Fareham and Gosport NHS
Primary Care Trust

FAREHAM AND GOSPORT PRIMARY CARE TRUST

A meeting of the Gosport G.P Group will be held at 12.30 – 2.00pm on Thursday 8th May 2003 in the Georgian Room, Thorngate Hall, Bury Rd, Gosport

(Lunch Provided)

AGENDA

12.30	Apologies for absence	
	Presentations:	
12.35	Provision of radiology and pathology services for Gosport residents (Paper to follow)	Ben Genevieve
12.50	Inpatient policy – Portsmouth Hospitals NHS Trust	Elaine Taylor / James Barton
1.05	Minutes of the meeting held on Thursday 6th March 2003 (attached)	
1.10	Matters arising:	
	▪ General physician enquiry	Dr Pennells
	▪ Guidelines for assessment and admission to GP Beds (Sultan Ward) – discussion (previously circulated)	Jan Peach
1.20	Update – GP beds (GWMH)	Jan Peach
1.25	Prescribing:	
	▪ Prescribing budgets 2002/03 (paper attached)	Peter King
	▪ Prescribing budgets 2003/04 (paper attached)	Peter King
	▪ Prescribing incentive scheme 2003/04	Nic Allen
	▪ District formulary	Sue Halewood
	▪ Top-sliced drugs	Sue Halewood
1.55	A.O.B	
2.00	Date of next meeting:	
	Thursday 3rd July 2003, 12.30 – 2.00pm	

FAREHAM AND GOSPORT PRIMARY CARE TRUST

GOSPORT GP GROUP

Minutes of the Meeting held on Thursday 6 March 2003 at Thorngate Hall, Gosport

PRESENT:

Dr Evelyn Beale
Dr Bob Pennells
Dr Tony Evans
Dr David Young
Dr Peter Lacey
Dr John Bassett
Dr Declan Lynch
Dr Tony Knapman
Dr Richard Try
Jayne Coulborne
Dr John Grocock
Margaret Smith
Jan Peach
Sue Halewood
Dr Nic Allen
Rachael Boyns

		ACTION
1	**Minutes of the Meeting held on Thursday 9 January 2003** These were agreed.	
2	**Matters Arising** <u>General Physician enquiry.</u> BP agreed to collate the responses, which will be discussed at the next meeting of the Gosport GP Group. RT reported that he had received a response from the Child & Family Therapy Service. It was noted that the department was in the process of reducing the length of time for follow up appointments and was seeking to appoint a GP Specialist in ADHD in order to address current capacity issues.	BP
3	**Update – GP beds (Gosport War Memorial Hospital)** JP reported that approximately 3-4 beds have been vacant on Sultan Ward over the last couple of weeks, and that the bed pressures experienced by the Acute Trust had decreased slightly. A document has been produced to clearly define the use of the GP beds and the process for admission and assessment. It was agreed the document should be circulated with the minutes and comments sent to Jan Peach. (e-mail address: **Code A** The document will be discussed at the next meeting of the Gosport GP Group.	All

It was noted that patients currently requiring IV therapy cannot be admitted to Sultan Ward. Further discussion is required with the Gosport GPs, as well as nurse training in the administration of IV therapy prior to this being able to occur.

It was noted that the issue regarding out of hours cover had been clarified with the out of hours providers.

4 **Prescribing**

Prescribing budgets 2002/03
SH reported that as at the end of December 2002, the Gosport practice prescribing overspend was £553,608. The forecast outturn for the end of March 2003 for both Fareham and Gosport practices is £1,181,179.

Prescribing budgets 2003/04
NA reported that practice prescribing budgets are currently being modelled for 2003/04 and will be presented at the next meeting of the Gosport GP Group. The modelling will incorporate the use of the low income scheme index (LISI). It was agreed that further information regarding LISI will be circulated to the Group. SH

Prescribing Incentive Scheme 2003/04
The Prescribing Incentive Scheme for 2003/04 was discussed. It was agreed that the development of practice specific targets should be explored and presented to the next meeting of the Group. NA/SH

The Group agreed that the incentive payment will be based on the performance of individual practices against the quality/cost targets and therefore will remain practice based.

It was noted that the Fareham and Gosport practices are high prescribers of asthma drugs and have high levels of admissions. It was agreed that comparative asthma data should be circulated to practices. SH

District Prescribing Formulary
The draft District Prescribing Formulary was presented to the Group. Comments regarding the Formulary should be sent to Sue Halewood. The Formulary will be circulated to all practices and placed on the extranet for reference.

5 **Personal Medical Services**

Margaret Smith reported that 175 practices had become PMS practices in Wave 5b and had received a total of 10.5 million gross funding. A key advantage of practices moving from GMS to PMS, is the potential funding a practice can receive for additional GPs and nurse practitioners. Under PMS, a practice could potentially receive approximately £60,000 for a GP and £30,000 for a nurse practitioner.

MS reported that PMS Wave 5b will commence in October 2003, and that interested practices must submit an outline proposal of interest by the end of March 2003. Practices who submit an expression of interest can withdraw their application prior to the commencement of Wave 5b in October 2003. Practices who are interested in PMS Wave 5b should contact Margaret Smith. It was noted that a further PMS Wave 6 is likely to commence in April 2004.

MS reported that the proposed GP contract had been launched last week. Copies can be obtained from the BMA website. Practices were encouraged to compare the advantages and disadvantages of the new GP contract and PMS.

6 **Any Other Business**

GP Appraisals
Andrew Paterson reported that new national guidance stated that all GPs must be given a date for their appraisal by the end of March 2003. Appraisal dates will therefore be allocated to all Fareham and Gosport GPs over the next couple of weeks. All Fareham and Gosport GPs will have been appraised by the end of March 2004. Further information regarding the appraisal process was circulated to the Group.

Child Care
Margaret Smith reported that a questionnaire is to be distributed to practices regarding child care. It was noted that the benefits of child care, for example, financial assistance with emergency child care, should also be available to primary care, as well as acute and community staff.

Non-Executive Directors
MS reported that the Non-Executive Directors are keen to be involved with primary care. It was proposed that each Non-Executive Director is allocated a certain number of practices with which they can develop a close working relationship and a joint understanding of current issues. The proposal was supported by the Group.

7 **Date of Next Meeting**

Thursday 8 May 2003, 12.30 pm to 2.00 pm. Venue: Georgian Room, Thorngate Hall, Bury Road, Gosport.

Prescribing Spending By Practice - April '02 to Feb '03

Fareham Practices

Practice	Annual Budget	Full Year Forecast	Var.	Var.	YTD Budget	YTD Expend.	Var.	Var.
	£	£	£	%	£	£	£	%
Bellenger	1,609,985	1,775,469	165,484	10.28	1,469,685	1,623,310	153,625	10.45
Biddle	1,218,447	1,133,033	-85,414	-7.01	1,115,783	1,035,934	-79,849	-7.16
Douglas	973,523	1,021,237	47,714	4.90	893,855	933,718	39,863	4.46
Evans P	949,122	985,533	36,411	3.84	866,880	901,072	34,192	3.94
Newman	1,015,959	971,204	-44,755	-4.41	930,313	887,909	-42,404	-4.56
Mowbray	1,058,298	1,018,819	-39,479	-3.73	967,444	931,505	-35,939	-3.71
Webster	1,905,644	2,026,677	121,033	6.35	1,743,555	1,852,992	109,437	6.28
Sommerville	1,145,197	1,203,341	58,144	5.08	1,047,273	1,100,216	52,943	5.06
Warner	1,554,372	1,760,803	206,431	13.28	1,421,691	1,609,903	188,212	13.24
Wolpe	805,984	794,144	-11,840	-1.47	737,714	726,085	-11,629	-1.58
Sub total	**12,236,531**	**12,690,260**	**453,729**	**3.71**	**11,194,195**	**11,602,644**	**408,449**	**3.65**
Gosport Practices								
Anderson	1,092,191	1,134,687	42,496	3.89	995,476	1,037,444	41,968	4.22
Bassett	783,227	836,791	53,564	6.84	717,524	765,078	47,554	6.63
Beale	274,349	347,498	73,149	26.66	250,839	317,717	66,878	26.66
Coonan	1,056,935	1,207,176	150,241	14.21	964,768	1,103,720	138,952	14.40
Evans DA	905,948	923,205	17,257	1.90	821,857	844,088	22,231	2.70
Grocock	774,439	870,599	96,160	12.42	712,414	795,990	83,576	11.73
Hajiantonis	698,086	724,687	26,601	3.81	639,020	662,579	23,559	3.69
Knapman	1,294,115	1,426,078	131,963	10.20	1,180,644	1,303,861	123,217	10.44
Lacey	539,842	617,754	77,912	14.43	493,235	564,813	71,578	14.51
Lloyd	365,375	423,979	58,604	16.04	339,767	387,645	47,878	14.09
Pennells	1,234,796	1,210,109	-24,687	-2.00	1,127,121	1,106,403	-20,718	-1.84
Sub Total	**9,019,305**	**9,722,563**	**703,258**	**7.80**	**8,242,666**	**8,889,338**	**646,672**	**7.85**
Total	**21,255,836**	**22,412,823**	**1,156,987**	**5.44**	**19,436,861**	**20,491,982**	**1,055,121**	**5.43**

Note: Practice budgets include estimate for Nurse Prescribing

Prescribing Budget Model 2003/04

Stage 1 - Baseline established as the lower of FOT or budget. Baseline then uplifted to equal 03/04 total target

Fareham Practices	Annual Budget 02/03	Full Year Forecast 02/03	02/03 Initial Baseline	Astro PU July '02	Astro PU Jan '03	02/03 Adjusted Baseline	Uplift % to 03/04	03/04 Target pre exp. drugs	Add back Expensive Drugs	03/04 Target
Warner	1,554,372	1,757,862	1,554,372	68,354	69,128	1,571,985	77,423	1,649,408	96,127	1,745,535
Sommerville	1,145,197	1,204,827	1,145,197	48,732	49,265	1,157,713	57,020	1,214,732	81,586	1,296,318
Douglas	973,523	1,020,313	973,523	41,029	41,282	979,524	48,243	1,027,768	43,701	1,071,469
Bellenger	1,609,985	1,764,561	1,609,985	68,128	69,179	1,634,826	80,518	1,715,345	104,110	1,819,455
Evans P	949,122	989,247	949,122	40,424	40,699	955,578	47,064	1,002,643	70,742	1,073,385
Mowbray	1,058,298	1,023,619	1,023,619	45,837	47,095	1,051,708	51,799	1,103,506	61,429	1,164,935
Newman (was AH Mowbray)	1,015,959	968,075	968,075	43,987	44,288	974,697	48,006	1,022,703	67,620	1,090,323
Webster (was LJ Palmer)	1,905,644	2,024,897	1,905,644	80,267	80,363	1,907,928	93,969	2,001,897	108,041	2,109,938
Biddle	1,218,447	1,140,567	1,140,567	50,723	51,066	1,148,291	56,556	1,204,847	74,063	1,278,910
Wolpe	805,984	792,863	792,863	33,930	34,605	808,636	39,827	848,463	51,131	899,594
Sub total	**12,236,531**	**12,686,831**	**12,062,967**	**521,410**	**526,970**	**12,190,887**	**600,425**	**12,791,312**	**758,550**	**13,549,862**
Gosport Practices										
Beale	274,349	340,136	274,349	10,594	12,545	324,862	16,000	340,862	22,414	363,276
Coonan	1,056,935	1,213,863	1,056,935	40,044	40,330	1,064,484	52,428	1,116,912	75,096	1,192,008
Bassett	783,227	841,410	783,227	31,879	31,422	772,006	38,023	810,029	42,300	852,329
Lacey	539,842	611,255	539,842	20,828	21,287	551,739	27,174	578,914	27,909	606,823
Grocock	774,439	865,784	774,439	29,088	28,910	769,692	37,909	807,601	48,038	855,639
Hajiantonis	698,086	729,271	698,086	27,255	27,545	705,504	34,747	740,251	35,379	775,630
Anderson	1,092,191	1,150,108	1,092,191	41,663	41,235	1,080,969	53,240	1,134,208	63,322	1,197,530
Beasley (was Knapman)	1,294,115	1,413,331	1,294,115	51,063	51,974	1,317,213	64,875	1,382,088	57,699	1,439,787
Pennells	1,234,796	1,218,769	1,218,769	47,463	47,479	1,219,175	60,047	1,279,221	77,584	1,356,805
Lloyd	365,375	408,248	365,375	13,159	14,414	400,230	19,712	419,943	24,886	444,829
Evans DA	905,948	923,851	905,948	32,963	33,219	912,976	44,966	957,941	75,540	1,033,481
Sub Total / Average	**9,019,305**	**9,716,026**	**9,003,278**	**346,000**	**350,360**	**9,118,850**	**449,121**	**9,567,971**	**550,167**	**10,118,138**
Total / Average	**21,255,836**	**22,402,857**	**21,066,245**	**867,410**	**877,330**	**21,309,737**	**1,049,546**	**22,359,283**	**1,308,717**	**23,668,000**

Practice Target	23,668,000
less Expensive Drugs	1,308,717
Target pre Expensive Drugs	**22,359,283**

NB. The prescribing budget has not yet been agreed.
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Prescribing Budget Model 2003/04

Stage 2 - Capitation adjusted for LISI using Need Index

Fareham Practices	Annual Budget 02/03	Full Year Forecast 02/03	List size weighted by Astro Pu (Jan '03)	LISI Scores	Need Index (20.53 + LISI)	AstroPU x Need Index	Flex to 2003/04 Target pre exp. Drugs	Add back Expensive Drugs	03/04 Target	% Inc/(Dec) over Budget	% Inc/(Dec) over FOT
Warner	1,554,372	1,757,862	69,128	2.00	20.54738	1,420,399	1,758,859	96,127	1,854,986	13.2	0.1
Sommerville	1,145,197	1,204,827	49,265	2.11	20.54834	1,012,314	1,253,533	81,586	1,335,119	9.5	4.0
Douglas	973,523	1,020,313	41,282	4.91	20.57267	849,281	1,051,651	43,701	1,095,352	8.0	3.1
Bellenger	1,609,985	1,764,561	69,179	6.29	20.58466	1,424,026	1,763,350	104,110	1,867,460	9.5	-0.1
Evans P	949,122	989,247	40,699	4.32	20.56754	837,078	1,036,541	70,742	1,107,283	9.2	4.8
Mowbray	1,058,298	1,023,619	47,095	3.51	20.56050	968,297	1,199,027	61,429	1,260,456	13.3	17.1
Newman (was AH Mowbray)	1,015,959	968,075	44,288	3.63	20.56154	910,630	1,127,619	67,620	1,195,239	11.0	16.5
Webster (was LJ Palmer)	1,905,644	2,024,897	80,363	7.84	20.59813	1,655,327	2,049,767	108,041	2,157,808	7.6	1.2
Biddle	1,218,447	1,140,567	51,066	5.35	20.57649	1,050,759	1,301,139	74,063	1,375,202	6.8	14.1
Wolpe	805,984	792,863	34,605	7.00	20.59083	712,546	882,334	51,131	933,465	9.5	11.3
Sub total	**12,236,531**	**12,686,831**	**526,970**			**10,840,657**	**13,423,820**	**758,550**	**14,182,370**	**9.7**	**5.8**
Gosport Practices											
Beale	274,349	340,136	12,545	6.15	20.58344	258,219	319,749	22,414	342,163	16.5	-6.0
Coonan	1,056,935	1,213,863	40,330	4.84	20.57206	829,671	1,027,369	75,096	1,102,465	-2.8	-15.4
Bassett	783,227	841,410	31,422	3.07	20.55668	645,932	799,848	42,300	842,148	2.1	-4.9
Lacey	539,842	611,255	21,287	6.65	20.58779	438,252	542,681	27,909	570,590	0.5	-11.2
Grocock	774,439	865,784	28,910	7.84	20.59813	595,492	737,389	48,038	785,427	-4.8	-14.8
Hajiantonis	698,086	729,271	27,545	7.20	20.59257	567,222	702,383	35,379	737,762	0.6	-3.7
Anderson	1,092,191	1,150,108	41,235	7.74	20.59726	849,328	1,051,710	63,322	1,115,032	-3.7	-8.6
Knapman	1,294,115	1,413,331	51,974	7.83	20.59804	1,070,563	1,325,661	57,699	1,383,360	2.4	-6.2
Pennells	1,234,796	1,218,769	47,479	7.62	20.59622	977,888	1,210,903	77,584	1,288,487	-1.9	-0.6
Lloyd	365,375	408,248	14,414	14.82	20.65879	297,776	368,731	24,886	393,617	0.9	-9.7
Evans DA	905,948	923,851	33,219	12.72	20.64054	685,658	849,040	75,540	924,580	-6.3	-8.1
Sub Total / Average	**9,019,305**	**9,716,026**	**350,360**			**7,216,001**	**8,935,463**	**550,167**	**9,485,630**	**-0.9**	**-8.0**
Total / Average	**21,255,836**	**22,402,857**	**877,330**			**18,056,658**	**22,359,283**	**1,308,717**	**23,668,000**	**5.2**	**-0.2**

Practice Target	23,668,000
less Expensive Drugs	1,308,717
Target pre Expensive Drugs	**22,359,283**

NB. The prescribing budget has not yet been agreed.
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Prescribing Budget Model 2003/04

Stage 3 - Percentage of Capitation model plus a percentage of FOT/budget baseline model.

Fareham Practices	Annual Budget 02/03	Full Year Forecast 02/03	% of Capit'n Target 10%	% of Baseline Target 90%	03/04 Target pre exp. Drugs	Add back Expensive Drugs	03/04 Target	% Inc over Budget	% Inc over FOT
Warner	1,554,372	1,757,862	175,886	1,484,467	1,660,353	96,127	1,756,480	6.8	-5.5
Sommerville	1,145,197	1,204,827	125,353	1,093,259	1,218,612	81,586	1,300,198	6.4	1.1
Douglas	973,523	1,020,313	105,165	924,991	1,030,156	43,701	1,073,857	5.8	1.0
Bellenger	1,609,985	1,764,561	176,335	1,543,810	1,720,145	104,110	1,824,255	6.8	-2.5
Evans P	949,122	989,247	103,654	902,378	1,006,032	70,742	1,076,774	6.0	1.7
Mowbray	1,058,298	1,023,619	119,903	993,156	1,113,058	61,429	1,174,487	5.2	8.7
Newman (was AH Mowbray)	1,015,959	968,075	112,762	920,433	1,033,195	67,620	1,100,815	1.7	6.7
Webster (was LJ Palmer)	1,905,644	2,024,897	204,977	1,801,708	2,006,684	108,041	2,114,725	5.3	-0.9
Biddle	1,218,447	1,140,567	130,114	1,084,362	1,214,476	74,063	1,288,539	-0.3	6.5
Wolpe	805,984	792,863	88,233	763,617	851,850	51,131	902,981	5.7	7.4
Sub total	**12,236,531**	**12,686,831**	**1,342,382**	**11,512,181**	**12,854,563**	**758,550**	**13,613,113**	**5.1**	**1.3**
Gosport Practices									
Beale	274,349	340,136	31,975	306,775	338,750	22,414	361,164	23.5	-0.4
Coonan	1,056,935	1,213,863	102,737	1,005,221	1,107,958	75,096	1,183,054	4.8	-8.7
Bassett	783,227	841,410	79,985	729,026	809,011	42,300	851,311	3.3	-3.9
Lacey	539,842	611,255	54,268	521,022	575,290	27,909	603,199	6.6	-5.9
Grocock	774,439	865,784	73,739	726,841	800,580	48,038	848,618	3.4	-7.5
Hajiantonis	698,086	729,271	70,238	666,226	736,464	35,379	771,843	5.5	1.0
Anderson	1,092,191	1,150,108	105,171	1,020,788	1,125,959	63,322	1,189,281	3.1	-2.1
Knapman	1,294,115	1,413,331	132,566	1,243,879	1,376,446	57,699	1,434,145	6.4	-2.6
Pennells	1,234,796	1,218,769	121,090	1,151,299	1,272,390	77,584	1,349,974	3.0	4.4
Lloyd	365,375	408,248	36,873	377,948	414,821	24,886	439,707	13.5	1.6
Evans DA	905,948	923,851	84,904	862,147	947,051	75,540	1,022,591	4.5	2.5
Sub Total / Average	**9,019,305**	**9,716,026**	**893,546**	**8,611,174**	**9,504,720**	**550,167**	**10,054,887**	**5.4**	**-2.2**
Total / Average	**21,255,836**	**22,402,857**	**2,235,928**	**20,123,355**	**22,359,283**	**1,308,717**	**23,668,000**	**5.2**	**-0.2**

Practice Target	23,668,000
less Expensive Drugs	1,308,717
Target pre Expensive Drugs	**22,359,283**

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Prescribing Budget Model 2003/04

Percentage of Capitation model plus a percentage of FOT/budget baseline model.

% Capitation	**0%**		**10%**		**20%**		**30%**		**40%**		**50%**	
% Baseline	**100%**		**90%**		**80%**		**70%**		**60%**		**50%**	
	% Inc over Budget	**% Inc over FOT**	**% Inc over Budget**	**% Inc over FOT**	**% Inc over Budget**	**% Inc over FOT**	**% Inc over Budget**	**% Inc over FOT**	**% Inc over Budget**	**% Inc over FOT**	**% Inc over Budget**	**% Inc over FOT**
Fareham Practices												
Warner	6.1	(6.2)	6.8	(5.5)	7.5	(4.9)	8.2	(4.3)	8.9	(3.7)	9.6	(3.1)
Sommerville	6.1	0.8	6.4	1.1	6.7	1.5	7.1	1.8	7.4	2.1	7.8	2.4
Douglas	5.6	0.7	5.8	1.0	6.1	1.2	6.3	1.4	6.6	1.7	6.8	1.9
Bellenger	6.5	(2.8)	6.8	(2.5)	7.1	(2.2)	7.4	(2.0)	7.7	(1.7)	8.0	(1.4)
Evans P	5.6	1.4	6.0	1.7	6.4	2.0	6.7	2.4	7.1	2.7	7.4	3.1
Mowbray	4.3	7.8	5.2	8.7	6.1	9.7	7.0	10.6	7.9	11.5	8.8	12.5
Newman (was AH Mowbray)	0.7	5.6	1.7	6.7	2.7	7.8	3.8	8.9	4.8	10.0	5.8	11.1
Webster (was LJ Palmer)	5.1	(1.1)	5.3	(0.9)	5.6	(0.7)	5.8	(0.4)	6.1	(0.2)	6.3	0.0
Biddle	(1.1)	5.6	(0.3)	6.5	0.5	7.3	1.3	8.2	2.0	9.0	2.8	9.9
Wolpe	5.3	7.0	5.7	7.4	6.1	7.9	6.5	8.3	7.0	8.7	7.4	9.1
Sub total	4.5	0.8	5.1	1.3	5.6	1.8	6.1	2.3	6.6	2.8	7.1	3.3
Gosport Practices												
Beale	24.2	0.2	23.5	(0.4)	22.7	(1.0)	21.9	(1.6)	21.2	(2.3)	20.4	(2.9)
Coonan	5.7	(8.0)	4.8	(8.7)	4.0	(9.5)	3.1	(10.2)	2.3	(10.9)	1.4	(11.7)
Bassett	3.4	(3.7)	3.3	(3.9)	3.2	(4.0)	3.0	(4.1)	2.9	(4.2)	2.8	(4.3)
Lacey	7.2	(5.3)	6.6	(5.9)	5.9	(6.5)	5.2	(7.1)	4.6	(7.7)	3.9	(8.3)
Grocock	4.3	(6.7)	3.4	(7.5)	2.5	(8.3)	1.6	(9.2)	0.7	(10.0)	(0.3)	(10.8)
Hajiantonis	6.0	1.5	5.5	1.0	5.0	0.5	4.4	(0.1)	3.9	(0.6)	3.3	(1.1)
Anderson	3.8	(1.4)	3.1	(2.1)	2.3	(2.8)	1.6	(3.5)	0.8	(4.3)	0.1	(5.0)
Knapman	6.8	(2.2)	6.4	(2.6)	5.9	(3.0)	5.5	(3.4)	5.1	(3.8)	4.6	(4.2)
Pennells	3.6	5.0	3.0	4.4	2.5	3.8	1.9	3.3	1.4	2.7	0.8	2.2
Lloyd	14.9	2.9	13.5	1.6	12.1	0.4	10.7	(0.9)	9.3	(2.2)	7.9	(3.4)
Evans DA	5.7	3.7	4.5	2.5	3.3	1.3	2.1	0.2	0.9	(1.0)	(0.3)	(2.2)
Sub Total / Average	6.1	(1.5)	5.4	(2.2)	4.7	(2.8)	4.0	(3.5)	3.3	(4.1)	2.6	(4.8)
Total / Average	5.2	(0.2)	5.2	(0.2)	5.2	(0.2)	5.2	(0.2)	5.2	(0.2)	5.2	(0.2)

NB. The prescribing budget has not yet been agreed.
Values shown on this analysis are for demonstration purposes only.

Fareham and Gosport NHS
Primary Care Trust

WORKING DRAFT

Guidelines for Assessment and Admission to GP Beds (Sultan Ward) Gosport War Memorial Hospital

24 February 2003

GOSPORT WAR MEMORIAL HOSPITAL
SULTAN WARD – GP BEDS

On 30 December 2002 there will be three distinct categories of beds on Sultan Ward at Gosport War Memorial Hospital. The underlying principles are that the beds can be used flexibly by both the Gosport Bed Fund GP's and Elderly Medicine Consultants and that utilisation of these beds is maximised.

CATEGORY 1 – Patients Awaiting Nursing Home

Up to six beds on Sultan may be used for this purpose at any given time. Rest Home/Nursing Home waiters will be notified to Elderly Medicine by Service Manager Community Hospitals, and reviewed by Elderly Medicine Consultants as appropriate prior to transfer to these beds. (Appendix 1)

CATEGORY 2 – Elderly Medicine Step Down

In circumstances where these beds are not being utilised for rest home/nursing home waiters, patients who meet the Gosport War Memorial Hospital Sultan Step Down criteria and are currently in Elderly Medicine wards, may at the discretion of the Consultant Geriatrician, be transferred to Sultan Ward. (Appendix 2)

CATEGORY 3 – GP Step Down Beds

Patients within Portsmouth Hospital Trust who meet the criteria for step down beds at Gosport War Memorial Hospital may be referred to Elderly Medicine who in conjunction with the patients GP will vet and manage appropriate transfers. (Appendix 3, 3a)

App 1

Access to Category 1 – Patients Awaiting Nursing Homes

Procedure for Assessing and Admitting to Elderly Medicine Beds on Sultan Ward

Suitable Patients

- Those over the age of 65 registered with a Gosport GP.
- Those from Elderly Medicine wards (preferable post acute, rehabilitation or continuing care) who need a step-down bed but the GP does not agree to look after them on Sultan Ward.
- Those in Elderly Medicine or Portsmouth Hospitals who are awaiting Rest or Nursing Home placement.

Patients Not Suitable

- Those who are medically unstable and hence need to remain on the acute site
- Those waiting for EMH Rest Home placement and/or have behavioural problems.

On a daily basis Sultan will notify Elderly Medicine admission office of empty beds available.

On a weekly basis the Service Manager working with Social Services and sit rep reports will notify by fax/e-mail the names and whereabouts of nursing/rest home waiters within Portsmouth Hospital Trust.

When there are 2 or more beds, elderly medicines admission office will arrange a ward visit by a consultant to assess suitable patients (appendix 3a)

If the patient is deemed suitable for transfer the admission office will arrange the transfer to Sultan.

On arrival to Sultan the staff grade physician will clerk the patient in.

In severe bed crisis patients can be transferred out of hours using relevant guidelines (appendix 3a)

App 2

Access to category 2 - Procedure for Assessing and Admitting to Elderly Medicine Step Down Beds

In circumstances where beds are not utilised in Category 1
Any patient currently within an Elderly Medicine ward, who lives within the Fareham and Gosport catchment area and meet the step down criteria, can be transferred under the care of the Consultant Geriatrician.

If a patient is deemed suitable for transfer the Elderly Medicine admission office will contact Sultan Ward with details of the patients and arrange transfer.

On arrival to Sultan the staff grade physician will clerk the patient in.

In severe bed crisis patients can be transferred out of hours using relevant guidelines (appendix 3a)

App 3

Access to Category 3 – Procedure for Assessing and Admitting to GP Step Down Beds

Patients can access category 3 by either:

- Being a patient within Portsmouth Hospital Trust who lives within Gosport catchment area and fulfils the admission criteria. (Appendix 3a)

- Admitted directly from home by GP and fulfils admission criteria (Appendix 3b)

If the patients fulfil the admission criteria a member of the PHT medical team should contact the GP to discuss the case. If the GP agrees to take on the patient's management the referring ward should then contact Sultan ward to book a bed and give a verbal handover. If no bed is available the patient will be placed on a waiting list and the referring ward will be contacted once a bed is available.

The referring ward is responsible for booking the transport and all transfers will take place between 0900 and 1300 Mondays to Fridays excluding bank holidays. Patients transferred after midday on Friday will not be seen routinely by a GP until the following Monday.

All documentation, x-rays, medication, patients' property and valuables are to be transferred with the patient. If any items are not transferred with the patient they must be sent immediately to Sultan ward by taxi ordered by the transferring ward.

App 3a

GUIDELINES FOR TRANSFER TO GP BEDS (SULTAN WARD)
GOSPORT WAR MEMORIAL HOSPITAL – 023 9252 4611

Gosport War Memorial Hospital is a modern community hospital located in central Gosport. There are 24 beds for patients admitted under the care of their GP on Sultan Ward. The ward clinical manager is Ann Haste.

As part of the development of intermediate care, there has been an additional investment in the development of an Enablement Service which complements the pre-existing transfer arrangements on Sultan Ward. There is no on site medical cover. Should the patient deteriorate then the GP (or nominated partner) will arrange transfer of the patient back to the referring acute hospital. Transfer back will be automatic and immediate.

SPECIALITIES THAT MAY TRANSFER

1. Orthopaedics and General Surgery

In 1998 strict criteria were developed for the transfer of Orthopaedic patients and these were refined in May 1999 to cover surgical patients also.

These criteria are unchanged and the patients must fulfil all the criteria listed below before transfer is discussed.

Criteria

1. No intravenous lines
2. Haematologically stable
3. Apyrexial (can be taking oral antibiotics)
4. No major discharging wound
5. Anticoagulant control stabilised or haematologist advising on control of anticoagulation)
6. Medically stable
7. No confusions leading to behavioural problems eg wandering, agitation and aggression
8. Anticipated medically fit for discharge within the next 14 days
9. Dying patient
10. If awaiting social services assessment and funding, this to have been done and discharge date agreed within the next 14 days
11. Does not need intensive rehabilitation.

2. General Medicine and Elderly Medicine

Patients for transfer from general medicine or elderly medicine wards must fulfil the criteria above (as developed for surgical and orthopaedic patients) and be negative on the Appropriateness Evaluation Protocol (AEP attached). This tool has been developed to ensure safe transfer of patients to non-acute hospitals

Procedure for Transfer

If the patient fulfils the criteria, a member of the medical team should discuss the case with the GP. If the GP agrees to take on the management of the patient, the referring ward should contact Sultan ward to book a bed. The referring ward should give sufficient information to Sultan ward for continuity if care to be given by the Sultan ward team. If no bed is available the ward will operate a waiting list and contact the referring ward when a bed becomes available. Ongoing rehabilitation and discharge planning should continue on the referring ward and the patient should be reassessed to ensure that transfer is still appropriate, and that the patient is fit for transfer. The referring doctor must "sign off" the patient on the day of transfer, as being both medically fit enough and suitable for transfer to a GP bed according to the above criteria.

The patient and carers must be involved and kept fully informed of transfer plans and progress by the referring ward.

The referring ward is responsible for booking transport.

Transfer Process

Transfers will take place between 0900 hours and 1300 hours Monday to Friday, excluding bank holidays. Patients transferred after midday on Friday will not be seen routinely by a GP until the following Monday.

On transfer, the following must accompany the patient:-

Name of contact person responsible for the patient prior to transfer:-

1. A complete set of medical and nursing notes with a details management plan.
2. Care pathways/copy of the care pathway and therapy notes.
3. X-Rays/pathology results
4. Handling profile, Barthel, Waterlow and Mental Test Score
5. Transfer of care information
6. Current legible drug chart and non-stock medical and/or dressing for 4 days (check with Sultan ward)
7. Essential equipment and appliances
8. Patient's property and valuables
9. Follow up outpatient and day hospital appointment if relevant

Any items not transferred with the patient must be sent immediately to Sultan ward by taxi.

Appendix 3b

ADMISSION CRITERIA FOR PATIENTS ADMITTED DIRECTLY FROM HOME BY GP TO A GP BED (SULTAN WARD) GOSPORT WAR MEMORIAL HOSPITAL

1. Patients with a short term (relatively) straightforward medical/nursing crisis whose needs it is felt, can be met and resolved on a GP ward. This would not include patients with complex medical problems and/or patients who need intensive rehabilitative input.

2. Patients requiring palliative terminal care. It is suggested that such admissions would be in accordance with protocols developed for the management of such patients in conjunction with the palliative care service (either the Rowans or Countess Mountbatten House).

3. Patients requiring urgent/emergency respite care in the event of a (short term) crisis at home.

4. Regular planned respite care for patients who are living at home and whose needs are such that they would otherwise be eligible for long term NHS continuing care.

Mild disorientation/confusion would not be a barrier to admission but wandering patients or those who have mild confusion/aggression/agitation would not be suitable.

Stroke Service Clinical Governance Meeting

Minutes from the meeting – 4th April 2003

1. Present

Jane Williams
Sarah Hardham
Karen Clarke
Tracey Dobson
Claire Simpson
Teresa Needham
Stella Tawoney
Elizabeth Viney
Clare Eastham
Helen Pound
Vicky Palmer
Ann Thorn
Cate Leighton
Sue Cooper
Janet Neville
Heather Brown
Sarah Easton
Vered Silberstein
Maureen Andrews
Jane Charlton
Linda White
Kathryn Hodgson
Nicky Carville
Lucy Arthur
Claire Terry
Bridgitte Cummings
Debbie Hunt
Vicki Hopton
Sandra McKinlay
Lynn Dangerfield
David Jarrett
Jill Robinson

Apologies

Marion Moffatt
Kim Hine
Sue Wright
Shirley Dunleavey
Val Vardon

2. Minutes of the last meeting

Accepted as an accurate record

3. Matters arising

GDS usage – all rehab areas but Daedalus recording the GDS as per guidelines. JW to check with Philip Beed. **ACTION: JW & PB**

Compression Hose – Cedar Ward reported having a problem with access to compression hose. JW to check with Ann Marie Evans **ACTION: JW & AME**

Modified diet – new soft moist diet menu being introduced from May - ? whether this is both QAH and SMH. Main meal reverting to lunch time. Risk event forms to be completed and a copy sent to Eileen Hawkins if problems arise with SMH/QAH meals.
Various meetings are being held with staff involvement re improving meals.

4. Research and Effectiveness

NSF Update

Stroke Coordinator – Sarah Easton. Sarah provided an overview of her 15 month project post. Work to date has focussed on tracking patients (all ages) through the system – acute, community and TIA patients. During the first month 100 patients were identified. 36 from PC, 24 EH and 29 F&G. 21 TIAs. Gender split of 63 females and 37 males. This is a huge task and Sarah has spent the first few weeks walking miles to keep track of patients as they have multiple moves through the system. Sarah is looking at ways of developing a stroke register.

TIA clinic

Waiting list currently running at 8 weeks. JT and DJ have less support in OPD clinics due to reduction in junior doctor hours and so fewer patients are seen. Audit on first 100 patient undertaken. Abstract for poster presentation has been accepted for the British Geriatric Society conference.

Acute Stroke

Mary Ward working well but still having 3-4 non-strokes at a time. Team examining ways of improving identification of stroke patients. Some delays in moving patients on through Mary Ward. DJ expressed concerns re younger stroke patients with atypical presentations and has written to BASP (British Association of Stroke Physicians) regarding this.
Therapists having to work with patients in the linen room – which is obviously less than ideal! NC reported positive response to recruitment of physios.
The issue of OT on Mary Ward was raised in relation to the inequity in service between under and over 65's and in-reach model of service delivery. This has been raised at the acute stroke group meeting and discussions are being held with regard to exploring this. Claire Simpson, F&G OT is looking at the issues for her PCT and can be contacted at Haslar – 023 9276 2426.

Community Stroke Rehabilitation Team

Project work continues. Briefing sheet for staff being produced (attached to minutes).

Stroke Review project

JW and NC completing the write up of the project before moving to the next phase of developing a draft review.

Under 65 Team

Following reconfiguration under 65 patients experience multiple moves and some wards/areas do not have the stroke specific skills or equipment to manage patients effectively. Therapy treatment areas have been reused at QAH as it was expected that patients would be at SMH. Risk forms are being completed to raise the profile of these problems.
12 rehab beds at Haslar have medical cover problems and patients have to be very stable before they can be transferred there.

Spasticity
Letter sent to Chief Executives from group raising the issue of management of tonal abnormalities.
Neuro-physio group have written guidelines for the assessment of patients for Botulinum Toxin treatment. They are meeting the Dysport rep on 14th October and talking with a physio in Southampton who is involved with the Bot Tox service there. SA reported back from a conference.

South Coast Stroke Research Group
We hosted the last meeting on 26th March which was positively evaluated. Topics presented were: The 'feed or not to feed' decision making process; Integrated Care Pathways; effects of caffeine on cerebral blood flow and proposing a pain scale for self reporting of shoulder pain.
No date for the next meeting but the venue will be Poole.

Guidelines
JT updating the primary and secondary prevention guidelines.
ACTION: JT
Physios have completed their update in line with the changes in the RCP stroke guidelines. To forward to JW for dissemination **ACTION: NC & JW**

5. Audit
Goal setting audit final report has been sent out for circulation. Reaudit will be planned at some point in the future.

JW suggested that audit of acute stroke ward would be appropriate to establish base line for future work/service development. To use RCP stroke audit package – uniprofessional audit tools. JW to progress via Acute Stroke Group meeting. **ACTION: JW**

6. Guernsey Ward Presentation – Therapeutic Activity Nurse
Jill Robinson presented the development of her role over the last two years.
Activities include – social and communication groups, money management, physical activities such as skittles, going out to use public transport, access to shops etc.
The aim is to boost individual patient's confidence in identified areas through involvement in goal setting and planning activities to augment therapy.
Development of the role is on-going.

7. Education and Training
In-house stroke course
Group need to reconvene and revamp course for support staff following success of revised course for registered professionals.
ACTION: JW

Southampton Module
Module available through Southampton school of Nursing and Midwifery, although the course has been designed for all professionals – 20 credits at level 2 or 3, introduction to care of the person with stroke/advances in care of the person with stroke. Course code WO267Q (HE2) or WO367Q (HE3).

Dysphagia Training
As a result of the CHI inspection of Gosport War Memorial a dysphagia training programme was developed and followed by 4 nurses. The purpose of the training is to prevent delay in the initial screening assessment of patients with dysphagia by having a dysphagia link nurse available each day. The feedback from the programme has been very positive and the SLT department are exploring the possibility of extending the programme to other community hospitals.
This is an issue that is being examined nationally – JW involved in this work looking at the possibility if developing a nationally recognised competency framework for nurses.

SLT department organising rolling programme of basic dysphagia awareness training to be held in SMH/QAH. This will commence later in the year and a whole year's dates will be organised and advertised.

Lynn Dangerfield requested that any specific training needs identified should be forwarded to her.

8. Staffing and Management
Positive response to all physiotherapy adverts and it is hopeful that soon all acute stroke physio posts will be filled.
Elizabeth Ward are examining the potential of developing an activity role for a HCSW.
SLT department are experiencing some difficulties particularly as Sarah Easton working as stroke coordinator for 4 days per week! Hoping to back fill Sarah's time with locum post.
Shannon Ward, SCH still struggling with staffing as currently 7 nurses off long term sick. Amalgamation of Shannon and Rosewood Ward to continue.

9. Risk Management
Risk event forms being completed by under 65 team when unable to provide treatment at SMH or QAH
Risk event forms being completed with regard to problems with meals.

10. Any Other Business
Dysphasia Support Organiser, Sandra McKinlay update the meeting regarding changes to the Dysphasia Support service. Now funded equally by the PCTS and provides support to stroke survivors with communication impairments equably. Sandra and the SLTs are working closely to ensure stroke survivors are offered targeted support and discharged from the service to enable a greater number of people to benefit from support.

Referrals can be made wither to Sandra Code A or via SLT department.
From the 1st May a 'Speakability' group will run from the Horizon centre. Contact Roz Rosenblatt on Code A for further information.
Elizabeth Ward - ahead of any changes in light of the community stroke rehab team project, the planned move to Exton 3, St Mary's will go ahead, probably in December.

11. Dates and Times next two meetings

- July 11th 2-4pm, Seminar Room QAH. Contact Sr Janet Neville, Elizabeth Ward Code A
- October 10th 2-4pm, Gosport War Memorial Hospital (room TBC), Contact C/M Philip Beed, Code A

Attachment: Briefing sheet No.1 – Community Stroke Rehabilitation Team

Unleashing the potential - developing a Community Stroke Rehabilitation Team

Briefing Sheet 1 – Produced by Jane Williams, April 2003

For many years I have felt that we don't offer the best possible preparation for stroke survivors' transfer home after their period of rehabilitation. It is well recognised that physical and psychological deterioration may occur following discharge from an in-patient rehabilitation service and that carer stress may be high. I have long held the wish to extend the service by being able to provide support during that transition by the development of a specialist Community Stroke Rehabilitation Team (CSRT).

I know some of you have been kept informed by Sarah Hardham and Janet Neville of the preliminary discussions that I have held. This briefing sheet will be published on a regular basis to keep us **all** in touch with developments and provide the opportunity for you to ask questions - and for me to answer them - or go away and find further information to enable me to answer them! In this way we can all be involved in this exciting development.

Why Elizabeth Ward?

he move from QAH to SMH gives us the opportunity to look at how we are working and use this time to create a better service.

Isn't it a waste of money upgrading a ward?

he simple answer is no. It is likely that the Elizabeth Ward move to SMH will go ahead as planned with the CSRT being launched at a later date. f and when the CSRT goes ahead, the ward will be used for another service.

What sort of patients will be under the care of the CSRT?

hose who have been admitted to hospital, diagnosed as having had a stroke and are medically fit to be managed at home. Patients' families will lso be involved and of course, be confident and able to assist with the overall care of their loved one.

What will happen to the staff?

he plan is to develop the CSRT from the staff that currently work in Elizabeth and Guernsey ward so that we have an in-patient 20 bedded stroke ehab' ward (Guernsey ward) and a CSRT covering patients from Portsmouth City and the south of East Hants area (these are the patients already eing cared for in these two wards)

taff will have a choice whether they want to move - if not they will be given priority help to find a post within the department.

ight staff are an important part of this development too. Some patients may need support at night when they first go home.

What about travelling to patient in their homes?

his is an area we are looking into. Kerry Bailey, Personnel Manager is working alongside us and will help answer those questions. Like other ommunity workers, mileage will be paid and journeys planned carefully to ensure maximum efficiency.

What's happening next?

team with representatives from each profession are visiting two similar schemes, one in Sheffield and the other in Dartford in May and June. We an then come back and really begin to look at the possibilities and potential challenges.

I NEED YOUR HELP! PLEASE SEND ME YOUR QUESTIONS AND CONCERNS. Please write to me, Jane Williams at: Amulree Day Hospital , SMH and share them with me, anonymously if you prefer, so we can work together to develop this project. Thank you.

Jane Willi

FC.

FAREHAM AND GOSPORT PRIMARY CARE TRUST

GOSPORT GP GROUP

file

Minutes of the Meeting held on Thursday 6 March 2003 at Thorngate Hall, Gosport

PRESENT:

Dr Evelyn Beale
Dr Bob Pennells
Dr Tony Evans
Dr David Young
Dr Peter Lacey
Dr John Bassett
Dr Declan Lynch
Dr Tony Knapman
Dr Richard Try
Dr John Grocock
Margaret Smith
Jan Peach
Sue Halewood
Dr Nic Allen
Rachael Boyns

ACTION

1 **Minutes of the Meeting held on Thursday 9 January 2003**

These were agreed.

2 **Matters Arising**

General Physician enquiry.
BP agreed to collate the responses, which will be discussed at the next meeting of the Gosport GP Group. RT reported that he had received a response from the Child & Family Therapy Service. It was noted that the department was in the process of reducing the length of time for follow up appointments and was seeking to appoint a GP Specialist in ADHD in order to address current capacity issues. — BP

3 **Update – GP beds (Gosport War Memorial Hospital)**

JP reported that approximately 3-4 beds have been vacant on Sultan Ward over the last couple of weeks, and that the bed pressures experienced by

the Acute Trust had decreased slightly. A document has been produced to clearly define the use of the GP beds and the process for admission and assessment. It was agreed the document should be circulated with the minutes and comments sent to Jan Peach. (e-mail address: Code A). The document will be discussed at the next meeting of the Gosport GP Group. All

It was noted that patients currently requiring IV therapy cannot be admitted to Sultan Ward. Further discussion is required with the Gosport GPs, as well as nurse training in the administration of IV therapy prior to this being able to occur.

It was noted that the issue regarding out of hours cover had been clarified with the out of hours providers.

4 **Prescribing**

Prescribing budgets 2002/03
SH reported that as at the end of December 2002, the Gosport practice prescribing overspend was £553,608. The forecast outturn for the end of March 2003 for both Fareham and Gosport practices is £1,181,179.

Prescribing budgets 2003/04
NA reported that practice prescribing budgets are currently being modelled for 2003/04 and will be presented at the next meeting of the Gosport GP Group. The modelling will incorporate the use of the low income scheme index (LISI). It was agreed that further information regarding LISI will be circulated to the Group. SH

Prescribing Incentive Scheme 2003/04
The Prescribing Incentive Scheme for 2003/04 was discussed. It was agreed that the development of practice specific targets should be explored and presented to the next meeting of the Group. NA/SH

The Group agreed that the incentive payment will be based on the performance of individual practices against the quality/cost targets and therefore will remain practice based.

It was noted that the Fareham and Gosport practices are high prescribers of asthma drugs and have high levels of admissions. It was agreed that comparative asthma data should be circulated to practices. SH

District Prescribing Formulary
The draft District Prescribing Formulary was presented to the Group. Comments regarding the Formulary should be sent to Sue Halewood. The Formulary will be circulated to all practices and placed on the extranet for reference.

5 **Personal Medical Services**

Margaret Smith reported that 175 practices had become PMS practices in Wave 5b and had received a total of 10.5 million gross funding. A key advantage of practices moving from GMS to PMS, is the potential funding a practice can receive for additional GPs and nurse practitioners. Under PMS, a practice could potentially receive approximately £60,000 for a GP and £30,000 for a nurse practitioner.

MS reported that PMS Wave 5b will commence in October 2003, and that interested practices must submit an outline proposal of interest by the end of March 2003. Practices who submit an expression of interest can withdraw their application prior to the commencement of Wave 5b in October 2003. Practices who are interested in PMS Wave 5b should contact Margaret Smith. It was noted that a further PMS Wave 6 is likely to commence in April 2004.

MS reported that the proposed GP contract had been launched last week. Copies can be obtained from the BMA website. Practices were encouraged to compare the advantages and disadvantages of the new GP contract and PMS.

6 **Any Other Business**

GP Appraisals
Andrew Paterson reported that new national guidance stated that all GPs must be given a date for their appraisal by the end of March 2003. Appraisal dates will therefore be allocated to all Fareham and Gosport GPs over the next couple of weeks. All Fareham and Gosport GPs will have been appraised by the end of March 2004. Further information regarding the appraisal process was circulated to the Group.

Child Care
Margaret Smith reported that a questionnaire is to be distributed to practices regarding child care. It was noted that the benefits of child care, for example, financial assistance with emergency child care, should also be available to primary care, as well as acute and community staff.

Non-Executive Directors
MS reported that the Non-Executive Directors are keen to be involved with primary care. It was proposed that each Non-Executive Director is allocated a certain number of practices with which they can develop a close working relationship and a joint understanding of current issues. The proposal was supported by the Group.

7 **Date of Next Meeting**

Thursday 8 May 2003, 12.30 pm to 2.00 pm. Venue: Georgian Room, Thorngate Hall, Bury Road, Gosport.

Fareham and Gosport NHS
Primary Care Trust

WORKING DRAFT

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24 February 2003

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In severe bed crisis patients can be transferred out of hours using relevant guidelines (appendix 3a)

App 2

Access to category 2 - Procedure for Assessing and Admitting to Elderly Medicine Step Down Beds

In circumstances where beds are not utilised in Category 1
Any patient currently within an Elderly Medicine ward, who lives within the Fareham and Gosport catchment area and meet the step down criteria, can be transferred under the care of the Consultant Geriatrician.

If a patient is deemed suitable for transfer the Elderly Medicine admission office will contact Sultan Ward with details of the patients and arrange transfer.

On arrival to Sultan the staff grade physician will clerk the patient in.

In severe bed crisis patients can be transferred out of hours using relevant guidelines (appendix 3a)

App 3

Access to Category 3 – Procedure for Assessing and Admitting to GP Step Down Beds

Patients can access category 3 by either:

- Being a patient within Portsmouth Hospital Trust who lives within Gosport catchment area and fulfils the admission criteria. (Appendix 3a)

- Admitted directly from home by GP and fulfils admission criteria (Appendix 3b)

If the patients fulfil the admission criteria a member of the PHT medical team should contact the GP to discuss the case. If the GP agrees to take on the patient's management the referring ward should then contact Sultan ward to book a bed and give a verbal handover. If no bed is available the patient will be placed on a waiting list and the referring ward will be contacted once a bed is available.

The referring ward is responsible for booking the transport and all transfers will take place between 0900 and 1300 Mondays to Fridays excluding bank holidays. Patients transferred after midday on Friday will not be seen routinely by a GP until the following Monday.

All documentation, x-rays, medication, patients' property and valuables are to be transferred with the patient. If any items are not transferred with the patient they must be sent immediately to Sultan ward by taxi ordered by the transferring ward.

App 3a

GUIDELINES FOR TRANSFER TO GP BEDS (SULTAN WARD)
GOSPORT WAR MEMORIAL HOSPITAL – 023 9252 4611

Gosport War Memorial Hospital is a modern community hospital located in central Gosport. There are 24 beds for patients admitted under the care of their GP on Sultan Ward. The ward clinical manager is Ann Haste.

As part of the development of intermediate care, there has been an additional investment in the development of an Enablement Service which complements the pre-existing transfer arrangements on Sultan Ward. There is no on site medical cover. Should the patient deteriorate then the GP (or nominated partner) will arrange transfer of the patient back to the referring acute hospital. Transfer back will be automatic and immediate.

SPECIALITIES THAT MAY TRANSFER

1. Orthopaedics and General Surgery

In 1998 strict criteria were developed for the transfer of Orthopaedic patients and these were refined in May 1999 to cover surgical patients also.

These criteria are unchanged and the patients must fulfil all the criteria listed below before transfer is discussed.

Criteria

1. No intravenous lines
2. Haematologically stable
3. Apyrexial (can be taking oral antibiotics)
4. No major discharging wound
5. Anticoagulant control stabilised or haematologist advising on control of anticoagulation)
6. Medically stable
7. No confusions leading to behavioural problems eg wandering, agitation and aggression
8. Anticipated medically fit for discharge within the next 14 days
9. Dying patient
10. If awaiting social services assessment and funding, this to have been done and discharge date agreed within the next 14 days
11. Does not need intensive rehabilitation.

2. General Medicine and Elderly Medicine

Patients for transfer from general medicine or elderly medicine wards must fulfil the criteria above (as developed for surgical and orthopaedic patients) and be negative on the Appropriateness Evaluation Protocol (AEP attached). This tool has been developed to ensure safe transfer of patients to non-acute hospitals

Procedure for Transfer

If the patient fulfils the criteria, a member of the medical team should discuss the case with the GP. If the GP agrees to take on the management of the patient, the referring ward should contact Sultan ward to book a bed. The referring ward should give sufficient information to Sultan ward for continuity if care to be given by the Sultan ward team. If no bed is available the ward will operate a waiting list and contact the referring ward when a bed becomes available. Ongoing rehabilitation and discharge planning should continue on the referring ward and the patient should be reassessed to ensure that transfer is still appropriate, and that the patient is fit for transfer. The referring doctor must "sign off" the patient on the day of transfer, as being both medically fit enough and suitable for transfer to a GP bed according to the above criteria.

The patient and carers must be involved and kept fully informed of transfer plans and progress by the referring ward.

The referring ward is responsible for booking transport.

Transfer Process

Transfers will take place between 0900 hours and 1300 hours Monday to Friday, excluding bank holidays. Patients transferred after midday on Friday will not be seen routinely by a GP until the following Monday.

On transfer, the following must accompany the patient:-

Name of contact person responsible for the patient prior to transfer:-

1. A complete set of medical and nursing notes with a details management plan.
2. Care pathways/copy of the care pathway and therapy notes.
3. X-Rays/pathology results
4. Handling profile, Barthel, Waterlow and Mental Test Score
5. Transfer of care information
6. Current legible drug chart and non-stock medical and/or dressing for 4 days (check with Sultan ward)
7. Essential equipment and appliances
8. Patient's property and valuables
9. Follow up outpatient and day hospital appointment if relevant

Any items not transferred with the patient must be sent immediately to Sultan ward by taxi.

Appendix 3b

ADMISSION CRITERIA FOR PATIENTS ADMITTED DIRECTLY FROM HOME BY GP TO A GP BED (SULTAN WARD) GOSPORT WAR MEMORIAL HOSPITAL

1. Patients with a short term (relatively) straightforward medical/nursing crisis whose needs it is felt, can be met and resolved on a GP ward. This would not include patients with complex medical problems and/or patients who need intensive rehabilitative input.

2. Patients requiring palliative terminal care. It is suggested that such admissions would be in accordance with protocols developed for the management of such patients in conjunction with the palliative care service (either the Rowans or Countess Mountbatten House).

3. Patients requiring urgent/emergency respite care in the event of a (short term) crisis at home.

4. Regular planned respite care for patients who are living at home and whose needs are such that they would otherwise be eligible for long term NHS continuing care.

Mild disorientation/confusion would not be a barrier to admission but wandering patients or those who have mild confusion/aggression/agitation would not be suitable.