PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

Purchasing for Health 1997/98 Consultation

Notes of the Meeting held Wednesday 30 October 1996 in Lee-On-Solent Health Centre

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Present:	P Humphris	PH	J Barton	JB
	J Henly	JH	C Tart	CT
	H Janes	HJ	W Dow	WD
	B Coonan	BC	R Pennells	RP
	D Evans	DE	J Beale	JB
	A Knapman	AK		

Discussion

PH outlined the Health Authority's current and projected financial position, explaining that in the past few years the HA had benefited from being below equity (the financial position against which HAs are measured and towards which they are moved) and therefore received additional growth monies. However, the HA was now nearing equity and would therefore receive less growth. The HA's current financial planning was based upon receiving 0.5% growth, but the exact figure will not be known until the end of November. The current HA budget for hospital and community care was £200 million, therefore the HA was likely to receive approximately £1 million. PH explained that whilst this may sound a lot, there were many new developments such as new drugs and projects including PHT's replacement linear accelerator which also required additional funding. This situation therefore meant that the HA needed to look not only at how the additional money was spent, but also at how the existing budget of £200 million was spent. Decisions on prioritising services needed to be made and this included decisions about the relative priority of the current inpatient and outpatient waiting time standard of 6 months and 9 weeks respectively.

JH explained that this year, following comments on last year's report, the format and style of the document had been significantly changed and he hoped that it was now clearer. JH outlined the current issues and explained that the document listed 20 health care programmes, with a set of actions against each programme and a number indicating the proposed funding priority. JH also explained the financial arrangements for the funding of Haslar and welcomed views from GPs on priorities for services offered by this hospital.

JH outlined the HA's current position on waiting lists, explaining that reductions in the number of people waiting excessively long times for hospital treatment had been attained. However, given the changes in the HA's financial position, the document proposed lengthening the times which less urgent patients had to wait before hospital treatment. The proposed changes to the maximum waiting times for non-urgent patients were as follows:

	Current standard	**Proposed standard**
Inpatients	6 months	9 months
Outpatient first appointment	9 weeks	13 weeks

DE questioned Haslar's ability to achieve these standards, given the present uncertainties with apparently continual changes in the number of consultants and the impact this may have upon the activity levels. JH explained that the HA have a Service Level Agreement with Haslar which sets out, by specialty, the level of service the HA would wish to see provided. However JH acknowledged problems in keeping Haslar to this agreement, explaining that the mix between specialties also changed due to new arrivals/departures of consultants. The HA was also concerned that an influx of consultants in one specialty may reduce the referral threshold, which could increase throughput of patients which may otherwise have not been referred, thereby adversely affecting the HA's financial position.

BC raised the issue of bone densitometry, questioning the current practice of Gosport patients travelling to QA and suggesting that perhaps Portsmouth patients could travel to Haslar. JH stressed the need for joint work between Haslar and Portsmouth Hospitals that would allow inbuilt flexibility of services.

CT expressed his concern that it may not be possible to sort out certain core issues locally. JH accepted this point and stated that the HA were having a series of meetings with the Defence Secondary Care Agency (DSCA), who were responsible for Haslar. CT commented that whilst there were good professional relationships between many local GPs and clinicians in Haslar, there were concerns over the consistency of the services offered. JH said that this was an issue that the HA were discussing with the DSCA.

WD raised the issue of cancer services. JH explained that there were two categories into which hospitals offering cancer services would be placed and that each category had a set of criteria against which the hospitals were measured eg the need for breast cancer units to see more that a certain number of new cases each year. This meant that some consultants in Haslar may therefore need to work outside of Haslar in order to keep their skills up-to-date. PH stated that PHT had been designated a cancer centre within the last week.

PH outlined the HA's current concerns regarding Haslar's performance, including the relatively low number of day cases and large number of single consultant specialties. The DSCA were still unable to tell the HA what capacity there was likely to be for the HA's civilian population and this therefore made planning services very difficult. PH also stressed the importance of local GP's attitude and approach to Haslar, explaining that Haslar relied upon referrals from local GPs in order to meet their training requirements. PH asked GPs whether referrals would drop if uncertainties about services offered by Haslar persisted and those present agreed that they would, although DE stated that many local patients want to be seen in Haslar and felt that in many cases they received a very good service. CT reiterated the need for Haslar to instill confidence in the local GPs over Haslar's ability to consistently provide core services.

DE raised the issue of children's services and there was general agreement amongst the GPs that they would not send young children into Haslar, other than in an extreme emergency. JH explained that the HA did have some concerns regarding the treatment of children within Haslar and was in the process of trying to set up a review of children's services.

RP asked whether the HA felt that waiting lists had been forced down by GP Fundholding practices. JH did not believe that this had been the case. RP suggested that perhaps some patients would be happy to wait slightly longer. JH explained that the HA had used £4 million to 'spot purchase' services in order to maintain existing waiting time standards and welcomed the view that a slight relaxation of these standards may be acceptable. JH also explained that any such relaxation would still mean that the HA standards were within the Patient Charter Standards and were still likely to remain amongst the lowest in the country. Such standards would also mean that only about 10% of patients would have to wait the maximum time. WD suggested that flexibility was the key, with those patients having the greatest need being seen first. PH agreed with this stating that the HA were trying to encourage their providers to adopt this approach. WD expressed a concern that waiting times should not be increased excessively, otherwise an increase in ECRs may occur. JH agreed that the HA wanted to avoid this problem, especially given the higher costs of ECRs.

DE raised the provision of dentistry in the area and asked what developments were planned in this area. PH explained that a number of bids had been put forward for national finance and the HA would like to see services developed to cover evenings, weekends and bank holidays. There was general agreement amongst the GPs that the standard of dental health in the local population had declined, whilst the dental-related workload of GPs had risen. PH stated that one of the bids was to enable patients in certain areas to be targeted by providing an additional payment for every new patient registered, but the HA does not yet know whether this bid will be successful.

BC expressed concern regarding the large amount of money available for HIV and AIDS, given the relatively small number of people. JH explained that this money was 'ring-fenced' specifically for use in this area, but the money had been used flexibly and where appropriate, other areas had benefited eg drugs awareness campaigns.

WD pointed out that there appeared to be no additional money allocated for palliative care. JH explained that additional money had already been put into this service, with two more beds at The Rowans. The current funding arrangements mean that the HA paid 100% of the cost for patients sent to Countess Mountbatten House (CMH), whereas due to fundraising carried out by The Rowans, their figure was nearer 50%. JB expressed concern that the GPs would lose the services of Consultants from CMH and there was general agreement that the service from CMH was excellent, especially Dr Beewee. CT was concerned that short term funding made planning very difficult. JH accepted this and stated that the key was achieving the correct balance between The Rowans and CMH.

RP suggested that much of the paper used by local providers and sent to GPs was too thick for the folders, especially that sent by Portsmouth HealthCare Trust.

AK was interested in the current review of the usage of hospital beds, especially the GP beds in Gosport War Memorial (GWM), as he felt that these were very useful. JH explained that the HA needed to look at everything, especially in light of the current and projected financial position. JB suggested that if there were no GP beds in GWM, patients would be inappropriately admitted to more expensive acute beds. RP suggested that there was room for improvement in the way Social services operated.

WD commented on the recent publicity concerning mixed sex wards. PH stated that she believed that the current position of seven wards at QA was unacceptable and that work would be done to try and reduce this number.

CT commented that the recently introduced team midwifery service did not appear to work. PH stated that this was a pilot and that it was due to end in February. The success, or otherwise, of this service would then be reviewed, but she noted the general comments expressed by the GPs that it had not worked and should not be continued.

JB raised the issue of practice-based mental health counselling, expressing concern that it appeared to work well in some practices, but not others. PH stated that this had been discussed at the Commissioning Board and that a service specification was currently being drafted which would hopefully suggest a better way of using existing resources. RP asked when this was likely to happen. PH confirmed that the existing arrangements would continue for a year, by which time a new solution should be in place. A timetable and action plan was due to be submitted to the Commissioning board in the next six weeks. CT expressed a view that GPs would like to be involved and PH agreed that this would happen.

HJ thanked everyone for attending.

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