

Primary Care Partnerships

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New GP contract good for doctors and patients but challenging for PCTs



Dr Michael Dixon OBE

The proposed new GP Contract is a welcome prescription for general practice and primary care says NHS Alliance Chair Dr Michael Dixon OBE.

For patients, the contract carries the promise of improved access, higher clinical standards and a new focus on personal and patient-centred care. For GPs, it will reward those who work harder and provide better care.

Indeed, a significant percentage of the payment that GPs receive will depend upon the quality of care. They will also be able to control their workload without finding that they are being asked to do more and more without the necessary resources and staff to do it. Recruitment and retention in general practice is likely to be further helped by greater flexibility in out of hours work, 100% reimbursement for IT and improvements in the forced allocation of patients to GP lists.

For PCTs, the proposals extend a much needed one year's grace to get things in place – particularly the new out of hours arrangements. With them come 33% extra funding over the next three years for improving and modernising general practice but the call on PCT resources is likely to be much greater. For instance, those practices performing highly in the ten clinical areas are likely to see a sharp increase in prescribing costs, which will put pressure on the PCT's unified budget.

The contract will also give added momentum to the development of locally enhanced services though some PCTs may have difficulty in establishing these as quickly and widely as they might wish (even though money for such services has been theoretically included in their baseline allocations).

Overall, the contract represents a vast improvement on the current GMS contract, which lacks accountability and effectively penalises GPs that provide better care for their patients. It is also a great improvement on the proposals that GPs voted on last year. NHS Alliance has campaigned for a less bureaucratic and more patient-centred contract, which is now being realised with the introduction of three tier (rather than five tier) quality markers and with 20% of quality payments being related to personal care.

There is also a recognition that both the patients and other professionals (particularly pharmacists) have a role in reducing the demands on GP time. Meanwhile, the government has also won its battle with 48-hour access to a GP being a further quality payment.

Will the proposed contract help GP recruitment, which has fallen from 50% of doctors wanting to enter general practice in the 1980's to a figure of just 20% today? The problem is that today's GPs feel that their work is under resourced, under supported, under appreciated but that they are evermore being asked to do more.

The proposals appear to offer the support, resource and recognition that they have been asking for. They could be the best chance in years of restoring general practice to its place as the 'jewel in the crown' of the NHS. A service that is modernised and accountable but where personal care still matters. Will GPs sign up to this vision? I hope so.

Editorial

The new GP contract has been negotiated between the BMA's General Practitioners Committee, the NHS Confederation and the four UK health departments but the negotiating team members were still battling to reach agreement 'right up to the wire' before the 'historic document' was launched on 21 February.

Speaking at its press launch, Dr John Chisholm said there had been some compromises all round but it offered 'huge extra resources for patients care and a much needed and major boost to GP earning through rewards for the delivery of high quality care to patients.'

Resources for general practice will rise by 33% over the next three years from £6.1 billion per year to £8 billion by April 2006.

Ballot papers have been sent to all 42,000 of the UK's GPs who have to vote by 11 April. It is certainly not just about money but if accepted, parts of the new contract will come into effect immediately and some GP could receive a 10%-50% pay rise. Other practice staff will also benefit from the new weighted formula based on practice workload and patient need.

Jenny Sims, Editor

New pharmaceutical services

Health Minister, David Lammy has given the green light to 14 new Local Pharmaceutical Services (LPS) pilots. Each has a dispensing element but some will provide a range of other services, such as focusing on patients 75 and over, and training and education for patients, carers and pharmacists. Mr Lammy said: 'I am keen to invite more PCTs to submit proposals for the next wave of LPS pilots. The closing date is 1 September 2003.'

Fraud reward

Pharmacists in England and Wales will be able to claim a £70 reward for identifying a fraudulent prescription or providing information leading to an investigation into pharmaceutical patient fraud, Health Minister Lord Philip Hunt has announced.

Pharmacists eligible for claiming the reward in England should contact the NHS Counter Fraud Squad on

Freephone 0800 068 6161 or for Wales, Health Solutions Wales on 029 2050 0500.
www.doh.gov.uk

Abolition of CHCs

Community Health Councils will be abolished, as planned, on 1 September, the government has confirmed. Patients fora will be in place as soon after that date as possible said Health Minister, Lord Philip Hunt. The Association of Community Health Councils has warned there could be a six month gap with 'no effective patient representation or scrutiny' until the new system is fully set up.

Bowel cancer screening

The government has agreed to develop a national bowel cancer screening programme but has not yet decided which method (either faecal occult blood testing or flexible sigmoidoscopy). Next month (April), Bowel Cancer Awareness Month, the charity Colon Cancer Concern will be making people aware colon cancer is the second largest cancer killer in England.

www.coloncancer.org.uk

Seizing the Day

A joint NHS Alliance and Royal College of Nursing Conference, *Seizing the Day – nurses redesigning healthcare in Primary Care Trusts* is to be held on 17 March, Royal Society of Medicine, London. Speakers include Dr David Colin-Thomé, National Clinical Director of Primary Care and Dr Beverly Malone, General Secretary, RCN.

For details call Yvonne Hunter on 0121 248 3399 or visit
www.nhsalliance.org

Obesity poll

Fifty five per cent of women think they are overweight compared to 33% of men, but only 13% of people who want to lose weight consider consulting their GP, according to a survey by the National Obesity Forum.

Details at
www.nationalobesityforum.org.uk

Integrated Care Network**Joining up health and social care services**

Health and social care organisations seeking to integrate services can get practical help from the Integrated Care Network. Shane Giles, its Director, explains how.



Shane Giles

The Integrated Care Network (ICN), launched by the government six months ago, provides an infrastructure of assistance, advice and support to frontline agencies seeking to improve service planning and delivery through integration.

Anyone seeking to integrate services needs information about configurations that have worked well, demonstrated good practice and have high quality. The ICN provides this.

Co-ordination of Resources

Though a wide range of resources for integrating services has been available, they have not always been well promoted or co-ordinated. The ICN is remedying this and co-ordinating development of these resources, which include:

- Frontline agencies with knowledge and expertise in integrated working
- Representative bodies such as the Association of Directors of Social Services, Local Government Association, Improvement and Development Agency and the NHS Confederation
- The National Primary and Care Trust Development Programme
- The Health and Social Care Change Agent Team
- The Department of Health
- The Office of the Deputy Prime Minister
- Strategic Health Authorities
- Academic Institutions.

Training Programme for Facilitators

There are a number of teams supporting various aspects of development within frontline organisations such as: NatPaCT's Area Facilitators; the Health and Social Care Change Agent Team; the Office of the Deputy Prime Minister's Strategic Partnerships Taskforce and the Valuing People Implementation Team.

The ICN has developed a programme of training for them which was launched in January.

National Meetings

The first bi-monthly, national meeting to engage, inform and update frontline agencies looking to integrate services was held in January and was attended by more than 200 health and social care workers.

Toolkit on Human Resource and Partnership Issues.

ICN is currently commissioning a toolkit to assist the development of integrated services.

Mental Health Care Trust Network

ICN has commissioned Birmingham University to support the development of these Trust sites through individualised and national support mechanisms. The two-year programme was launched in January.

Developments

ICN is:

- Launching a website this month (March).
- Currently liaising with the Directorates of Health and Social Care and Strategic Health Authorities to help forward the integration agenda within their geographical areas. We are particularly keen to help build local networks and action learning sets.
- Exploring the possible involvement of academic institutions to support us and the integration projects of health and social care communities.

Contacts

If you would like to receive updates on Network activities please send your details (name, job title, organisation, email address and telephone number) to mbicn@doh.gsi.gov.uk.

If you would like to discuss how you could be part of or use the Network please contact either **Shane Giles on 0113 254 3804 or Jeremy Hallett on 07971 580869.** Alternatively email either at mbicn@doh.gsi.gov.uk

Letter

On 17 January 2003, the Office of Fair Trading (OFT) published its report on the impact of control of entry regulations on the retail pharmacy market in the UK, following a year-long investigation by the OFT's Markets & Policy Initiatives (MPI) division.

The report concluded that the existing control of entry regulations (which help protect access to pharmacy by vulnerable patients, such as the elderly, those in rural areas and those on low incomes) distorted competition in the pharmacy market and resulted in increased costs for consumers. It therefore recommended a sweeping deregulation.

This position is heavily lobbied for by some supermarket pharmacy operators, despite the fact that the report found the regulations are working well for patients – giving them high levels of access to community pharmacy and high levels of satisfaction. The report also found no evidence of excess profits for pharmacy companies.

It can be argued that patient satisfaction levels, coupled with the introduction of the NHS LIFT process and an invigorated Local Pharmaceutical Schemes (LPS) programme (of which the second wave of 14 were recently announced) give enough flexibility at local level to meet everyone's future needs.

However, if implemented as is, the OFT's recommendations could have a significant impact not only on the pharmacy market but on patients and healthcare planning in general.

The potential market destabilisation could raise doubts about meeting government targets set in a myriad of health and public health policy documents! (especially around drug abuse and EHC)

Andy Murdock, Director of Pharmacy & Superintendent Pharmacist Lloydspharmacy

*Readers' views on this topic are welcomed. Please email enquiries@medman.co.uk

Can PCTs combine both roles successfully?

There are powerful arguments for the dual role of the Primary Care Trust (PCT) as commissioner and provider, particularly focused on securing a patient-centred NHS, says Ailsa Claire, Chief Executive, Barnsley PCT and Cathy Edwards, Head of Collaborative Services, NORCOM



Ailsa Claire



Cathy Edwards

The successful management of both roles poses a significant challenge to PCTs, particularly where the provider function is large.

There are situations when the two roles conflict and the leadership and management roles are different. Clarity about and the development of specific skills for the two functions are required. Credible commissioning requires transparency and even-handedness.

PCTs must collaborate to discharge their commissioning function for specialist services and there are clear advantages to sharing skills and expertise.

Consistent, well-managed clinical networks, advised by and advising the commissioning are vital.

Barnsley PCT (established in April 2002), population approximately 235,000, has a provider function which includes integrated mental health, care of the elderly and physical disability services as part of a comprehensive pooled budget and integrated provider arrangement with Barnsley Metropolitan Borough Council (MBC).

The PCT businesses unit, the 'provision' side, is managed separately from our commissioning function.

The provider function is subject to the same contract monitoring/negotiation processes as any NHS provider and responds to the specifications/contract monitoring of Barnsley MBC for the integrated services.

The provider performance management, including all governance arrangements, is overseen by the Professional Executive Committee (PEC).

The medical director is responsible for all medical staff, including consultants and PCT salaried GPs, and the director of public health will be a joint appointment with Barnsley MBC and run a joint public health department in both organisations.

The PCT commissions specialist and other services via consortia arrangements across South Yorkshire and North Trent.

The Consortium – NORCOM – comprises the PCTs in South Yorkshire, North Derbyshire and Bassetlaw. NORCOM is a joint sub-committee of the 13 PCTs and there is a formal establishment agreement which defines the membership, the working arrangements and lines of accountability.

A central specialist team of 12 people is hosted by Barnsley PCT to support the activities of NORCOM. The member PCTs fund the work

of the NORCOM through a capitation based levy. Each PCT leads and provides expert advice to an area of work.

NORCOM achieves commissioning of specialised services and supports the development and maintenance of clinical networks which work within a common framework.

Working with the provider Trusts, NORCOM develops, maintains and monitors the seven existing clinical networks. Each network has dedicated network management support as well as a lead clinician and where appropriate a lead nurse. Several more clinical networks are envisaged in the future.

The main focus of the specialised services work is the planning and review of services and agreeing a common framework for local contracting. The central team co-ordinates a limited pooled budget for selected high cost procedures to reduce financial risk. All the other service budgets continue to be held by the individual PCTs.

NORCOM thus reinforces PCT responsibility for specialist services commissioning, ensures economy to scale, sharing/developing of expertise and proper support to networks.

Opinion

Foundation Hospitals are a 'step in the right direction' to the democratisation of the NHS says Dr Roger Bolas, Chief Executive, Easington Primary Care Trust

The government's announcement of a major new player in the healthcare market place has been the subject of a great deal of speculation. What are the functions of this new organisational form? Why are they necessary? What are the dangers and what are the opportunities that they will bring with them?

I believe that there is no mystery here. Foundation Trusts will develop hospital services and they will have a vested interest in running those services as an integral part of the local health and social care system. Foundation Trusts and PCTs have a common interest in reaching the challenging waiting times targets. Each needs the other to manage the pressure of referral and to streamline services to separate emergency from planned services.

The key to understanding why they are necessary can be found in health ministers' frustration at the length of time it takes to radically improve the patients' experience of the NHS. If those Trusts, which are

acknowledged to be among the best in the land, are given the freedom to innovate while remaining locally accountable, the momentum of service modernisation will accelerate.

Foundation Hospitals represent a major step forward in public and patient involvement in the NHS. Not only will the boards of governors be built up from local people and local interest groups but also local communities will have a direct say in how they are run. There are some risks attached to this approach. People are very supportive of their local hospital and find it difficult to stomach the idea that local is not always best when it comes to the provision of specialised services.

Nevertheless, we can't modernise the NHS in a vacuum. There are many good examples of high trust initiatives where sharing the need for change with local people and with the workforce leads to creative solutions and better value for money to the public purse. The arrival of Foundation Hospitals will provide the catalyst for doctors and nurses

in hospitals, primary care and community settings to sit down with local people and thrash out how best to address local issues. They won't make difficult issues go away. They will provide much needed realism to the debates about resources, training, buildings and involvement of the private and voluntary sector in managing services that are patient-centred, responsive, co-ordinated and affordable. That has to be a step in the right direction.



Dr Roger Bolas

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A new partnership in cholesterol management

Auditing Age Discrimination: A practical approach to promoting equality in health and social care

By Ros Levenson

Research shows that tackling age discrimination is too low on the agenda of many health and social care agencies. Staff and managers struggle to recognise ageist practices, says the author who offers practical guidance on how organisations can work to eradicate age discrimination. **Available from the King's Fund bookshop on 020 7307 2591 or www.kingsfundbookshop.org.uk £15 (£7.50 voluntary organisations)**

Ensuring the effective discharge of older patients from NHS acute hospitals

By Sir John Bourn

More trusts should start discharge planning earlier says this National Audit Office report. Other recommendations include: NHS Trusts and PCTs should involve private sector care providers more in the planning an development of older people's services; delays in the non-acute sector should be investigated further and patients and carers should be more involved in discharge decisions.

**Available at: www.nao.gov.uk
Hard copies from The Stationery Office on 0845 702 3474 £10.75 ISBN 0102920621**

Patient Information What's the prognosis?

By Wendy Garlick

This Consumers' Association report identifies where people are not getting any information or are missing out on the right data. Patient groups, industry and the government contributed to the report, which makes recommendations on how to address the deficiencies.

£20 To order a copy, call 0845 924 5000, quoting reference PAINFO

Mental Health Services in Primary Care - A review of recent developments in London

By Rebecca Rosen and Clare Jenkins

There have been improvements in the overall quality of mental health services in London and in liaison and communication between primary care and specialist mental health services, but not in all areas. The report contains a number of recommendations for PCTs on service development and capacity. **Available from the King's Fund bookshop on 020 7307 2591 or www.kingsfund.org.uk**

Smoking Cessation Matters in Primary Care

By Marcus Munafo et al

This practical guide offers a straightforward review of up-to-date evidence and shows how primary care teams can develop a comprehensive and effective smoking cessation strategy for their patients. It clearly explains the organisation of national smoking cessation services and offers contacts for resources on setting up a service in the practice.

£24.95 ISBN 1-85775-442-5 Online ordering at www.radcliffe-oxford.com

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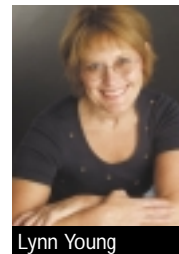
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Will they or won't they?

Nurses vote soon on whether to accept the proposals in the government's Agenda for Change document. Lynn Young, Primary Health Care Adviser, Royal College of Nursing says they should have faith in its potential.



Lynn Young

Agenda for Change (AfC) has arrived, following four long years of hard slog and tenacity but hopefully will prove in the longer term, to be worthwhile negotiations. Pay modernisation is here and the expectations of front line staff are, with justification, high. The details are now publicly available to all and RCN members have been advised by their General Secretary and Council to vote in favour of implementation.

If the vote is a positive one, the end of clinical grading for nurses is nigh and a more modern, appropriate and positive salary scale lies ahead but disappointment is already being voiced by groups of nurses, so progress might be difficult to achieve. Much energy is required to help raise understanding and awareness among nurses of what the wider and future implications are.

First, AfC is not about significant, above inflation pay rises in the short term.

Second, AfC is more about facilitating an attractive and appropriately rewarded nursing career - for those nurses who want it and have the talent to rise to the challenge of increased responsibilities.

Third, AfC is about terms and conditions of services and high quality continuing professional development, aimed at the provision of better services, as well as the salary received by nurses at the end of the month.

Fourth, it is a system which aims to reward high level decision-making, leadership and clinical skills - not necessarily the title held by particular nurses.

Therefore - and this will be a difficult message to get across, similar titled nurses could be banded differently. For example, practice nurses could be banded 5, 6 or 7 and district nurses and health visitors at 6 or 7.

AfC focuses on job evaluation and looks at many disciplines working within the NHS - it does not include the medical profession

who negotiated themselves out of the system! Jobs were profiled by looking at the following factors:

- Responsibility
- Freedom to act
- Knowledge
- Skills
- Effort and environmental.

Bandings range from 1 (domestic assistant) to 8 (consultant midwife) and salaries start at £10,000 with a maximum of £54,000.

However, there is more work still to be done, so the full picture cannot yet be properly assessed. Gateway points leading to a higher band can only be achieved through the acquisition of enhanced knowledge and skills but the anticipated skills and knowledge framework is still not complete and will not be fully implemented until 2006.

So, it feels that AfC is more about the future than the here and now which could be hugely frustrating to many nurses who have expanded their roles and responsibilities beyond all recognition since the early days of NHS modernisation.

Nurses need to have faith in the potential that AfC holds for their profession. A challenging and financially rewarding career could lie ahead for a large number of able nurses but at the same time we can safely anticipate many difficulties and conflicts in the near future.

The early Trust implementers will, without doubt, be under the spotlight and some tough lessons need to be learnt. The pilot sites need support from colleagues, so that genuine progress is achieved, not dishonest but seductive spin, which could lead to many nurses voting with their feet - and walking away from healthcare.

For more information visit: www.rcn.org.uk

Death of directorates of health and social care

The four directorates of health and social care are to be disbanded, employees learned in a letter from NHS Chief Executive, Sir Nigel Crisp.

The letter promised a completely remodelled department by 2004. The recently established directorates employ more than 400 staff in London and Leeds.

They were set up, following the *Shifting the Balance of Power* reorganisation, to be responsible for overseeing the development of the NHS and social care, assess the performance of health and social care services, guide senior NHS staff, improve public health and provide support to ministers.

Critics suggest the action has been provoked by government concerns about its delivery agenda. There was no prior public announcement and the news has surprised managers and other staff.

Ken Jarrold CBE, Chief Executive, County Durham and Tees Valley Strategic Health Authority, said: 'It is a major shock.

They were only set up 12 months ago and now they're closing. It doesn't look like good management.

'The issue for PCTs is that they need to be working with Strategic Health Authorities to see what it means for them.'

Keeping the NHS Local: A New Direction of Travel

Smaller local hospitals will be supported to develop new roles at the heart of local communities, Health Secretary Alan Milburn has said.

New guidance on the NHS.* challenges the mindset that 'biggest is best.' It outlines ways local hospitals can be helped to provide patient-focused care while ensuring staff are supported to work safely without excessive workloads. Consultation ends 14 May.

*Available at www.doh.gov.uk/configuringhospitals