PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

GOSPORT GP STEERING GROUP

Thursday 4 March 1999, 12.30 pm - 2 pm, Seminar Room, Gosport War Memorial

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AGENDA

1. **Apologies for Absence**

2. **Notes of Previous Meeting**

   (previously distributed)

3. **R.H. Haslar** — PG

   Dr Phillip Gray will attend discuss the item

4. **Gosport Naval Service**

   Surgeon Commander Peter Nichol RN, Principle Medical Officer for HMS Sultan/Representative of the three naval bases in Gosport will attend to discuss how links with the PCG/GP's could be established.

5. **Management costs and GP remuneration** — JK

   (paper attached)

6. **GMS Development priorities 1999/2000** — JK

   (paper attached)

7. **AOB**

8. **Next Meeting**
   Thursday 1 April 1999, 12.30 - 2 pm, Seminar Room, Gosport War Memorial Hospital

FILE

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

Gosport GP Steering Group

Notes of the Meeting held on 7 January 1999 at Gosport War Memorial Hospital

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Present:	Hugh Janes	HJ	Penny Humphris	PH
	Jane Barton	JB	Jonathan Hildebrand	JH
	Bob Pennells	BP	David Evans	DE
	Declan Lynch	DL	Wendy Mills	WM
	Evelyn Beale	EB	Angela Duthie	AD
	John Grocock	JG	Brendon Coonan	BC
	Jayne Colebourne	JC	Kathryn Rowles	KR
	Wendy Harrison	WH	Hazel Bagshaw	HB
	David Young	DY	John Kirtley	JK
	Peter Lacey	PL		
	John Bassett JB.			

No	Discussion	Action
1.	**Apologies for Absence**	
	Liz Ross	
2.	**Background to Haslar**	
	Due to the number of beds - 300 beds planned, 250 actual beds tensions was expressed about Haslar not providing adequate service to military personnel.	
	There is a 400,000 population base for DGH services.	
	The content of the announcement re: Haslar closure was made available to the Health Authority On 11/12 December. This stated that the aim was to close Haslar in 2002 but not until other arrangements have been put in place to provide services.	
	It was reported that the clinical collaboration project has had some success.	
	There will no longer be a urology facility at Haslar. Portsmouth HealthCare Trust (PHT) are to put together a package to sort this out.	
	The Ministry of Defence is currently paying in the region of £30m to run Haslar. A valuation done by PHT set the NHS level of activity at £11m with a discount of £7m. This was attributed to an uncertainty and a lack of efficiency in areas such as day care where 60% is provided by PHT and 40% by Haslar.	

3. **Action Required**

- It was agreed that there needs to be support plans on a 4 - 5 year basis for the Haslar-PHT integration.

- It was acknowledged that in the short-term it would not be possible to provide the capacity required.

- The wing on PHT (Seven Oaks School site) will be used for the Ministry of Defence Hospital Unit (MDHU). It will therefore be necessary to work with DSCA to plan this.

4. **Local Provision of Secondary Care**

It was noted that this is an issue which primarily concerns Primary Care Groups and it was agreed that close work was required between the PCG's, the Royal Hospital Haslar (RHH) and PHT particularly in view of the 70,000 outpatient attendances.

There was some discussion about the reconfiguration of Gosport War Memorial.

With regard to Accident & Emergency services PH said that she would be talking about this at the Queen Alexandra Hospital (QAH) next week. PH

A principle concern was expressed that it will no longer be affordable to continue to provide everything that the RHH currently provides.

5. **GP Concerns**

a. Collapse of Haslar

There were concerns raised about the timetable set out for the closure of Haslar and it was felt that the hospital would collapse before that time. PH talked about the joint work which needs to exist between both new and existing NHS Consultants. She added that acute admissions would be treated at QAH.

b. ICU

BC asked what the situation with Intensive Care Unit (ICU) beds would be. PH response was that these were to be part of MDHU.

c. CHD

DL raised the point that the nearness of Haslar and the recent guidelines on administering streptokinase may have contributed

directly to the fall in CHD. PH stated that the ambulance service may develop this expertise. She would be involved with discussions with the NHS Executive regarding funding in the short-term.

d. Paediatrics

JB questioned what would happen to the paediatric service at Haslar. PH informed the group that a draft letter to GP's was awaiting agreement from Haslar. Several problems were highlighted; the dubious opportunity for cover when there are only 2 Consultants now in this field working at the RHH; the non-existence of any middle-grade staff; the insufficient number of RSCN's; the impossibility of PHT Consultants covering Haslar as they already cover two sites.

Although it was pointed out that a day care nursery existed the concern was expressed that the child may be too sick to be discharged. The present occupancy rates for children's ward were quoted at 1.5 - 2 children per night.

e. Accident & Emergency

DE stated that from 31 March 1999 the Consultant in A&E at Haslar (Ian Rees) will not be able to admit patients. It appears to have been accepted that the Anaesthetist would deal with post-operative patients. PH said that she would be in contact with Ian Rees to establish the A&E position. DL queried whether, with the closure of the A&E at Haslar, additional funds would be directed to the Gosport War Memorial Hospital (GWMH) with a view to providing a similar service. PH replied that this may be part of the package.

6. **Physiotherapy**

AD reported that the practice-based waiting lists are now back, but they are currently sorting out the problems.

WM informed the group that the project had been stopped by Ian Latimer and apologised for this. Each practice will now have a named physiotherapist and that person will be responsible for practice liaison.

JG asked for information on which patients did not attend. AD advised that this information would be available by the end of January 1999. She would also share with the group the referral guidelines. AD

7. **Prescribing**

HB reported that in the majority of practices the annual growth rate had fallen and outlined the main growth rates. A letter to GP's had been drawn up asking them to allow prescribing data at the practice level to be shared. Regarding wound care products HB agreed to circulate the details of costs.

8. **Laser Care**

There was considerable interest shown by the group in finding out more information on laser care.

9. **Changes to Board**

John Bassett resigned from the Board although he still is interested in staying on the Steering Group and on the Prescribing sub-committee. DE agreed to approach Dr Rachael Sharp. DE is to meet with Gosport Council. It was agreed that DE could lead further discussions at Gosport Medical Committee. Other information from practices should be sent to DE by telephone.

10. **Next Meeting**

The meeting on 11 February has now been cancelled so the next meeting will be at 12.30 on 4 March at Gosport War Memorial.

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

Gosport and Fareham PCG's Management Costs

The overall management budget for the Health Authority has been increased with an allowance for PCG's. The revised annual budget for the Health Authority, including the PCG's is around £5.5m.

This Health Authority has the lowest overall management costs in the new South East region, which consists of 14 Health Authorities; it had the second lowest costs within the former South West region which consisted of 12 Health Authorities.

The allocations for Fareham & Gosport management costs, based on an allowance of £2.42 per head of a weighted population amounts to around £423k.

The total estimated funding which the Health Authority will make available for the Fareham and Gosport management team, including the PCG Board is around £431k.

This figure is based on 1998/9 pay and price levels and allowances. It is estimated that an additional £32k would be required to meet the costs arising from inflation for 1999/2000. The total estimated management cost budget sum for the Fareham & Gosport PCG management team is therefore £431k+ £32k= £463k. It will be seen that this figure exceeds the allowance to the Health Authority by around £40k.

It should be noted that the costs of Pharmaceutical Advisers and locum costs are excluded from the definition of management costs and therefore excluded from the estimated management costs, set out above.

Fareham & Gosport

A summary of the costs totalling around £431k is set out below:

Senior Manager Grades:	6.6 posts	£242k
A&C staff	2.5 posts	£37k
Chair & Board Members		£122k
Non Staff costs		£30k
Total		£431k

Additional costs excluded from the management costs definition are Pharmacy Advisers and locum costs for Board Members.

PCG Board Member payments are set out in the Department of Health guidance circular HSC 1998/190 as follows.

For a level 2 PCG with a population in excess of 75,000:

	Allowance	Locums (Max)
Chair	£15125	£6000
Board Members	£4000	£3000

The national circular sets out the following:

The Chair of a level 2 PCG may be expected to spend the equivalent of perhaps between 1 - 2 days per week on PCG business, depending on the level, size and organisational development of the PCG. However, this will ultimately be determined locally taking into account the volume and the mix of work to be undertaken by the PCG and the Chair's own working preferences.

It is expected that PCG's will decide on a pattern of meetings to suit their locum circumstances and those of individual Board members. As a rough guide PCG Board Members might be expected to spend perhaps 2 - 2.5 days per month on PCG Board business.

These commitments will vary according to the level of the PCG and how the PCG Board organises itself. They are also likely to vary with time, the size of the PCG and its geography.

Board Responsibilities and Workload: GP's

There are currently four elements to this:

- Chair's responsibility
- Corporate involvement in Board meetings
- Lead responsibility in a key priority area. For example HimP and Commissioning; these may include non-Board GP's e.g. clinical governance and prescribing
- Participation in GP groups - GP Board members representing each practice.

Appropriate remuneration for each of these elements set out above must be funded from within the estimated budget set out earlier.

Decisions are required on maximising the use of the funds available to ensure that Board member GP's, or other GP's taking a lead role on behalf of the Board are appropriately remunerated for the time commitment.

A purely illustrative division of funding across these areas is set out below, against the £42k available for Gosport PCG.

GP Board Members	6 x £4k (say 6 Board Meetings per annum)	= £24k
Board Leads	2 x 3k locum payments	= £6k
Clinical Governance	3k	= £3k
Prescribing	3k	= £3k
GP Group meetings	3 x £360 (6 meetings per annum)	= £1.1k
Reserve for ad hoc projects		= £4.9k
Total		**= £ 42k**

GOSPORT PRIMARY CARE GROUP

GMS DEVELOPMENTS 1999/2000

Background

GMS budgets will be confirmed during March. Some growth funding will be required for pay increases for practice staff above the 2.7% funded level. In addition, further funding will be required for additional costs on current budgets in relation to relief and computer support and maintenance.

Initial estimates are that around £45k will be available to the Gosport PCG for recurring staffing developments, after allowing for factors set out above.

The total cost of recurring bids received by the PCG is around £44k. In addition, bids totalling around £4k for non-recurring staffing have also been received.

The PCG will also have non-recurring funding of around £100k available to it to support one-off expenditure such as improvement grants and computer system upgrades and replacements.

A stock-take of IT development needs by practice is currently being undertaken. However, the likely costs of requirements for non-recurring investment in computer systems is not yet known. Similarly, whilst there are proposals being developed for new practice premises any likely financial commitments during 1999/2000 are not yet clear.

Because of the uncertainty in a number of areas it may be prudent to avoid committing the full £45k potentially available for recurring staff developments, at the start of the financial year.

It is therefore suggested that priorities are considered so that funding can be agreed and released from a recurring development programme at the beginning of the year, which could be supplemented later on in the year with additional developments agreed when the overall funding position becomes clear.

Recurring Staffing Development

The following proposals are for discussion in connection with recurring staffing bids.

First Priority

First funding priority should be to maintain existing service levels where ongoing posts were funded on a non-recurring basis in 1998/9. These posts should now be funded recurringly to prevent a service reduction.

Second Priority

Second priority should reflect responses to changing service needs. An example of this is a revision of boundary changes between two practices, necessitating a review of GMS support.

Third Priority

Remaining bids should be considered against current funding levels of practices. The Health Authority has a system which compares current funding levels (SCOPE). This allows bids to be ranked as high, medium or low priority depending on current funding levels for the practice submitting the bid, compared to similar practices. It is suggested that, initially, practices with low and medium current funding levels should be supported with approval of such bids.

It is suggested that, initially, those practices currently ranked as high on current funding should not have bids approved immediately. Further discussion should take place with these practices to set out a detailed case for further investment in practice staffing. It is suggested that the outcome of these discussions should be considered when the need for expenditure on other areas of the GMS programme is clear. It is suggested that a decision concerning these bids should be taken no later than September.

It is possible that as the work of the PCG progresses, needs for further investment in practice staffing to support the PCG as a whole may emerge. An example would be the employment of a nurse involved in work specifically related to asthma to provide a service across all practices within the PCG. Such proposals should be considered before further funds are committed in September.