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The NHS Alliance and NatPaCT would like to thank the Primary Care Trusts – and the many doctors, nurses, allied health professionals, pharmacists, managers and support staff – who gave their time so generously for this publication.

The NHS Alliance is grateful to the National Primary and Care Trust Development Programme, part of the NHS Modernisation Agency, for its support for this publication.

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## CLINICIANS AND PCTs IN THE NEW NHS

Two years on from *Shifting the Balance of Power*, very many examples of good working relationships between PCT's and their clinicians are transforming health services for patients and the public. In April 2004, we contacted the various NatPaCT and NHS Alliance networks for PCT leaders, including managers, GPs, nurses and other primary care professionals. This is the stunning result. It demonstrates the **can do** attitude of clinicians and PCT managers working together to make a difference. This sample bodes well for the future of PCTs. As a catalogue of success of clinician engagement and service improvement in over 100 Primary Care Trusts it will help others realise the potential this brings for change.

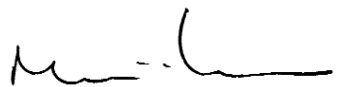
These tales of success do not come from managers and clinicians aiming to please superiors and meet national targets. They are voluntary submissions, whose foundations are sheer enthusiasm, pride, public service commitment and a wish to show how clinicians in Primary Care Trusts are making a real difference. That is the significance and weight of this document. It reveals a developing success story, which follows a period of rapid change, when PCTs have had to fight hard to engage clinicians and become effective commissioners. This work shows that it can be done and that it is being done. It should provide inspiration, hope and some practical examples that will inspire clinicians and commissioners within every PCT to innovate and improve services for their patients.

The importance of effective engagement with front-line clinicians in delivering the NHS reforms cannot be underestimated. This rich selection

demonstrates that clinicians up and down the country are actively involved with their PCTs in strategic decision making, redesigning and improving services, ensuring good practice and improving local health. Both the diversity of professional groups and also their enthusiasm for their work is extremely positive.

The NHS Plan was a ten-year plan. But already, Primary Care Trusts, commissioners and the clinicians that work within them are beginning to show substantial evidence of achievement. This is only the beginning but it provides a sound base for sharing and celebrating success. It is an accolade for Primary Care Trusts and a call for them to go further in engaging clinicians in redesigning services and ensuring that services commissioned are used cost effectively. It is a story of success. A story where there is no room for complacency. The battle goes on but this document shows that the battle for a modern NHS can be won.

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# Introduction

**It is hard to overstate the importance of primary care trusts and their clinicians engaging with each other. Unless they do so, the NHS will suffer severe paralysis.**

As the drive continues to devolve more and more decision-making powers to organisations on the front line, and with the allocation of three-quarters of the health service's budget to PCTs, primary care professionals have a chance to exert real influence over the direction of change as never before. To do so, they must become vigorous participants in the system; if instead they choose detachment, the NHS reform programme will be scuppered. Clinical engagement will make the difference between success or failure.

'Only connect' should therefore become the motto of primary care trusts and their clinicians.

Effective clinical engagement has the potential locally to improve services, enhance the patient's experience and the outcomes of their treatment, boost staff morale and aid recruitment and retention, while helping achieve national policy objectives. But clinical engagement must amount to more than a vague sense of belonging, and it must encompass not only GPs, but nurses, primary care practitioners and allied health professionals.

Clinicians who are genuinely engaged with their PCT know they are fully informed about its priorities and able to influence its agenda. They share the PCT's aims and are committed to helping achieve them. They feel like members of the PCT and are treated accordingly, enjoying mutual support and trust whether they are independent contractors or direct employees. They are ready to work with each other across organisational and professional boundaries, sharing expertise and speaking with one voice. They take part in the PCT's management, planning

and decision making - as an integral component, not an afterthought. Their participation may be through membership of the professional executive committee, representation on sub-committees and working groups or professional forums, or less formal altogether. And the enthusiasm of the most involved percolates to those on the front line who inevitably are less so.

For its part, the PCT must allow its clinicians to be involved, and anticipate who will need to be involved in future as change takes hold. It should ensure its clinicians have access to any education and training that will facilitate their participation. The PCT that is engaged with its clinicians recognises the tensions that may arise from trying to reconcile such participation with demanding workloads. Members of its senior management team will have a real knowledge and understanding of clinicians; they will appreciate the importance of harnessing clinicians' enthusiasm and skills if they are to create dynamic and cohesive organisations. They are prepared to look beyond immediate business and the routine grind of reaching targets to invest time and energy in nurturing relationships that will bring long-term but lasting dividends. A PCT knows it has engaged its clinicians when it simply cannot ignore them and clinicians eagerly choose to be involved because the value of being so is self-evident to them.

These benefits - for clinicians themselves, their professional group, their patients and the health of the wider community - must be clear if engagement is to happen. Clinicians have practical daily experience and specialist skills to



contribute to PCTs. In return, PCTs can offer clinicians opportunities to work beyond hands-on clinical boundaries. The shared focus on procuring and providing high-quality care is a potent combination for bringing about massive gains.

Obstacles to clinical engagement in PCTs cannot be ignored. In places they are formidable. Some PCTs are subsumed in the culture of targets to the detriment of all else; some are less interested in engaging with clinicians than exerting firm managerial control over every aspect of their business. GPs in particular are reluctant to take part in some PCTs' agendas, whether because they are alienated by the prevailing culture they find, are sceptical that it would lead to better services or fearful that a closer relationship would render them vulnerable to unwarranted scrutiny and interference, stifling bureaucracy or restrictions on their professional autonomy. For others, the relentless burden of their workload deters them from even contemplating involvement.

Yet, as the wealth of examples in this report shows, clinicians and their PCTs are engaging with each other up and down the country to notable effect. In commissioning, service provision and local health improvement, clinical engagement is proving that it is the way forward for the NHS. Where it is encouraged to flourish, a world of possibilities opens.



# 2 Commissioning

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**If PCTs are to plan local health services effectively - and improve on them - they must tap into the expertise and experience of the whole spectrum of frontline clinicians, whose contribution is essential to forming a comprehensive view of health and care needs.**

Commissioning must be shaped by active communication with, and the free flow of information from GPs, practice nurses, dentists, pharmacists, optometrists and other allied health professionals. They should be involved across the spectrum of commissioning, from assessing need to monitoring performance (though not all clinicians need to be actively engaged all the time). Clinicians with relevant experience should be encouraged to become commissioning leads where appropriate.

Yet a danger exists that primary care professionals may feel much less involved in their PCT than other NHS staff groups do in their organisations. After all, practices had no say in which PCT they were allocated to. PCTs are comparatively new organisations, and several may have been created by dividing one health authority or a single PCT formed by amalgamating several primary care groups. Most clinicians are physically located not in the PCT itself but in general practices or community clinics. The advent of the PCT will probably have brought no immediate change in their terms of service or their day-to-day business. A PCT may therefore risk appearing remote or irrelevant, or having its role misunderstood, if it fails to engage its clinicians and offer them a route to influencing how it is run, how services are redesigned and patients' care pathways defined.

However, examples abound of PCTs that are beginning to do this successfully. The prize is a strategy that has credibility 'on the ground' and which ensures that decisions are appropriate to both patients' and practices' needs.

## How PCTs are engaging clinicians in top-level decision-making

Frontline clinicians can engage and be involved in shaping and making decisions through the PCTs' professional executive committee, forums, professional groups and networks.

Determining priorities is always difficult, and getting ownership of them even more so. In response, **Adur, Arun and Worthing Teaching PCT** has developed a forum for its clinical PEC members and clinical directors at Worthing Hospital. The forum examines developments in prescribing, referral management and clinical evidence, and determines how to apply them locally. 'This is now the main priorities forum for the health economy, and is beginning to flex its muscles for the benefit of patients,' says PEC chair Dr Alison Smith. The forum has recently decided to stop the investigation of patients with uncomplicated microscopic haematuria, and not to discharge patients prescribed benzodiazepines unless they were taking them when admitted. 'Small steps, but wholly owned and effective,' says Dr Smith.

**Durham Dales PCT** has delegated powers to its PEC to commit up to £100,000. 'This means that all our clinicians are keen to be on the PEC,' says its chair, Dr Stewart Findlay. 'We have full representation from all independent contractors, and almost everything the PCT does is driven by clinicians.' As a result, the PCT has well developed IT systems, a strong record on implementing national service frameworks - particularly coronary



heart disease - and a well established out-of-hours system that is run mainly by the PCT and pre-dates the new GP contract. 'The key is to let PEC members have both the power and the responsibility to make purchasing decisions - this really guarantees clinical involvement,' says Dr Findlay.

Meanwhile, **East Devon PCT** plans to devolve budgets for all commissioning decisions to GPs in stages, providing incentives to examine alternatives to referrals. So far, almost half have agreed to be involved in the initial stage. The PCT has convened a high-level steering group, including the PCT chief executive, to ensure the project's progress continues. These delegated responsibilities will offer practices incentives to innovate and develop new models of service provision.

**Bristol North PCT** pays practices to send a representative to regular GP clinical forums. 'We use these as an excellent way of testing out the appropriateness and acceptability of clinical plans as well as capturing the concerns of local professionals,' says PEC chair Dr Will Warin.

'Clinical engagement is a major strength of **Darlington PCT**,' according to its director of primary care, Carole Harder. The PCT has produced a strategy for strengthening clinical engagement and leadership in the coming years. It has teams of clinical leads for all key areas in each practice. 'This group is helping us shape patient services and primary care commissioning via the personal medical services contract, which applies to 100% of our practices,' says Ms Harder. The PCT also has a multiprofessional nurse development group, nursing leads for disadvantaged communities, integrated nursing teams and leads for key service development and clinical issues. Staff attend national leadership training, and the PCT has invested over £500,000 in nursing staff, the

introduction of healthcare assistants and new nursing roles.

**Morecambe Bay PCT** boasts involvement of GPs in many aspects of its business. It offers secondment opportunities for them to work more closely with the PCT. Sessions for this work are funded by the PCT, and ensure good communication between GPs and the organisation. Staffing levels in multi-handed practices enable colleagues to cover the GPs' absence while they are on PCT business. The PCT also employs three part-time practice nurse facilitators for 11 to 15 hours per week. They plan the PCT-wide practice nurse forum meetings that are held twice a year, promote and find placements for practice nurses and nurse practitioner trainees, ensure that practice nurses' training and development needs are met and advise practice nurses on issues that arise within general practice.

Four neighbourhood teams in **Blackburn and Darwen PCT** are led by clinicians 'to give a local focus to the PCT and national agenda,' explains PEC chair Dr Malcolm Ridgway. 'This more or less coincides with council social services neighbourhoods, which will improve partnership working with them,' he says. The PCT has incentive schemes covering areas such as quality standards and referrals to encourage clinicians to help it achieve targets, and it boasts a large number of clinical leads covering topics from coronary heart disease to drug misuse.

PEC members at **Telford and Wrekin PCT** have 'portfolio' responsibilities reflecting NSFs and other national and local priorities. They sit on local implementation teams to influence commissioning with other stakeholders. Each member reports progress on their portfolio work to the whole PEC meeting. Matters needing the whole PEC's decision are tabled and given more air time. 'Overall, documents are managed fairly well so

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that we are all clear on where progress is being made or not,' says PEC chair Jo Banks.

The PCT has introduced the new role of GP advisors to the PEC. 'This came about due to clinicians' workload, and hopefully addresses some of the succession planning to the PEC which we will face,' explains Ms Banks. Three advisors have been appointed so far; each is paid and has a job specification. 'I want to ensure that the purpose of the PEC remains as the organisation grows,' says Ms Banks.

One of **Sedgefield PCT's** greatest successes has been its clinical policy board (CPB), which comprises PEC members and clinical leads - GPs and nurses who individually lead, mainly for commissioning purposes, in specific clinical areas. At least half the PCT's 50 GPs lead on something. The CPB gives clinicians an opportunity to discuss the clinical implications of policy in detail - which the PEC would find too time-consuming - and is able to involve all interested clinicians. It meets monthly, reports to the PEC and is supported by the chief executive and commissioning director.

**North Peterborough PCT** supports forums for GPs, practice managers, and receptionists. Each is chaired by a member of the PCT primary care team, except for the GP forum, which is chaired by a local GP and attended by the PEC. Director-level input from the PCT clearly signals the importance of these groups for the PCT's business.

In **South Sefton PCT** 'clinical champions' - a team of doctor and nurse or therapist working alongside modernisation managers - examine specific topics. Diabetes, chronic obstructive pulmonary disease, heart failure, falls and children's health have been covered so far; unplanned care will follow soon.

**South Somerset PCT** has a newly established multidisciplinary clinical forum with members from primary and secondary care who plan to look at

joint initiatives, beginning with stroke services. Their future programme will cover each national service framework, as well as musculoskeletal services.

**North Tees PCT** appreciates that maintaining clinical engagement requires hard work. It visits practices annually, holds PCT education events, publishes newsletters, organises a multi-professional forum, provides GP welcome packs and has set up links to its teaching PCT college.

Education events are an important aspect of clinical engagement at **Heart of Birmingham PCT** too. Protected learning time was introduced initially for GPs and practice staff, but now covers all employed and contracted staff. The PCT funds locum cover for GPs to attend monthly formal teaching sessions, which are based in practices every other month. Nurses, dentists and allied health professionals have their own quarterly discipline-based forums, while the pharmacists' forum meets bi-monthly.

About 20 to 30 GPs attend the monthly GP forum held by **West Lincolnshire PCT**. At least one from each practice attends a meeting with the PEC GPs and selected PEC management or guest speakers. This is an open forum where a wide range of issues are raised: common views or problems on community and hospital services, current service delivery and commissioning issues, future service planning - and whether it chimes with GP opinion - reaction to national issues, such as out-of-hours services, the GP contract or patient choice. It also provides an opportunity to find out whether service delivery could be augmented or efficiency improved by any networking of practices.

In addition, West Lincs holds a monthly 'clinician to clinician' meeting at the local acute trust, where PEC GPs meet consultants, together with PCT and trust managers, to discuss common issues and solve cross-organisational problems. Topics have



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included the use of diagnostics, outpatient referral triage, the use of the medical assessment unit and the performance of two-week cancer and chest-pain referral clinics.

The PCT's visiting schedule ensures each of its 40 GP practices has at least one annual visit from a team that comprises a PEC GP, a non-executive and a director. The team meets the practice GPs, nurses and manager. 'The purpose of the visit is for a two-way exchange of issues and perspectives, and to engender continuing close working on a range of initiatives as well as problem-solving,' says PEC chair Dr Peter Calveley.

Nurses working for **New Forest PCT** have their own newsletter to keep them informed of local issues and the local implications of national initiatives, the result of the PCT's GMS nurses' day, at which nurses shared ideas and concerns. The PCT is also planning a pilot project that involves practice nurses mentoring pre-registration students for the first time. 'Student nurses do not normally get placements in general practice, and this pilot highlights the need for that to change,' says Paula Hull, professional lead for practice nursing and dental nursing. 'If we are to affect recruitment and retention in primary care we need to bring student professionals into general practice to see how things have changed.'

The PEC is strengthening its links with practitioners through a multiprofessional advisory group to ensure the PCT agenda is sensitive to local clinicians' needs. In addition, primary care forums for all staff have been held in the evening. 'The purpose has been to engage clinicians in the agenda-setting for the PCT, and to raise awareness and concerns regarding the new GMS contract,' explains Ms Hull.

Community nurses in **Trafford** have set up a professional nurse council that operates across both PCTs to enable them to send and receive information to the PEC, as well as encourage

nurses' innovative ideas. The group helps individuals to solve problems, win support and gain confidence. It has access to a small budget, and successes include introduction of a drop-in clinic in an area of traditionally poor appointment attendance, increased support for young parents and fire-prevention training for all staff to increase their awareness of risk prevention strategies in people's homes.

**Burnley, Pendle and Rossendale PCT** has professional advisory forums in each constituent borough, based on the former primary care group locality forums. The forums are multi-disciplinary, meeting regularly to discuss working practices, conditions and PCT policy. Their discussions feed into the PEC agenda, with PEC members invited to attend their borough meetings. The PEC uses feedback and discussion from the forums as part of its decision-making process.

Allied health professionals too are getting together to develop local strategies: for example, the *Strategy for Allied Health Professions in Bedfordshire 2004-2007* applies across PCTs and trusts. AHPs have also compiled *Making it happen in West Hertfordshire: an overview of the West Herts Therapy Service Review 2002-2003*.

In **Doncaster** an allied health professions college covers three PCTs, and AHP PEC members are elected from it. The college's main aims are to facilitate two-way communication between AHPs and PCTs and to act as a forum for developing AHPs in community services. Key clinical topics are discussed at away days and 'paperless meetings'. 'Buddy' arrangements have paired AHPs with PEC members for one-to-one discussions about their roles and involvement in the PCT.

In **Torbay and Teignbridge PCT**, allied health professional PEC members hold drop-in sessions to update staff on PCT business. Discussions have included the PEC representative's role, communication networks, progress on integrating

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health and social care, the local delivery plan, the effect in the community of appointing an extra orthopaedic consultant at the district general hospital and problems with the occupational therapy kitchen in a community hospital. PEC representatives encourage staff to take formal and informal opportunities to meet and talk to the PCT board, other PEC members and directors.

**North East Lincolnshire** has a clinical and therapy (CATS) group, where allied health professional service leads meet monthly and have found issues in common. The group allows AHPs a powerful and effective common voice. Often one representative will go to meetings from the group to represent all professions, pooling resources and saving time.

**Mansfield District PCT** has set up an AHP modernisation forum to develop a strategy and annual action plan including leadership, workforce, clinical governance and public health. All AHPs are represented, including those from the acute trust.

**West Hams and South Devon PCT** has developed good AHP networks and clear lines of managerial and professional accountability for all AHPs, whether managed within the PCT or one of its partner organisations.

## Engaging clinicians in redesigning services and care pathways

A NatPaCT redesign programme has brought clinicians together in Dudley to develop a primary care model for looking after complex-needs patients in the community in response to a local private finance initiative project. ‘We have won the hearts and minds of our clinical colleagues in the acute trust and other local PCTs,’ says Dr Steve Cartwright of **Dudley Beacon and Castle PCT**. ‘But most importantly our own clinical workforce is buzzing with enthusiasm at the new approach and the improved care we are giving our patients. We

are achieving change against resistance and challenging the old commissioning style of the NHS.’

Key features are provision of a nurse consultant for the 100 most commonly readmitted patients, rapid-care co-ordinators in nurse teams and a practitioner with a special interest in medical assessment. A locality structure with a population base of 50-70,000 ensures special attention is paid to areas of deprivation and disease prevalence.

**Tower Hamlets PCT** has involved its clinicians in negotiations with its local acute trust on ‘small but important schemes’, such as a specialist pharmacist to support monitoring of hospital-prescribed complex medications, a single pathology helpline for test results that eliminates the need to telephone different laboratories, and a unified structure for anticoagulation clinics instead of separate clinics being run by different departments. Clinical leadership on musculo-skeletal commissioning and education has revealed need and led to initiatives such as a physiotherapy triage scheme to reduce unnecessary referrals to rheumatology and orthopaedics.

In **North and East Cornwall PCT**, a team of clinicians from all disciplines who were to work in a new, £7m 52-bed community hospital was involved at every stage, meeting architects and PFI partners throughout the two-year design and construction period.

Clinicians and commissioners from across primary, secondary and tertiary care in the **South West Peninsula Cardiac Network** have been involved in radically redesigning patient flows for cardiac surgery, including pre-assessment in primary care, commissioner-held waiting lists, alternative providers and follow-up in primary care. This has taken place alongside the redesign of heart-failure services. ‘This work has involved considerable



clinical engagement, and would have been impossible without the multi-professional team being involved in strategic steer of the work as well as frontline involvement,' says the network's programme manager, Lorna Potter.

**Airedale PCT** and Airedale NHS Trust are taking part in a three-year care pathways project with Durham University. The project is mapping pathways across all parts of health and social care. The PCT and the acute trust have a well established joint clinical meeting every six weeks, which is a forum for senior clinicians and managers to discuss joint district-wide visions for service change.

Engaging clinicians has helped **Welwyn Hatfield PCT** shift treatments from secondary to primary care. For example, over 90% of dermatology referrals are now seen in four general practices, and the PCT is looking to host this service on behalf of North Hertfordshire and Stevenage. It is also hoping to extend the work of its musculo-skeletal assessment team there too. Out of the team's first 1,000 consultations, less than 30% had to be referred to an orthopaedic consultant. The PCT would next like to develop primary care services for patients with certain neurological conditions.

Welwyn Hatfield has restructured its counselling service to focus on assessing patients' needs, developing an appropriate counselling care pathway and providing a stepped approach to psychological therapies with a single point of access for referrals. It has also set up a process to secure professional accreditation and registration for all counsellors along with training in brief psychological interventions.

**North Tees PCT's** philosophy is to try to use clinical engagement as an integral part of its management and development strategy. Its clinical leads in commissioning and in primary and community development are both closely involved in redesigning services. They belong to small teams

that work with PCT directors and staff to develop and improve services, which have included COPD outreach, rapid-access chest pain, musculo-skeletal services and a new out-of-hours service. Clinicians have been involved in designing new practices in deprived parts of the PCT and in specialised PMS practices for refugees and drug misuse. Nurses have led the PCT's community service nursing review, joint assessment of patients with social services and development of nurse leadership.

**Bristol North PCT** is in the process of establishing service improvement networks (SINs), jointly led by clinicians and managers, to examine quality and service redesign. The GP and clinical forums have identified priority areas, while the SINs are posing questions such as: what sort of service would we like to see available in every practice, and what services could be provided for some practices to a wider population than their own patients?

The clinical modernisation group in **New Forest PCT** has helped make possible the closure of a former Victorian workhouse used for elderly care with the savings invested in locality teams. It has also overseen the complete revision of gynaecology services, reconfiguration of GI services with joint surgical/medical working, one-stop clinics and training for nurse endoscopists and the development of pain care and a pain-management programme within the PCT.

Much of the work on the treatment centre project at Shepton Mallet has been led by **South Somerset PCT's** clinical steering group, which has examined the impact on other services and is involved in disseminating information about the project.

The GPs, practice nurses, district nurses, health visitors dentists and other clinicians from **Maldon and South Chelmsford PCT** have joined with local residents to form a group that is committed to ensuring health services are provided as close to home as possible. With the group's support, GPs

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funded a one-year pilot ultrasound project managed by the PCT, which commissioned an organisation to provide a comprehensive clinical and administrative service. Patients waited no longer than four weeks for an appointment, and GPs received results on the same day of testing, with advice from a radiologist within 48 hours if required. The scheme has now been implemented trust-wide.

**Brighton and Hove City PCT** is exploring whether pharmacists could initially be involved in identifying undiagnosed COPD patients and later managing them, perhaps using supplementary prescribing. It is also developing a minor ailments service run by community pharmacies to relieve pressure on GPs while increasing choice and access for patients.

After an extensive review, **Cambridge City PCT** set up an integrated community occupational therapy service. This has had an impact across the system, with improved patient care and management of those with complex needs, fewer patients needing admission to hospital, earlier intervention and discharge, more scope for patients with terminal conditions to remain at home or live at home longer and better multidisciplinary team-working.

**In Barnet PCT** a specialist multidisciplinary team - doctor, nurse, pharmacist, physiotherapist, occupational therapist, speech and language therapist and dietician - has been set up in primary care to improve access for patients to clinical specialists, reducing the workload in secondary care and freeing consultant time for more complex cases.

**Fareham and Gosport PCT** provides in-reach occupational therapy services to Portsmouth acute hospitals. Since the redesign of elective orthopaedics, elderly medical care, over-65 stroke rehabilitation and community OT services, the first OT to assess the patient usually follows them

through their journey from the acute hospital and rehabilitation to their home. For people with long-term illness receiving help from social services occupational therapy, their social services OT follows them through, into and out of the health system. All OTs are empowered to recommend and manage basic grant work, including stair lifts.

A clinical forum for GPs, consultants, clinical directors, chief executives, senior managers and secondary care staff to discuss problems with care pathways has been set up by **Horsham and Chanctonbury** and two neighbouring PCTs. Meetings last no more than 90 minutes. 'This means that decisions on changing care are agreed then and there, and the final decisions validated on the night,' says PEC chair Dr Jace Clarke. Topics discussed so far include orthopaedics, ENT, urology and gynaecology. Changes as a result include direct access for GPs to the tonsillectomy waiting list, consultant acceptance of referrals from physiotherapists for back pain and from cytologists for abnormal smears, pre-operative assessment at the time of the consultant outpatient appointment and the setting-up of an acute trust website for patient information.

District nurses have led their own comprehensive review of their service with assistance from the Audit Commission in **Herefordshire PCT**. A district nurse initiated the project and managed it, and its far-reaching recommendations will be taken to the PEC for discussion. 'The district nurse service is keen to take forward radical changes following this approach to review,' says Trish Jay, the PCT's lead executive nurse and director of operations.

**Sussex Downs and Weald PCT** is undertaking a wide-ranging clinical services review. 'It has brought together managers of community hospitals and community services with clinical staff, and is leading to integration of disciplines and agencies,' says Lynne Thomson, director of nursing, operations and primary care. 'It has been



particularly effective in bringing members of the community rehabilitation teams and district nurses together, as well as health visitors and school nurses, to improve resource availability and care pathways for clients locally as part of the NSF for older people's services and the green paper, *Every Child Matters*,' she says.

**Teignbridge PCT**'s modernisation lead is head of physiotherapy services for South Devon, covering two PCTs and an acute trust. She has led work on modernising back pain services locally as part of the Modernisation Agency's orthopaedic collaborative, and has reviewed stroke services across three PCTs, an acute trust and two social services departments, resulting in revised guidelines. Both projects involved a range of clinicians. Triage has now been introduced into physiotherapy services, with patients referred to secondary care by physios, who will also list some patients for surgery. The service has introduced a physiotherapy consultant, and extended-role physios work alongside medical staff. It is planning to implement direct access for patients, reducing the need for GPs to refer.

When a hospital consultant, nurse practitioner and PEC members revisited patient pathways in **East Yorkshire PCT**, the result was a nurse-led primary care endoscopy service and urea breath-testing clinics in each locality, led by healthcare assistants.

**Sedgefield PCT**'s nurse representative, a health visitor and a dermatologist in secondary care developed guidelines to manage eczema in primary care.

A GP and the acute trust's medical directorate led development of a stand-alone computer system for **Northamptonshire Heartlands PCT** that generates a discharge summary when a patient leaves hospital so that no other letter is needed.

'Feedback has been terrific,' says PEC chair Dr Leszek Piechowski. 'It undoubtedly helps to crack a really old chestnut - the less than useful discharge summary.'

Clinicians in **South Leicester PCT** have worked closely with University Hospital Leicester to change the referral pathways available to GPs for imaging, reducing the number of unnecessary x-rays, particularly of the spine, and opening up access to MRI and CT scanning. It has recently launched direct cataract referral, which could potentially mean all 6,000 cataract patients a year following this route.

Community optometrists are working with **Ealing PCT**, Ealing Hospital and local GPs to provide diabetic retinopathy screening using digital retinal photography. Agreement was reached on a joint approach, with GPs registering diabetes on the chronic disease register and Ealing Hospital offering patients a choice of appointment with either the hospital, a health centre or an accredited community optometrist. It is planned to extend the service to more optometrists, using NHSnet to transfer the retinal picture.

Primary care dieticians in **Leeds** have supported development of care pathways which are the basis of service redesign and commissioning by producing and distributing across the city's five PCTs and hospital trust a *First Steps Guide to Diet for People with Diabetes*. The guide is evidence-based and provides a consistent message to patients for the cornerstone component of diabetes care.

**Redbridge PCT** reports that podiatry waiting times have been significantly reduced through service redesign and changes in working practices.

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# 3 Service Provision

**PCTs that succeed in engaging their clinicians can reap rich rewards when it comes to providing services for their populations. If clinicians are open to new ways of working and ready to be flexible, PCTs can help them lead the way in breaking down professional boundaries and improving teamwork, which can lead in turn to better access to services and more choice for patients, more appropriate use of services and better uptake.**

In this way, PCTs can alleviate the workload in secondary care by reducing referrals, follow-up appointments, avoidable admissions and delayed discharges - all of which will have a beneficial effect on waiting times. They can also eradicate gaps in care provision, whether affecting geographical areas or particular demographic groups.

### How engaging clinicians is helping PCTs improve access, expand capacity and extend the reach of primary care

**North Peterborough PCT** has set up a peripatetic 'parachute team' to help practices improve access to services for all, but particularly patients who find it most difficult, such as those from minority ethnic groups, asylum seekers, homeless people and travellers. The team comprises one full-time GP, two full-time specialist nurses, 1.6 whole-time equivalent healthcare assistants and a half-time outreach worker. A practice must apply to the PCT to use the team, and a 'contract' of engagement is agreed. The team will be 'parachuted' into a practice to take over from the practice staff and do their clinical work while the staff take time out to consider their own solutions for improving access. The team offers advice and facilitates change where it is needed.

North Peterborough is a designated cluster area for asylum seekers, and two practices agreed to accept registrations from this group. However, they struggled to keep their lists open to new

patients due to the additional workload and staff turnover. The PCT now supports one of these practices to act as an induction centre for general practice services, manage all new-patient screening and provide any necessary treatment. After six months most patients are invited to register with another practice for continuing services. All practices are on a rota to receive assigned patients to maintain equity of workload.

The PCT has also established and funded a 'violent' patient scheme, to which patients who are violent, or who threaten violence, towards practice staff are referred for six months. If they need primary medical services, they must attend the police station to see one of four police surgeons. GPs are said to value the scheme. Patients have a right of return to 'normal' general practice services after six months, but will be assigned to a practice different from their original one. In its first year of operation eight patients have been referred to the scheme.

**Nottingham City PCT** has opened a general practice as a personal medical service site for unregistered patients unable to access healthcare services, such as refugees, asylum seekers and homeless people. It has also set up a scheme to provide specialist home teams, supported by community psychiatric nurses and specialist occupational therapists, to help people with dementia live in their own homes.



The scheme is run in partnership with the social services department, and received the Queen Mother Award for Innovative Practice.

**Tower Hamlets PCT** has developed a general practice to meet the specific needs of homeless people. Premises have been created to meet these patients' health and other needs, such as shower facilities.

In **East Kent Coastal PCT**, Dover Medical Practice, which has a large number of patients with complex or multiple needs and drug and alcohol-dependency issues, has developed an integrated team to provide a patient-centred approach to primary care services. It includes GPs, nurses, health visitors and a practice manager, as well as representatives from drug and alcohol services, mental health services, social services, charities and the local council; other agencies will be included when needs arise. As a result, on-site services are being developed that improve client uptake and provide faster access to specialist services.

In nearby Aylesham, the same PCT is piloting joint working by a district nurse and a care manager. They will be providing joint monthly drop-in sessions at warden-assisted flats and residential homes, which will also be open to the public. The sessions will improve access and appropriate use of other services, as well as promote independence and enhance elderly people's quality of life. The PCT envisages that the pilot will focus on adult services in Aylesham that are currently lacking.

Meanwhile in Thanet, the PCT is piloting an early-support team to identify through a single assessment process low-level vulnerable families with children aged up to four years. 'The service is a chance for midwives, health visitors, GPs and social workers to work together in preventive roles, minimising the need for future crisis intervention,' says Vanessa Chidwick, the PCT's project manager for community services. Envisaged outcomes

include a reduction in the number of children entering the child protection process, professionals working more effectively together and an increase in the uptake and appropriate use of services.

A primary care nurse-led service treats patients with suspected deep vein thrombosis in the NHS walk-in centre at Arrowe Park Hospital, Wirral.

**Birkenhead and Wallasey PCT** developed the service in partnership with doctors, nurses and pharmacists to reduce waiting times and avoidable hospital admission. Since the end of 2003, it has seen over 200 patients - most referred by their GPs - of whom a quarter were suffering DVT. In addition, the PCT's intermediate musculo-skeletal service (IMS) has helped reduce waiting times to see consultants at Arrowe Park. All referrals for any musculo-skeletal service are directed to a central triage, from where they are sent to the most appropriate service for their condition: orthopaedics, rheumatology, physiotherapy, the back pain service and IMS clinics. These last are staffed by GPs with a special interest and by extended-scope practitioners with nursing support.

By engaging GPs, hospital clinicians, pharmacists and their staff, **Sheffield South West PCT** has designed a service to monitor patients on oral anticoagulation therapy in primary rather than secondary care. 'We are particularly proud of this service as it bridges professional and primary/secondary care boundaries, delivering a much better patient experience as a consequence,' says Andrew Hartley, pharmacist member of the PEC. 'Discussions had taken place in Sheffield for more than 10 years to try and agree the transfer. The health authority and then the PCTs had considered virtually all conceivable scenarios, but had previously been unable to agree on a model or the funding.'

The scheme involves pharmacists or trained staff performing the test in the pharmacy, and the GP taking clinical control of the dose adjustments.

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Referral criteria and standard operating procedures have been agreed with secondary care. The patient does not need an appointment and the test takes only a few minutes, so it is not disruptive even when the pharmacy is busy. This means GPs can ask a patient to test every other day when necessary, without causing the patient inconvenience or discomfort. The service has improved patients' understanding of their condition and its management, and is viewed positively by other stakeholders. 'This is a whole-team approach to facilitating access for all patients,' says Mr Hartley.

Community pharmacists in **Brighton and Hove** have enabled warfarin monitoring to move from secondary to primary care - more convenient for the patient as less travel is involved, and likely to make savings in ambulance transport costs. The area has a high level of substance misuse, and as part of the new GMS contract community pharmacists will offer needle-exchange services and manage patients undergoing supervised consumption of methadone. The PCT has also commissioned pharmacies to offer specialist medicines-management services to patients who have difficulty taking their medicines. This includes pharmaceutical assessment, domiciliary visits and provision of compliance aids. Some provide medicines-management support to patients with Parkinson's disease, while other specialist pharmacies offer smoking-cessation services.

Community pharmacies in **Hillingdon PCT** deliver a primary care diabetes-management service, available to all adults taking medication for the condition. Each patient has a consultation with the pharmacist at least six times a year. Pharmacists agree referral criteria with GPs for problems such as intolerable side-effects, that cannot be resolved in the pharmacy.

In **Camden**, the Greenlight Pharmacy provides an outreach diabetes service to the Bangladeshi population with type-2 diabetes. It includes a

review of patients' medication, monitoring of blood pressure and group education sessions as well as lifestyle advice.

Specially trained community pharmacists in **Barnet** assess selected patients and offer them blood-pressure monitoring and urine testing with the aim of identifying undiagnosed hypertension and/or diabetes. When appropriate, patients are referred to their GP.

In **Hull** and **East Yorkshire**, patient hospital discharge information is faxed to community pharmacists for high-risk patients - such as those aged 75 or over on complicated dosage regimens - if hospital admission has been due to medication problems. The community pharmacist visits the patient at home for a medication review, liaises with the GP, produces a care plan and continues to monitor the patient.

Community pharmacists in **Stockport PCT** carry out annual medication reviews in the homes of older people identified as being at risk of medicine management problems by social services, Age Concern and secondary care.

In **South Derbyshire**, all five PCTs fund the Southern Derbyshire Medicines Support Service, aimed at any patient who has problems taking or managing their medicines. Twenty community pharmacists have completed training, including an MSc module on the pharmaceutical care of older people. The assessing pharmacist contacts the patient's GP and regular dispensing pharmacist for details of current medication and medical history. The patient is visited at home, with the carer or referrer if appropriate. Joint visits are made with the key workers for mental health patients, and with learning disability nurses for their patients. The visit includes a full medication review, assessment of the patient's needs and a discussion about the medicines to develop a tailored pharmaceutical care plan. A copy is given to the patient or carer, referrer and dispensing pharmacist, and a letter is sent to the GP.



This is a busy service with over 1,500 referrals received to date.

In **Richmond** community pharmacists provide care for patients with mental health problems, since the closure of the Richmond Royal Hospital pharmacy. The scheme enables patients to follow a treatment path designed specifically for them, which may include monitored dose systems, instalment dispensing at pre-agreed intervals and a regular dispensing process. A rapid-response system enables community pharmacists to access consultants or nurse specialists, should additional care, advice or compliance issues need to be discussed.

In **Harrow and Hillingdon PCTs**, 20 community pharmacists have agreed to be organised in a rota for a week at a time to ensure that medicines from a pre-determined list and oxygen are available within one hour of a request by a GP from the local out-of hours co-operative visiting the patient at home. The service involves the pharmacist dispensing a prescription at the pharmacy, and operates from midnight to 9am, seven days a week.

**North Sheffield PCT** has an older people's specialist team working with GPs, nurses and therapists that offers support and development to nursing and residential homes. Care homes are invited to participate in a structured approach, which aims to reduce avoidable hospital admissions by providing care in the patient's home. The programme comprises intensive case management methodology and intensive practice development. 'The programme is being evaluated, and although it is too early to provide conclusive evidence, early indications are very positive,' says the PCT's assistant director of health improvement and service delivery for older people, Linda Tully.

North Sheffield's south Asian diabetic patients have language and cultural differences that can lead to poor clinic attendance and non-compliance. In response the PCT has set up an Asian diabetic

support group, which provides publicity, educational information, guest speakers and transport. The diabetes local implementation team, a city-wide joint planning group facilitated by the PCT, is reviewing the current model of care for patients. The proposed new model increases the PCT's role in diabetic patient management, providing a better-quality and more accessible service to patients.

Each consultant geriatrician in Epping Forest holds a weekly multidisciplinary conference involving social workers, occupational therapists, a physiotherapist, the discharge co-ordinator, ward managers, intermediate care lead, modern matron and staff-grade nurses. 'The older people's services directorate in **Epping Forest PCT** has always had a strong multiprofessional approach to achieving person-centred care, including proactive clinical engagement,' says Jenny Minihane, director of older people's services and nurse lead.

All inpatients' health and social care needs - including their discharge arrangements - are reviewed. Sharing professional expertise ensures needs-led and timely discharge planning, the PCT has found. 'Clinical engagement has been pivotal in attaining person-centred care, and the case conferences have promoted good discharge-planning for the benefit for the individual. This would not have been achieved without the clinical engagement,' says Ms Minihane.

A dietician-led guideline and pathway for nutrition support has been implemented across five PCTs in **Leeds** for chronic disease management of COPD. GPs can make clinically effective decisions using a patient-education resource that focuses on improving food intake, and if necessary they can now prescribe nutritional supplements in an effective and managed way. Audit has shown that prescribing costs for supplements have been reduced and patient outcomes improved.

At **Ashton, Leigh and Wigan PCT** all orthopaedic referrals are assessed first by a team of

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physiotherapy specialists based in primary care. Patients are then referred to the most appropriate specialist - who could be an occupational therapist, a physiotherapist, a podiatrist or an orthopaedic consultant. Patients can now expect to be seen within six weeks. Referrals into secondary care have fallen by 38%.

**Colchester PCT** employs seven GP care advisors who work across all practices. They take a range of referrals, including those from the primary care health teams, social services and the voluntary sector. Their remit is to deal with non-medical issues that impact on a patient's health - for example, they give help and support to carers struggling to deal with personal responsibilities and will refer them to appropriate services for respite care.

GPs in **Southampton City PCT** have committed their practices to support a Saturday rota organised by the PCT. 'There is a feeling that although practices will shut on Saturday morning, we all have a collective responsibility to make sure we continue with a safe local service that benefits patients,' says PEC chair Dr David Paynton.

Nurses lead a tissue viability clinic one day a month for **Maldon and South Chelmsford PCT**. Clinical engagement has also given rise to diabetic nurse-led clinics, the setting-up of an assessment and rehabilitation unit and a GP-led minor operations clinic.

**Haringey PCT** has set up a bank of senior-grade practice nurses available to local practices. Nurses are recruited and supported through an accredited induction programme. Bank staff speak positively about the opportunities this provides and the support they receive. The PCT has been able to manage nursing vacancies successfully because of the practice nurse bank.

Establishing **East Leeds PCT's** COPD service involved the effective engagement of respiratory

physicians as well as GPs, and has benefited patients by helping with early discharge and pulmonary rehabilitation, as well as preventing many admissions in the first place. GPs also work in a shared-care drug scheme, the SLIP project, which is an integrated palliative care service.

**Wednesbury and West Bromwich PCT** has set up an enuresis clinic in a general practice, while the Sure Start project at Friar Park, Mesty Croft and Woods has firmly established links with clinicians who are helping facilitate geographical rather than GP-attached caseloads and working as part of a fully integrated, multi-agency, multi-disciplinary team. Engaging clinicians has enabled the PCT to introduce geographical working for health visitors, which has led to improved access to, and increased uptake of, baby clinics with multi-agency input.

In **North East Lincolnshire**, optometrists have telemedicine links to ophthalmic consultants, allowing the ophthalmologist to review remotely concerns about patients who would previously have been referred to hospital. The scheme has reduced referrals to ophthalmology and means fewer patients need to attend hospital.

**Trafford PCT's** one-stop resource centre for equipment and adaptations seeks opinions from OTs, physiotherapists, district nurses and carers before choosing equipment. It also holds 'referrer days' to ensure professionals are made aware of what is available to patients and how to access it. Close liaison with professional discharge and OT staff at local hospitals and with the manager of older people's services helps avoid delayed discharges.

In **Enfield PCT**, waiting times for podiatry were reduced from over a year to four weeks after an audit of the service, consultation with patients and joint work with partner agencies. The PCT was able to reorganise the service so it better fits



patient need - for example, by improving the appointment system. Local people now appreciate the service, which is also more rewarding for staff.

The podiatry team in **West Gloucestershire PCT** undertook extended training to develop a multidisciplinary seamless service to assist in meeting the diabetes national service framework targets.

**Durham Dales PCT** has developed a website on health matters for teenagers ([www.talk4teens.co.uk](http://www.talk4teens.co.uk)) which has depended for its success on nurse involvement.

Engagement with GPs by **Ashfield PCT** has resulted in a cryotherapy service to cut dermatology workload and waiting times, and enhanced intermediate care services with GP medical cover.

**North Kirklees PCT**'s 'first dressing initiative' has replaced the traditional use of 'boot stock' dressings, ensuring patients receive timely and appropriate interventions for wound care by allowing non-nurse prescribers to apply dressings from assessment until a prescription is generated.

### The benefits of nurturing practitioners with a special interest

Long waiting lists for skin lesions, local steroid injections and sigmoidoscopies led **Canterbury and Coastal PCT** to set up a scheme across East Kent for 14 GPs with a special interest to carry out these procedures on patients referred directly by other GPs. The result was faster access times for patients, and operating theatre time at local hospitals released for more major procedures. Similarly, long cardiology waiting lists prompted the PCT to ask a local cardiologist to train GPWsIs, so relieving pressure on consultant appointments.

**Dudley and Beacon PCT** employs a nurse consultant in primary care who works with a target group of the population that accounts for 30% of unplanned admissions and revolving-door syndrome. She is evaluating her role using patient stories as well as more traditional methods. One story concerns an alcoholic patient whose wife called the nurse when he had a fit at home. The nurse visited, giving essential nursing care to the patient and skilled support to his wife, who would otherwise have dialled 999. A&E nurses would have been unlikely to have had the time to observe the patient or support his wife so intensely, and he may well have been admitted overnight or for longer.

A GP and practice nurse have set up a community diabetic clinic in **Cambridge**, while a consultant dermatologist has established a training course for general practice and transformed the secondary care dermatology service. Occupational therapy services are being integrated across health and social care, demonstrating the efficiencies that can occur and reducing waiting times.

**South Somerset PCT** jointly appointed with its local acute trust a stroke nurse specialist, who works across the PCT and two acute trusts and has established professional forums to promote stroke care.

**Welwyn Hatfield PCT** has recruited two nurse specialists to pilot work with COPD and rheumatology in primary care-based clinics in Welwyn and Hatfield, which will extend across East Hertfordshire in the near future. Referrals to the PCT's multidisciplinary falls clinic for falls risk assessment now average 50 a month from general practices, accident and emergency, ambulance and social services. Physically or mentally frail patients can be assessed at home by a nurse specialist. About half are referred to other services, including physiotherapy, occupational therapy, exercise classes or their GP, or they are given pendant alarms. Most patients receive

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at least one follow-up visit to support advised changes and encourage exercise uptake. Specialist cancer nurses in **Poole PCT** work with palliative care nurses to provide a range of cancer treatments in the community, such as chemotherapy in the home. A specialist heart failure nurse assists people with chronic heart failure to manage their condition at home.

**Cannock Chase PCT** is working with Staffordshire University on piloting training for practitioners with a special interest.

**South West Staffordshire and Cannock Chase PCTs** are developing an emergency care practitioner role by looking at re-designing posts to manage first contact for patients out of hours.

Waiting times for patients with ear, nose and throat problems have fallen from 26 weeks to two weeks following the introduction of a GP-led clinic by **Horsham and Chanctonbury PCT**. A GP with a special interest in ENT runs a weekly clinic for patients with minor complaints such as swallowing problems, nasal congestion, tonsillitis, nasal polyps, ear infections and throat problems. GPs would previously have referred patients to hospital, where they could wait 26 weeks for an appointment. The new clinic sees patients within two to four weeks, and treats about 10 a week. About 17% are referred on to the hospital, while the rest are cared for solely within primary care.

The seven-GP Langton Medical Group in **Lichfield** has a nurse practitioner among its partners, who is able to bring her expertise and perspective to all management decisions. The practice's hypertension service is now run by nurses, who estimate the number of patients they will see over the year and plan clinics accordingly, ensuring enough time for thorough consultations that allow correct diagnosis, discussion of lifestyle issues and the patient's full involvement in care and treatment decisions. Patient compliance with treatment has

improved as a result. The practice has hit all the targets for the quality outcome framework in advance of the new GMS contract.

## Encouraging sound clinical governance

As providers of patient-focused services that are based on evidence-based practice, clinicians have a vital role in clinical governance. Practices appreciate measures for ensuring the safe delivery of services that are practical and supportive, and they are more likely to be successful if clinicians are consulted and involved in how they operate. PCTs are expected to integrate clinical governance arrangements across all primary care services. Those with strong clinical governance arrangements stand a better chance of enabling staff to understand the PCT's priorities and the importance of their own role in achieving them.

The Audit Commission found that **South Tyneside PCT** has a strongly led clinical governance department. It produces performance indicators for all practices, tailored to practice demography and benchmarked staff costs. These are presented graphically and discussed at each practice's annual facilitated workshop. Progress is reviewed against objectives in order to produce practice development plans. The performance indicators are largely linked to PCT objectives. If practices need support, a PCT 'in-reach' practice support team is available. Medical, nursing and practice management support are available through PCT-funded sessions. Support team members are practising clinicians, well known and trusted locally.

**Solihull PCT** has used clinical audit findings to develop guidelines - known as the 'Solihull Approach' - and a resource pack for care professionals to use when working with children who have sleeping, feeding, toileting and behavioural difficulties. The PCT has received national recognition for this initiative.



**Durham Dales PCT**'s clinical governance group is 'probably our best example' of clinical engagement, says PEC chair Dr Stewart Findlay. All practices are represented, and membership includes a non-executive, a pharmacist and nurses.

As part of its clinical governance quality framework, **Reading PCT** has an incentive scheme that is also used to monitor PMS contracts. It covers prescribing, NSFs, risk management, health and safety, information systems and public involvement. Some elements may change from year to year, as achievements and priorities change. Each area is given a target, which may be about establishing registers, processes for disease management - for example, risk assessments of patients with diabetes - processes for audit or intermediate outcomes, such as the proportion of patients with diabetes who have good glycaemic control. Each target has a stated rationale: it may be linked to an NSF target or be a local priority, for example. There are 15 targets in total, each with a point value: practices may achieve a total of 100 points, and incentive payments are linked to the points. The PCT believes this scheme will help it work with practices to establish systems for monitoring the quality and outcomes framework in the new GMS contract.

**Airedale PCT** has taken over a practice quality-reporting scheme. Practices and GPs are encouraged to report all their commissioning glitches to the PCT, from delayed or illegible discharge letters to prescribing cost transfers and clinical complaints from patients. These are forwarded to the hospital trust for comment and action. Trends have been identified and procedures improved as a result.

**Taunton Deane PCT** has a planned training programme for GPs, practice staff, pharmacists and dentists to familiarise them with local child protection policies and procedures. This programme is a mandatory requirement of the

PCT's primary care practice quality programme. Practice staff in surgeries do not receive quality payments unless they complete the training.

**Tower Hamlets PCT** has commissioned a clinically led academic unit to provide practice-level audit training.

A one-day workshop to provide a clear vision of clinical governance for community pharmacists was held by **Welwyn Hatfield PCT**.

### Ensuring good practice in prescribing

GPs readily appreciate practical help and support on prescribing, and many PCTs have risen to the challenge.

**Morecambe Bay PCT** employs 7.2 whole-time equivalent support pharmacists, who have all been in post for at least three years. They support 58 practices and are attached to a practice for half to one day per week, funded by top-slicing the prescribing budget. The support pharmacists aim to improve medicines management and the cost-effectiveness of prescribing by carrying out prescribing audits; monitoring prescribing reports from the Prescription Pricing Authority; carrying out medicines management reviews with patients; reviewing repeat prescribing; providing educational support to general practice staff and agreeing priorities with practices each year, based on practice priorities, clinical governance targets and the prescribing incentive scheme. Prescribing expenditure is generally within budget across the PCT, despite variations in overspends and underspends between practices. Practices are monitored on achievement of targets set out in the clinical governance programme and the prescribing incentive scheme.

**Solihull PCT**'s 16 sessional pharmacists are contracted to work by the general practice for one to two sessions per week.

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They support 32 practices, focusing on cost-effective and appropriate prescribing by carrying out prescribing audits; reviewing older people's medicines; helping practices to develop protocols and furthering the prescribing incentive scheme. The prescribing advisor and sessional pharmacist meet the practices bi-monthly to review performance.

**Barnsley PCT** has engaged clinicians to review medication errors and the prescribing process. Medical staff are involved in incident-reporting systems, record-keeping training and peer audit, while use of benchmarks is improving outcomes.

Meanwhile, **North Kirklees PCT** has introduced safe practice guidelines on giving, discontinuing and disposing of cytotoxic drugs in community settings, and has developed training and education sessions for staff.

After consulting local ethnic minority groups, **Newham PCT's** medicine and prescribing team distributed information about the use of medicines during Ramadan. The information is available in several languages and has been successfully implemented in partnership with mosques and Muslim community groups.

Community pharmacists in **Brighton and Hove** have recently been involved in a voluntary error-reporting project conceived by the local pharmacy forum, supported by the PCT and managed by an MSc student at the local school of pharmacy. They are also involved in medication review for older patients in partnership with GPs, aimed at maximising medication benefit and reducing prescribing costs when clinically appropriate.

**Southwark PCT** has engaged prescribers in agreeing targets in its prescribing incentive scheme. All GP and nurse prescribers were consulted on the potential targets using a survey. The results were presented to the PCT's medicines management group before the set of targets was finally agreed. The survey results were fed back to the prescribers with the finalised prescribing incentive scheme.

# 4 Improving local health

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**Improving the health of the community - by assessing its health needs and preparing plans, tackling health inequalities, leading partnership working with local authorities and others - is one of the main functions of a PCT. Here, as with commissioning and service provision, engaging clinicians is a vital means of fulfilling it.**

Engaging local people in health improvement activities is essential to tackling health inequalities. Since 2001 the Healthworks healthy living network in Newcastle upon Tyne has done just this, harnessing local people's commitment to addressing health inequalities and encouraging community participation in planning, managing and delivering NHS services. Healthworks has successfully supported interventions in accident prevention, working with black and ethnic minority communities, diet and nutrition, education, homelessness and housing, physical activity, substance misuse, sexual health and supporting vulnerable communities. It has succeeded in attracting high levels of participation in healthy living activities by communities traditionally seen as 'hard to reach'.

**Newcastle PCT's** health development service (HDS) worked with Healthworks to run a health event for members of the Sikh community. Over 180 people attended the event, which included workshops on heart disease, medication and diabetes, health information stalls, activities for children and feedback from participants on their perceived health needs. Healthworks and the HDS also ran a 'Heartstart' course to train bilingual community health workers to deliver emergency life-support courses in other community languages, accredited by the British Heart Foundation. Frontline staff have begun to work closely with healthlink workers to prevent and manage the risks for coronary heart disease, diabetes and cancer presented by poor diet, obesity and physical inactivity. A community healthlink worker is to conduct an exercise programme in an acute psychiatric ward.

Specially trained and accredited community pharmacists in **Sutton and Merton PCT** run a holistic lifestyle healthcare management programme for individual clients who attend three community centres as part of the Merton Horizons Healthy Living Centre. Many clients have complex and multiple health needs as well as social problems. The ethnic mix is diverse, and clients include all age ranges, from young single mothers to older people and people with disabilities and long-term illness. The service aims to improve knowledge of and compliance with medication; increase take-up of screening for diabetes, cholesterol, high blood pressure and hypertension; provide smoking-cessation advice and treatment; introduce sustainable lifestyle changes; reduce the demand on primary and secondary care and the number of 'information-only' appointments with GPs, establishing clear referral pathways to other projects within Merton Horizons. A referral system has also been developed from social services, the acute sector and other agencies.

**South West Kent PCT** conducted formal needs assessments in Edenbridge - a geographically isolated and fairly deprived area of the PCT. It held population focus groups, public meetings and meetings with community interest groups. A summary of the needs assessment report was disseminated widely across the Edenbridge community in a newsletter. The PCT is implementing a detailed action plan.

# 4 Improving local health

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A project organised by a community dietician in **South Leeds PCT** and a community worker responded to a locally identified need for fresh fish in the Asian community. Fresh fish from Grimsby is now delivered twice a month to a community centre in South Leeds. The project has enabled an already disadvantaged group to achieve a healthier lifestyle by improving their access to fresh fish on a regular basis. The project has become sustainable as the fishmonger now includes the community centre in his local round.

The clinician members on the PEC of **Tower Hamlets PCT** have brought their practical clinical experience to bear on such as arrangements for target issues such as flu campaigns and breast screening.

Community nurses in **Trafford** have helped introduce a multidisciplinary scheme for distributing condoms, while health visitors carry out screening of the local population who have reached retirement age and offer increased support for young parents.

Practices in **Welwyn Hatfield PCT** have undertaken smoking-cessation training, and are delivering intermediate smoking-cessation services as part of a county-wide initiative. The PCT is also examining initiatives to improve diet and nutrition with links to the national schools fruit scheme.

**Wednesbury and West Bromwich PCT's** 'New Deal for Communities' project at Greets Green has engaged clinicians in multi-agency, multidisciplinary working to target a broad range of health issues from healthy eating and growing healthy foods to Sure Start and children centre initiatives.

**Luton PCT** has assigned a nurse consultant to work on long-term health gain for Asian communities, specifically developing new approaches to infant weaning and teaching local community members how to deliver the service themselves.

**High Peak and Dales PCT** is targeting farming communities in a public health initiative that identifies ways of addressing health inequalities using a partnership approach. The project is nurse-led and believed to be the first of its kind in the UK.

Health visitors in **North Staffordshire** have well developed performance outcomes measuring health gain related to breast feeding and nutrition, injury prevention, identification of postnatal depression, child behaviour management and smoking-cessation interventions.

In **Newcastle-under-Lyme PCT**, health visitors have agreed to further develop their smoking cessation in response to the local delivery plan and local health need. This opportunity arose from the PCT's smoking-cessation steering group, and has links to midwifery smoking-cessation services, health promotion, paediatric services, the pharmacy advisor and public health directorate.

# 5 Conclusion



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## Factors for ensuring clinical engagement in PCTs

- Clinicians are enabled to become an integral part of the PCT's management, planning and decision making.
- They are kept fully informed about the PCT's priorities and have ample opportunity to influence its agenda, making their voices heard not only through the PEC but via a flourishing network of sub-committees, professional forums, working groups and other meetings.
- The whole spectrum of clinicians - not only GPs, but nurses, primary care practitioners and allied health professionals - should be engaged.
- If necessary, the PCT will instigate measures, such as protected learning time or paid locum cover, to enable busy clinicians to reconcile their participation with demanding workloads.
- The benefits of clinical engagement - for the clinician, their professional group, patients and the wider community's health - are communicated clearly.
- Clinicians are involved in the entire commissioning process, from assessing need to monitoring performance.
- Those with relevant experience are encouraged to become commissioning leads.
- Relationships with clinicians foster openness to new ways of working and a readiness to be flexible; building on this, they become involved in radical change, redesigning services and care pathways that in some cases can help solve age-old problems previously thought intractable.
- Involvement in even small-seeming schemes can bring important gains.
- Engaged clinicians are ready to work across professional boundaries, improve teamwork and help each other.
- PCTs with strong clinical governance arrangements stand a better chance of enabling staff to understand the PCT's priorities and their own role in achieving them.

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## ABBREVIATIONS

AHP - allied health professional  
COPD - chronic obstructive pulmonary disease  
GMS - general medical services  
LPC - local pharmaceutical committee  
NSF - national service framework  
PCT - primary care trust  
PFI - private finance initiative  
PMS - personal medical services

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With support from NatPaCT



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National Primary and Care Trust  
Development Programme