches to CHD that place people and their communities at the centre of developments. The North East Edinburgh LHCC 'Khush Dil' Happy Heart Project is an excellent example of such work focusing on South Asian people. The project only started in May this year but already its part-time staff have demonstrated significant progress in engaging with numerous partner organisations to provide a range of new initiatives for local people.'

Mary Douglas, Development Manager at North East Edinburgh LHCC, said: 'I would like to thank the Minister for the Award and MSD for their sponsorship and support which

encourages innovation in the management of Diabetes and CHD in Scotland.

'The success of the 'Khush Dil' project is down to the commitment of the project team lead by Gill Mathews and Anita Bhatnagar, who are working incredibly hard above and beyond the call of duty. Close working and involvement with voluntary and community groups and the commitment of community leaders also plays a large part in the project's success. Khush Dil is not just the 'adaptation' of existing services and has been designed specifically for an identified 'at risk' sector of our LHCC population, recognizing and respecting their cultural requirements to ensure they can access the health care services they need.

'The project is initially funded for one year and is due to finish in May 2003, hopefully, recognition through Awards such as this will encourage further funding to allow the

valuable work to carry on. Thank you again.'

Dr Peter Leslie, Consultant Physician and Helen Clark, Diabetes Nurse Specialist from Borders and Borders West LHCC, the runners up for this year's Award were also present at the lunch.

For More information on the Khush Dil Happy Heart Project call Mary Douglas on 0131 536 8836 or email mary.douglas@ipct.scot.nhs.uk

Our new sponsors



MSD Schering-Plough Ltd

A new partnership in
cholesterol management

Medical Aspects of Intermediate Care

A new report from the Federation of the Royal Colleges of Physicians of the UK considers the organisation and co-ordination of intermediate care schemes for older people in the UK. It examines how intermediate care can best be formalised to provide the best quality care for patients and meet the targets in The NHS plan and *National Service Framework for Older People*. **Price £7 (inc p&p) from the RCP Publications Department on 020 7935 1174 ext 358 or see website www.rcplondon.ac.uk for ordering details**

Primary Solutions

An independent policy review on the development of primary care mental health services

People with mental health problems need much more support from primary care services according to this report published by the Sainsbury Centre for Mental Health in association with the NHS Alliance. It argues that over-stretched GP services are frequently unable to offer the level of care needed by people with mental illnesses but it shows that innovative approaches to primary mental health care do exist and can work.

Price £12 (plus p&p) ISBN 1 870480 56 2 Available at 020 7827 8352 or online at www.scmh.org.uk

Protecting Smokers, Saving Lives Royal College of Physicians Report

Tobacco is a uniquely dangerous consumer product, which kills over 100,000 people a year in the UK, says this major report. It calls for a Tobacco and Nicotine Regulatory Authority to protect public health in the UK. The RCP first made this recommendation in its report *Nicotine Addiction in Britain* two years ago. Since then, its Tobacco Advisory Group has been investigating possible options for such a regulatory authority.

See website www.rcplondon.ac.uk for ordering details.

Great to be Grey: How can the NHS Recruit and Retain more Older Staff?

By Sandra Meadows

One in seven workers in the NHS (about 150,000 people) are aged 50 years or over. This report finds that experienced and skilled older workers are retiring early from the NHS in ever-increasing numbers due to heavy workloads, long hours and low morale. It warns the government that its modernisation plans are in danger unless older people are encouraged against taking early retirement and more older staff are recruited to fill vacant health service posts. It also says the NHS should adopt flexible working practices such as those pioneered by some private sector employers.

Price £8 Available from the King's Fund bookshop on 020 7307 2591 or at www.kingsfundbookshop.org.uk

PUBLISHED BY:



Medical Management Services

Creating Successful Partnerships

Medical Management Services (UK) Ltd
24 Gay Street, Bath BA1 2PD
Tel: 01225 333711 Fax: 01225 422533
Email: enquiries@medman.co.uk

How charities are backing up health services



Donna Covey

Donna Covey, Chief Executive of the National Asthma Campaign (NAC), explains how charities can help health professionals

Campaigning health charities can sometimes be seen as yet another source of trouble for the health service, with their calls for improved services and demands for higher standards of care. The smart health professionals, however, know that health charities can add value to their work, providing services that complement their care and bring real benefit to the patient.

At the NAC, we make no apologies for being so vocal in calling on government to make asthma a national and local health priority. Like all health charities, we want healthcare provision for our cause to be exemplary. Yet we recognise that this cannot be achieved in isolation and that charities can play a useful role in the process by supplementing advice and care for patients.

The period immediately following diagnosis is a critical time for people with asthma. They are hungry for information and need guidance and advice on managing their condition. Up until October 2001 there were no free, easily accessible materials specifically targeted at newly diagnosed asthma patients. In a move to fill this void, the NAC developed new materials that were given to health professionals free-of-charge to be issued to all people with newly diagnosed asthma. *Asthma and Me* and *Asthma and My Child* provided information on asthma management as well as support and reassurance. In this way, the charity aided the role of health professionals by providing a written resource that the patient could take away and read to remind

them of the advice in the consultation.

Living with asthma raises many questions and concerns that the average consultation doesn't always have time to cover. For this reason, the NAC set up the Asthma Helpline (Tel. 08457 010203). Receiving over 15,000 calls a year, the Helpline is staffed by asthma nurses who have the time to discuss issues which have often only occurred to callers after they have left the clinic or surgery. A call to the Helpline gives people with asthma the information they need, puts their mind at rest and saves an extra appointment. Many other charities have similar helplines.

Many patients are increasingly turning to the web as a primary source of information on their condition. Health charity websites can offer a vital information service, providing advice and information that is both independent and patient focused. The NAC's website www.asthma.org.uk helps people to understand their asthma and achieve a better quality of life.

Through delivering high-quality advice and information resources, health charities can bring real benefits to patients and healthcare professionals alike.

For more information on the National Asthma Campaign call 020 7704 5888.

If you are interested in attending a workshop on reducing hospital admissions by improving community respiratory services please email enquiries@medman.co.uk

PCT Allocations (cont'd) from Page 1

The funding previously earmarked for the rejected Consultant Contract has been distributed to PCTs but for now, the funding for the new GP Contract is retained at the Department.

Otherwise the amount of central 'ring-fencing' of resources has been dramatically reduced. In recent years managers have criticised the level of 'ring fencing' for reducing local flexibility and being counter productive in achieving targets.

Mr Milburn said: 'The allocations to PCTs include resources to finance the costs of pay reform, new drugs and treatments and additional NHS capacity. They include the commitments that we set out in the NHS plan. However, none of the growth money has been identified for specific purposes. PCTs will be able to use these extra resources to deliver on both national and local priorities.'

The Healthcare Financial Management Association welcomed the three-year allocations and the level of the increased funding but warned that directors of finance will require much more detail than is currently available to be able to shape local financial strategy.

Three year allocations will allow PCTs to start developments with more confidence that funding will be available ending much of the 'stop-start' nature of NHS planning. PCTs will be able to plan the use of

resources more flexibly. There may be more opportunity to plan brokerage between years with the Strategic Health Authority.

However, with new opportunities come new responsibilities. NHS managers will have to manage risk across three years. This will mean estimating inflation levels, additional prescribing costs and the cost of *Agenda for Change* pay deals.

PCTs will also need to prepare for the introduction of new financial flows from April. The technical guidance and standard tariffs were announced shortly after the allocations. Although the new 'Payments by Results' arrangements are being phased in, by 2005 they will cover the bulk of secondary care spending and present significant risk management problems for PCTs and NHS Trusts.

Many PCTs will start 2003/04 needing to find funding for uncovered recurrent spending increases from 2002/03. Primary Care prescribing spending has increased significantly as GPs implement NSF and NICE recommendations. In most PCTs the increases have exceeded the budgeted funding.

So, record additional funding, certainty about its distribution and opportunities for better forward planning but some current funding pressures to be addressed and increased risk to be managed. PCTs will continue to face a challenging agenda in the foreseeable future.