File ; Gen 12

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PCG Leads meeting to be held on Friday 8 December 2000 at 2pm at Professional Centre (Following LMC meeting)

AGENDA

1. **Apologies for Absence**

2. **Notes of the previous meeting** — **Attached**

   To agree the notes of the meeting held on 10 November 2000

3. **Matters arising**

   Dermatology — **Attached**

4. **Introduction of molecular testing for chlamydia in Portsmouth** — **Attached**

5. **Criteria for Continuing Care**

   To consider Martin Sever's letter — **Attached**

6. **District Commissioning Group** — **Attached (*2)**

   To receive the minutes of the November meetings (7 and 21st)

7. **PCG/T Updates**

   IOW
   Fareham
   Gosport
   Portsmouth
   East Hants

8. **Any other business**

9. **Dates of future meetings**

   To agree the programme of meetings for 2001

8/12

PORTSMOUTH & SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

Notes of the PCG Leads meeting held on 10 November 2000

Mrs S Robson
Chief Exec - EHPCG
Finchdean House

Present:	Dr C Lewis	Mrs S Clark
	Mr J Kirtley	Dr G Somerville
	Mr D Crawley	Mrs S Robson
	Dr J Barton	
Apologies for absence	Dr J Hughes	Dr M Johns

No.	Discussion	Actio
1.	**Minutes of the previous meeting**	
	The minutes of the meeting held on 13 October 2000 were agreed	
2.	**Maters arising**	
	Dermatology – In his absence, Dr Johns was asked to submit details of all interested GPs to the Trust and not just East Hampshire ones. It was confirmed that PCGs were not undertaking any quality/competence checks on those who had expressed interest in undertaking the work.	**MJ**
3.	**Commissioning Group**	
	Rehabilitation services – it was noted that the new Rehabilitation consultant was visiting all PCGs, keen to develop a local service and receive appropriate referrals. It had been stressed that service development would need to be within existing resources.	
	Dr Jorge's letter regarding continuing care eligibility criteria was discussed. JK agreed to convene a meeting with Jackie Charlesworth and Sally Pastellas (IOW to confirm nominee) as representatives to review the application of current continuing care criteria for young physically disabled.	**JK** **DC**
	Infertility Treatment – It was agreed that the IOW PCG should become involved in this review.	**DC**
4.	**Commissioning Arrangements**	
	SR reported that the Chief Executives had been asked to meet to review commissioning arrangements, particularly the monitoring and review of Portsmouth Hospital's performance and to make recommendations to improve accountability. At the meeting it had been agreed that the arrangements, which had been proposed at the beginning of the year, had not been given chance to prove themselves, with the Whole Systems Group being seen to be the focus for decisions. It was proposed that the substantive arrangement should continue, with the monthly monitoring group being chaired by one of the Chief Executives, in rotation.	
	The group endorsed these proposals.	
	It was agreed that SR would respond to Portsmouth Hospitals Trust's consultation on their new structure on behalf of the group, asking for monitoring arrangements to be reconsidered.	**SR**
5.	**Links to Education**	

SR reported ongoing difficulties in the relationship between the PCG and 'education'.

SC reported that this was the experience in other PCGs and that a workshop was being set up in the new year with two aims:

- To discuss current arrangements
- To revisit Martin Sever's proposal for PCG involvement in education

It was suggested that Martin should facilitate the first part of the workshop with SC facilitating the second. She agreed to take these suggestions back to the group that were making the arrangements. SC

6. PCG/T Update

JK reported that Portsmouth Hospital's Outline Business Case for PFI had been supported at the Health Authority meeting on 9th.

Fareham and Gosport - Both PCG Boards would be discussing the way forward into Trust status in the next few weeks.

IOW – DC was congratulated on successful establishment of the Trust. He reported that Val Anderson had been announced as Chair and the announcement of two NEDs was expected shortly. He anticipated the Chief Executive appointment being made before Christmas.

East Hampshire – PCT application now submitted with a meeting planned for 1 December to receive SERO perspective on the application.

DC advised that between submitting his PCG's application and his meeting with SERO, he had received a number of telephone calls from Brain Courtney and as a result he had been able to submit additional supporting information to amplify certain aspects of the application.

Portsea Island – CL reported that the PCG had met with every service within PHCT and 2-3 services in PHT as part of the consultation exercise. Each had received a standard presentation and had been asked a set of five questions; the responses had now been collated. Each service had identified generic questions about education, audit, governance arrangements and professional cover. There had also bee a number of service specific issues raised.

SC reported that Julie Hawkins and David Barker were undertaking a piece of work to finalise service specifications for each service for all PCG/Ts on the mainland.

It was noted that Penny Humphris was commissioning an external consultant to review 'phase II' service configuration. CL reported that the consultants within PHCT had agreed to abide by the outcome of the review.

7. Ethic committee representation

The ethics committee was approaching Dr G Robinson directly.

8. Cancer Representation

It was understood that the Cancer network was seeking one GP, to represent all GPs is 15 PCGs. SR would contact Liz Steele to seek details of the recruitment process. SR

Liz to ask at Central SC.
Mtg 24/10.

	Each PCG would be receiving £10k management costs to allow Cancer Lead arrangements for the PCG to be set up. More details were awaited.	
9.	**Alert Training**	
	Each PCG had a slightly different understanding of what had been agreed as part of the costs for local intermediate care arrangements. It was agreed that each PCG would respond directly to Nicky Pendleton's letter.	**SC/JK/SR**
9.	**Allocation for extended access to primary care**	
	Noted to have been handled differently in different PCGs. Fareham and Gosport had included plans in their PCIP, IOW were to employ a salaried doctor to provide locum cover, tied to a bursary award, within the PCG to allow GPs to be freed up to provide specialist services. DC agreed to share his proposal (attached to these minutes).	**DC**
10	**Date of next meeting**	
	2pm (to follow LMC tripartite meeting). At the Professional Centre, Sundridge Close, Cosham.	**All**

PROFORMA FOR BIDS

EXTENDING PRIMARY CARE

PROPOSAL TO APPOINT SALARIED DOCTORS

1. Bid summary.

The bid is based on appointing two salaried doctors to the PCT whose role will be

- to provide locum cover into practices when GPs are working in special clinics
- to provide cover into practices when GPs are undergoing training to become accredited as specialist GPs
- to act as accredited specialist GPs in their own right for clinics operated by the PCT

It is thought that having permanent locum availability of a good standard may make GPs more willing to use this service and to move forward on their own personal development.

Such locum costs could be more cost effective for primary care than current arrangements and the flexibility of PCT locum cover where there was some permanence may be attractive to primary care and candidates if the post involves other areas of service provision.

2. Background information on current situation.

Currently there is a shortage of good locums on the Island. The PCT could act as a resource for practices where they need locums to allow GPs to step outside of the practice and act as specialist GPs.

Locum cover is essential to the running of primary care and will become more important as a PCT is established. The PCT wants to establish specialist GP roles but the barriers to achieving this can look significant. Salaried GPs providing support to practices and partners will help overcome these barriers.

3. How does the bid meet priorities?

It facilitates the extension of primary care by allowing GPs to extend there skill by removing some of the barriers that exist for GPs to gaining accreditation.

By working as specialist GPs it also extends the role of primary care.

4. Aims and objectives/benefits/problems to be resolved.

Aim is for the PCT to put in place support systems for GPs allowing them scope for development without worrying about finding locum cover.

It will facilitate the setting up of locality clinics for various disease areas.

It will provide a permanent source of locum cover for practices.

5. Details of proposal - what will be done, by and for whom, to what timescales?

Agree proposal can be progressed	October 9
Develop outline job descriptions	October 31
Agree salary and other terms and conditions	October 31
Advertise	November 14
Appoint	November 30
In post	January 30 to April1

6. Costs - recurrent and non-recurrent from anticipated start date.

Locum costs could be recharged to practices at an economic level when it is to cover the cost the GP running a specialist clinic – payment for clinic work should cover such costs and still reward GP, but could be met through bursary funding (see separate business case) when a GP is undergoing training.

Cost could also be potentially met from HCHS funding as part of the role will be based on service provision as part of the PCT.

Ultimately this depends on the salary that we appoint at. There is likely to be a deficit in funding that would have to be met but this provides an opportunity to free other GPs to develop.

Costings associated with proposal

	One wte £	1.6 wte £
Salary cost (say eight days provision) Two 0.8 wte	50,000	80,000
Oncost	6,000	9,600
	56,000	89,600
Travel and training	2,500	4,000
	58,500	93,600
Potential funding		
Recharge to bursary scheme (see separate bid)	8,500	15,000
Other locum work in primary care (primary care)	32,000	55,000
Specialist doctor work (HCHS funding – waiting lists)	18,000	25,000
Potential cost of locum per session (based on 43 wks)	£150	

Funding is dependent upon primary cares willingness to use the service – which is cost-effective and lower than current locum costs. It is also dependent upon substantive specialist GP roles being established by the Primary Care Trust and finding candidates with those interests. The proposal attempts to remove some of the barriers to GPs making a transition to dedicating part of their time to specialist services.

This could be self-funding but there could be a residual cost that is not recovered. As such there is risk associated with this development. However, it may be necessary to accept that risk if we are to overcome barriers to clinicians stepping outside of the normal practice boundary and working for the PCT.

7. Expected outcomes (including savings in other areas of expenditure).

- More GPs working in a specialist role across practices
- More skilled workforce
- Easier access for some GPs to training and development
- Better locum cover in pirmary care

8. Consideration of any alternative proposed way of achieving objectives, and why these have been discarded.

No other alternative has been considered. The proposal is about increasing capacity and it is considered that there is no mileage in doing so without finding additional doctors.

9. Reality check - any anticipated likely problems/future knock on costs.

Willingness of GP principals to use locums and to undertake training to become accredited specialist GPs. Proposal could be self-financing if fully utilised and can increase capacity of primary care to provide care to patients.

The scope of the bid is to set aside an initial contingency to meet any shortfall in income for this post but there is a general feeling that this can be self-financing.

INTRODUCTION OF MOLECULAR TESTING FOR CHLAMYDIA IN PORTSMOUTH

INTRODUCTION

Chlamydia Trachomatis is the most common curable sexually transmitted infection in the UK. Over 45,000 new infections are diagnosed in genitourinary medicine clinics in England and Wales each year. (1) Reports of chlamydia Trachomatis in England have increased by nearly 50% in the past 10 years reflecting in part increasing testing and screening (1). This has public health significance because chlamydia Trachomatis can have serious long-term consequences especially in women. It is a well-established cause of pelvic inflammatory disease leading to infertility, ectopic pregnancy and chronic abdominal pain which are expensive to treat and have major life time consequences for the individuals concerned. Chlamydia also causes ophthalmia neonatarum and pneumantis in children born to infected women. The aim of screening men and women for chlamydia in conjunction with effective clinical management (including treatment and partner notification and advice on risk reduction) would reduce the morbidity associated with chlamydial infection as well the incidence and prevalence of infection. This will produce considerable health gains and in the long term is expected to reduce health costs and be cost effective.

In 1998 the chief medical officers expert advisory group recommended opportunistic screening of women aged under 25 years and all women older than this with more than two partners in the proceeding 12 months. (2) The recommendations also included diagnostic testing offered to all men and women presenting with symptoms which are associated with chlamydial infection, genitourinary medicine clinic attenders (of both sex), women seeking termination of pregnancy and to consider on an individual case basis opportunistic screening of any women undergoing instrumentation of the uterus.

TESTING METHODS

Chlamydial infection can be diagnosed using a variety of testing approaches including cell culture, direct flourescent antibody tests, enzyme immunoassay and nucleic acid amplification technique. The specificity and sensitivity of these test methods vary and depend on the sample used.

As most chlamydia trachomatis infections is asymptomatic there is a need to screen at risk patients to reduce the morbidity from infection as well as to decrease the incidence and prevalence of this of pathogen in the population at large (3&4). Traditional screening procedures for detection of chlamydia infection necessitated a speculum examination to collect the infected cells of columnar epithelium from the endo cervix in women and a urethral swab in men. The current molecular testing for chlamydia with nucleic acid amplification assays such as ligase chain reaction (LCR) has the advantage of being more sensitive and specific compared to other methods and could be tested on urine specimens.

CURRENT TESTING METHOD USED IN PORTSMOUTH

At present chlamydial antigen by ELISA on cervical and urethral swabs from women and urethral swabs from males are used to screen patients for chlamydia.

The chlamydia pilot has been in progress in Portsmouth from 1st September 1999. The screening test used for this pilot is nucleic acid amplification with LCR on urine specimens. During this period patients attending the GU Medicine was also screened with cervical and urethral swab in women and urethral swab in men with ELISA.

PRELIMINARY RESULTS - LCR V's ELISA

We have analysed data collected during the first six months of the trial looking at the positive rate of chlamydia by urine and ELISA in men and women. A number of tests initially showed equivocal results. For the purpose of preliminary analysis we have excluded the equivocal results.

230 male patients were diagnosed with chlamydial infection (if either urine for LCR or urethral swab for ELISA is positive) all 230 patients were positive with LCR on urine. 105 were negative with ELISA (46%). (figure 1)

551 female patients diagnosed with chlamydia (being positive for chlamydia either with urine LCR or cervical/urethral swab by ELISA). 388 patients were positive with both test 164 patients were positive on urine with LCR and negative with cervical/urethral swab. 3 patients were positive on cervical/urethral swab and negative with urine LCR. Out of 548 patients with positive urine results 160 were negative on cervical/urethral swab (30%) by ELISA. (figure 2)

This preliminary test result shows that we would have missed 46% of men and 30% of women if we had only performed ELISA testing on urethral swabs in men and cervical/urethral swabs in women.

PRELIMINARY RESULTS - CO-INFECTION

All patients attending the GU Clinic with positive chlamydia results were offered screening for other sexually transmittable infections. 42% of female patients and 25% of male patients attending GU Medicine, 19% of chlamydia positive diagnosed outside GU Medicine and 14% of sexual partners of chlamydia positive patients had one or more sexually transmittable infections (figure 3). Overall 24% of patients had sexually transmittable infections (figure 4)

In view of high prevalence of associated STI's all chlamydia positive patients should be screened for STI's.

PRELIMINARY RESULTS - CONTACT TRACING

76% of traceable partners with chlamydia infection were seen and treated. Contact tracing is a vital component in the management of chlamydia.

In order to reduce the risk of re-infection and also reduce the pool of infection in the community, active contact tracing should be carried out when managing chlamydia positive patients.

CONCLUSION

The aim of chlamydia screening is to improve case detection and treat patients adequately in order to reduce the chronic sequale of chlamydia.

The detection of chlamydia by LCR in first catch urine in both females and males has been reported to have high sensitivity and specificity (5).

Collection of clinical samples by non-invasive methods such as urine tests also have an added benefit of high patients compliance and acceptability, compared to the current testing method.

REFERENCES

1. Lamagni T, Hughes G, Rogers P, Paine T, Catchpole M. New cases seen at genitourinary medicine clinics: England 1998. Commun Dis Rep CDR Suppl 1999; 9 (suppl 7): S1-S12.

2. Chief Medical Officer's Expert Advisory Group. Main report of the CMO's expert advisory group on Chlamydia trachomatis. London: Department of Health 1998.

3. Wilcox MH, Hoy C. PCR testing for genital Chlamydia trachomatis infection in pregnancy. 38th Interscience Conference on Antimicrobial Agents and Chemotherapy, San Diego: American Society for Microbiology, 1998 (Abstract D33).

4. Verkooyen RP, Luijendijk A, Huisman WM, et al. Detection of PCR inhibitors in cervical specimens by using the AMPLICOR Chlamydia trachomatis assay. F Clin Microbiol 1996;34:3072-4.

5. Van Doornum GJJ, Buimer M, Prins M, et al. Detection of Chlamydia trachomatis infection in urine samples from men and women by ligase chain reaction. F Clin Microbiol 1995;33:2042-7.

Female Chlamydia --Results

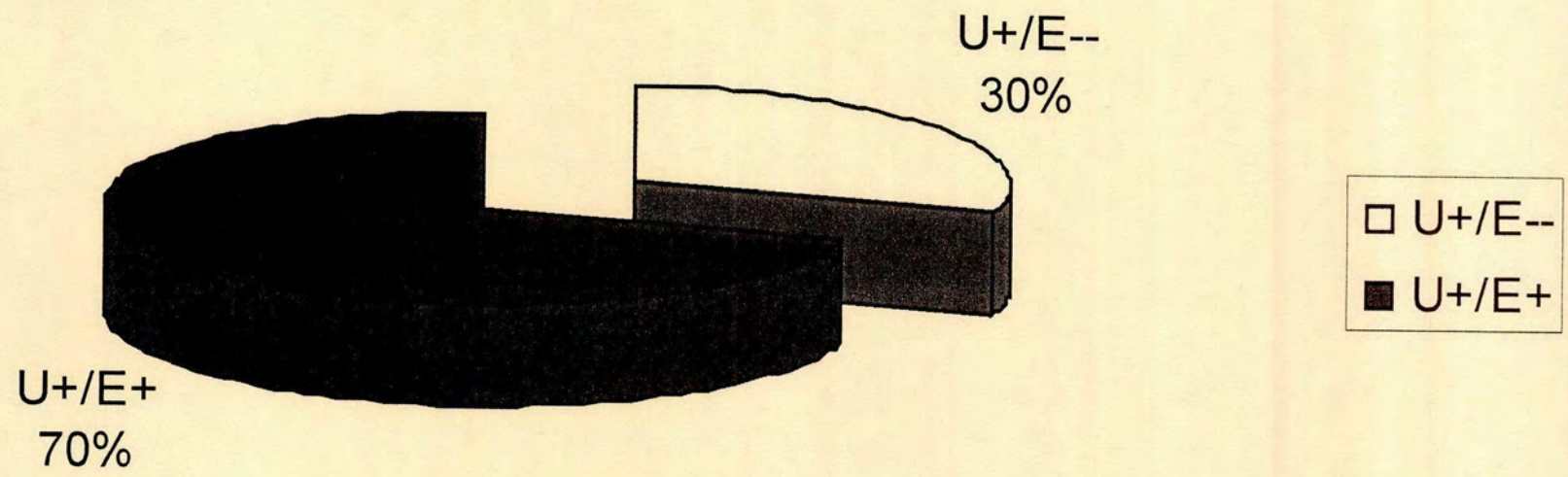
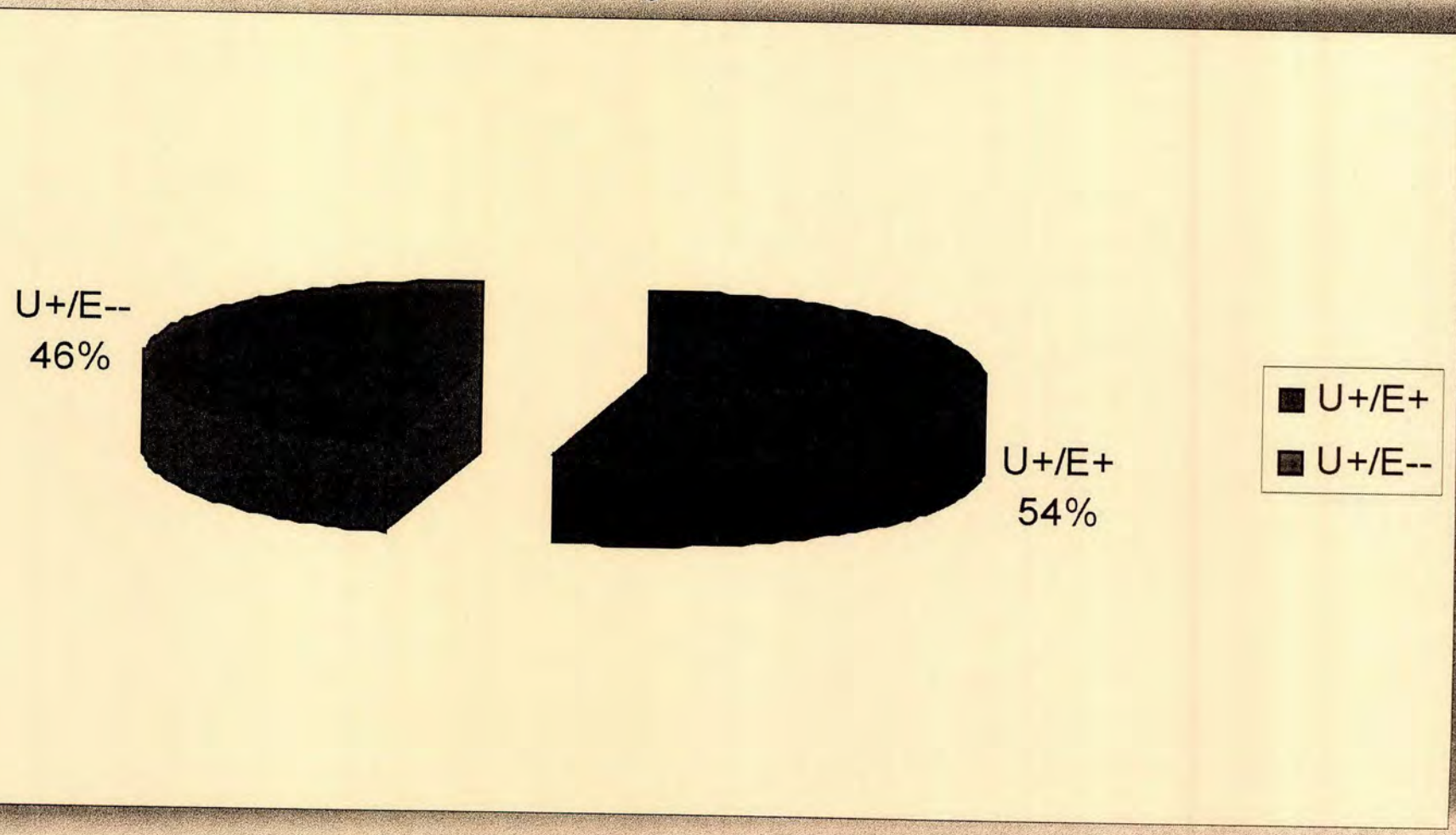


figure 1

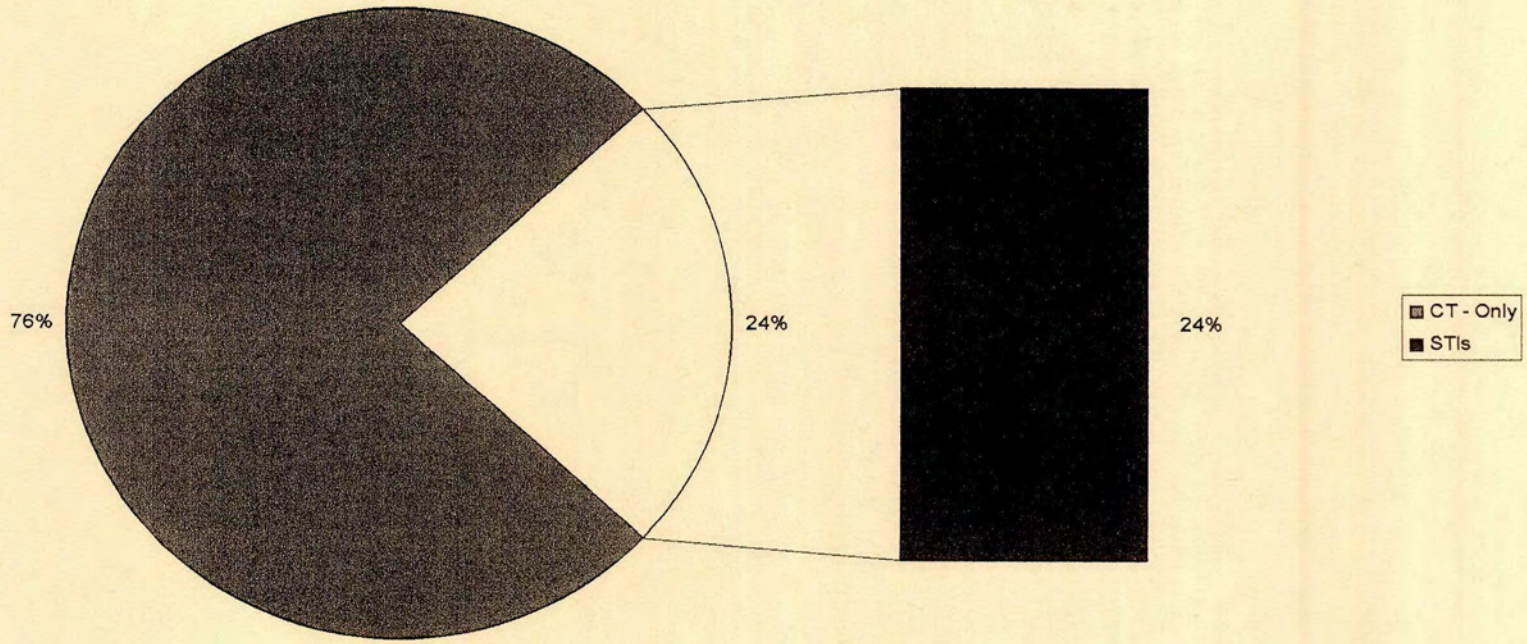
Male Chlamydia-- Results



Dr.V.Harindra GUM Portsmouth

figure 2

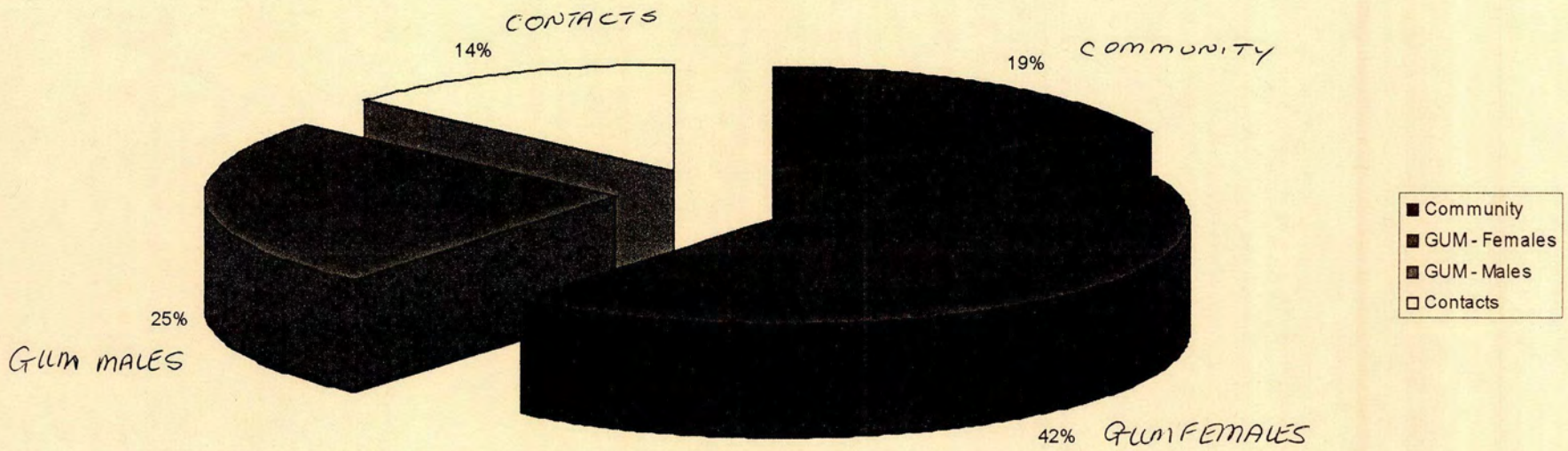
Co-infection



Dr. V.Harindra GUM Portsmouth

figure 3

STIs in Chlamydia Posotive Patients



Dr. V. Harindra GUM Portsmouth

figure 4

cc: S. Clark
S. Robson
J. Kitley

PORTSMOUTH HealthCare NHS TRUST

MPS/MW

Sheila, Sue, John,
Do I assume that PCGs will be dealing with this issue and replying to Martin accordingly
Code A
13/11/2000

1st November 2000

Penny Humphris
Chief Executive
Finchdean House
Milton Road
Portsmouth

Dear ~~Penny~~ Elizabeth

This is a personal note to suggest that we do as a health economy need to reconsider our criteria for NHS continuing care, and equally the criteria for institutional care, for example.

We have a situation whereby clients – patients in St Christopher's Hospital in Fareham where I am now working would fulfil the criteria of Code 2 from social services, namely to qualify for a higher rate of funding in residential care, but not fulfil the criteria for nursing home care which is Code 9 and would fulfil current NHS continuing care if reliant on only one component that of the Barthel index.

On the legal position I have been ~~flying~~ applying the Coghland Judgement tests, the social services codes of practice, as well as the current version of NHS continuing care, but the exact nature of the current NHS continuing care eligibility criteria does differ. I do think this is an area which needs fairly urgent attention, if our capacity to undertake intermediate care in community hospitals and other settings is to progress satisfactorily.

Kind regards.

Yours sincerely

Code A

Professor Martin P Severs FRCP
Professor in Health Care of the Elderly

PCG leads
Agenda 8/12

cc
Max Millett
Dr I Reid
Dr E Jorge

Portsmouth and South East Hampshire NHS
Health Authority

Primary Care Groups in Portsmouth

Finchdean House, Milton Road
Portsmouth, PO3 6DP

District Commissioning Group

Notes of the Meeting held: 7 November 2000

Present:

Jane Pike
Bob Weeks
Mike Johns
Sue Robson
Pat Rimmer
Tracy Green
Nicholas Hicks
Linda Fuller

No	Discussion	Action
1.	**Membership and Apologies for Absence**	
	Apologies received from Paul Edmondson-Jones, and Ann Bullen.	
	Agreed it was still very appropriate for Jane Pike to attend. Tracy Green agreed to contact Lin Kennett to invite to future meetings.	TG
	Pat Rimmer noted his discussion with Brian Courtney and had given an open invitation to him to attend future meetings. Tracy Green agreed to e-mail Brian the agendas for every meeting.	TG
2.	**Notes of the Previous Meeting**	
	The notes of the meeting held 24 October were agreed.	
3.	**Matters Arising**	
	None.	
4.	**Service and OAT Issues**	
4.1	**Acute Services Strategy**	
	Sue Robson noted that Nicola Hartley was leading this piece of work.	
4.2	**Prioritisation of Whole Systems Group reserve list**	
	The group discussed and prioritised the list of outstanding bids tabled at the last Whole System Group meeting. Two further bids were added to the original list. One in respect of infection control	

measures and one in respect of establishing radiology day case unit at Haslar.

Attached is a summary of the list – split into two sections : those not agreed and those agreed and prioritised.

Jane Pike agreed to write to the infection control team explaining the group's decision and the other potential sources of funding and to let Elizabeth know. JP

This would be shared at the next whole system group meeting JP/TG

4.3 Cancer 2 Week Waits

Pat Rimmer raised issues regarding staff awareness of the standard and the process to be followed. Awareness sessions being undertaken with all relevant staff within the Trust to ensure the appropriate processes were followed. In addition it was noted that the Trust had now established extra clinics as had previously been agreed.

Nick Hicks said he was concerned if there was a discrepancy between information provided by the Trust at the review meetings and the information provided to the Health Authority for monitoring and sent to SERO. Sharon Palser was currently exploring the reasons for this.

Nick Hicks stated that he had recently been informed that the Trust were now meeting the colorectal and dermatology waiting time standards and a problem only remained with gynaecology. However confirmation would only be made on receipt of the latest figures. Pat Rimmer agreed to pursue the issues of discrepancies at the monthly review meeting with PHT and to let Nick have an update following the reviews. PR

4.4 Health Authority policy on Continuing Care

The letter to PCG Chief Executives from Elizabeth Jorge was noted which raised concerns from the rehabilitation consultants regarding the criteria and process. Jackie Charlesworth had agreed to meet with Rachel Boynes and Sally Pastellas in order to consider the issues and the response.

A letter from Neil Stubbs regarding funding for the placement of two individuals into Uplands Nursing Home from Cheriton was discussed. Pat Rimmer agreed to review the patient files and discuss a response with Tracy Green. It was agreed that we needed to establish what commitment the Health Authority had previously given for these two clients. PR/TG

5. SAFF

5.1 SLA Progress 2000/01

	Noted SUHT still outstanding.	PR
	Hammersmith had been returned with a covering letter saying signed but actual document was not signed and therefore being returned for signature.	TG
5.2	**2001/02 SLA Negotiation arrangements**	
	Bob Weeks noted that the finance SAFF sub group had agreed to produce a negotiation brief at its next meeting to guide SLA lead managers for negotiations with out of district providers. This would be based upon the financial principles being agreed for the health economy.	BW
	Pat Rimmer agreed to set up a series of monthly meetings of the SLA leads to co-ordinate the negotiation process. This would need to include the IOW leads.	PR
5.3	**Escalation Policy for SLA difficulties**	
	The group agreed the policy drafted by Tracy Green.	
6.	**NICE/NSF**	
	For next agenda	
7.	**Any Other Business**	
7.1	**Winter Pressures and Intermediate Care Outstanding Issues from PHCT**	
	Pat Rimmer to arrange a meeting with Julie Hawkins and Ann Bullen and Tracy Green to discuss these issues.	PR
7.2	**OATs Matrix 2001/02**	
	Bob Weeks noted that Sue Pepper was currently validating the matrix from SERO. There were several providers over the £50k limit and consideration needed to be given as to whether it was appropriate to enter into a SLA next year.	
	It was agreed that both the SLAs and the OATs portfolios needed to be combined for the IOW and PSEHHA.	
	Linda Fuller agreed to provide Bob and Tracy with an analysis of the SLAs held by the IOW this year split by financial value of what is PCG purchased and what would be considered specialist.	LF
	Linda Fuller also agreed to provide the OATs data combined with supporting information regarding the financial split across elective, emergency and outpatient costs.	LF
	Bob Weeks and Linda Fuller to merge the two sets of OATs/SLA data together so that a complete picture could be seen as regards	BW/LF

SLAs for next year. This analysis would also include analysis by individual PCGs and specialist services to inform the placing of SLA co-ordinating leads for the new health economy.

Agreed to put SLA 01/02 process on the next agenda.

TG

7.3 GP Referral Data

It was agreed that the PHT monthly review meeting should be the only forum for discussing and progressing these issues in order that 'myths' about data provided do not materialise.

Pat Rimmer to prepare paper regarding the PHT monitoring process. PR

Noted Jan Elliot arranging a meeting with PCGs to discuss taking forward outpatient individual specialty discussions. Agreed to include as part of this review the progress of otherwise of all the demand management projects PCGs have tried to pursue. Pat Rimmer agreed to co-ordinate this across the PCGs. PR

7.4 PHCT Review Mechanism

Bob Weeks noted that PHCT would not report activity to PCG level for those services devolved in the latest round until they had a SAVO raised to formally notify this. Sue Robson agreed to arrange this. SR

Sue Robson noted a wash up meeting following the divisional review meetings was taking place on the 20 November when any performance issues would be discussed and action plans to take forward agreed.

The need to also review on a district wide basis, involving all commissioners, the activity and finance performance against the SLA was recognised. Sue Robson agreed to discuss with Ann Bullen with a view to arranging a six month review meeting involving the HA and all PCGs. SR/AB

7.5 SAFF Finance Sub Group

Bob Weeks requested that any district wide funding issues be raised for consideration by the SAFF finance sub group. It was agreed to bring issues to the next meeting of the district commissioning group on the 21 November which preceded the next meeting of the finance sub group which was meeting on the 23rd. ALL

8. Date of Next Meeting

Next Meeting to be held Tuesday 21 November 2000 from 12 – 2pm in the small meeting room – lunch to be provided. ALL

Circulation: All present and apologies

Prioritisation of Whole System's Group Outstanding Bids (November 2000)

Bids agreed by the District Commissioning Group and ranked in order of priority – should additional funding be made available

Rank	Scheme Ref.	Bid	Value	Comments
1 Jt	1	Social Care Packages – Portsmouth City Council	£210,000	Top priority
1 Jt	2	Social Care Packages – Hampshire County Council	£346,000	Top priority
3	16	Additional Locum Geritrician for zoned beds	£50,000	Next priority if related to already agreed £101k scheme
4	10	HSDU	£180,000	Medium priority
5 Jt	4	Early Discharge – weekday pharmacy	£141,221	Low priority – funding will be less due to lead time
5 Jt	5	Early Discharge – respiratory home care	£18,000	Low priority – funding will be less due to lead time
5 Jt	6	Early Discharge – phlebotomy	£30,000	Low priority – funding will be less due to lead time
5 Jt	7	Early Discharge – OT service to A&E (non peak hours)	£30,000	Low priority – funding will be less due to lead time
5 Jt	8	Early Discharge – Physio service to A&E/MAU (no peak hours)	£33,000	Low priority – funding will be less due to lead time
6	17	AMH Schemes Outstanding	£32,000	Lower priority – funding may be less due to lead time
7	18	Radiology Day Case Unit at Haslar	£30,000	Lowest priority – funding an estimate

Bids not agreed by District Commissioning Group as priority against winter pressures funding

Scheme Ref.	Bid	Value	Comments/Reason
15	Celliulitis	£25,020	No bed capacity to implement this financial year
11	Direct Access Pathology/Radiology	£218,000	00/01 SAFF issue – not a winter planning issue
14	Communication	£9,800	To be funded from existing communication budgets
12	Community Pharmacy	£2,500	To be funded from PCG existing funding
3	ITU Ambulance Issues	£270,000	SAFF issue for next year - £60k for HAS agreed this yr
9	HDU – disengagement costs	£?	Not winter planning issue
13	EMH Step Down/Short Stay	£46,800	Believe lead time prevents scheme running in 00/01
19	Infection Control	£60,000	Internal issue – other funding sources explored

Executive Team

G:\District Commissioning Group\241000 Commissioning Group notes.doc

5/12

Portsmouth and South East Hampshire NHS
Health Authority

Primary Care Groups in Portsmouth

Finchdean House, Milton Road
Portsmouth, PO3 6DP

District Commissioning Group

Notes of the Meeting held: 21 November 2000

Present:	Jane Pike	Pat Rimmer
	Bob Weeks	Tracy Green
	Mike Johns	Nicholas Hicks
	Sue Robson	Linda Fuller
	Ann Bullen	Lin Kennett

No	Discussion	Action
1.	**Membership and Apologies for Absence** Apologies received from Katie Hovenden and Paul Edmondson-Jones.	
2.	**Notes of the Previous Meeting** The notes of the meeting held 7 November were agreed.	
3.	**Matters Arising** **Infection Control SLA with PHT (item 4.2)** Pat Rimmer reported that he had just discovered a letter was attached to the SLA when it was returned addressed to Andrew Swinney stating that the Trust were not able to sign up to this section. Andrew had not received a copy of the letter direct. It was agreed to pursue the issues raised in the letter directly through the PHT service review meetings. Tracy Green agreed to bring the matter to Penny Humphris' attention. **AMH Continuing Care (item 4.4)** Tracy Green reported that Neil Stubbs has agreed to send the paperwork from the continuing care criteria assessment to the PCGs in order that approval could be formally given for these 2 clients. It was noted that these clients had been included on the previous reprovision schedule and therefore a prior commitment had already been given. Pat Rimmer noted that there were 8 clients in Cheriton who	PR TG

potentially could be placed. It was noted there was a joint service review being undertaken regarding the use of NHS beds which may proposed these clients be placed in a nursing home.

SUHT SLA 2000/01 (item 5.1)

Pat Rimmer noted that this had been agreed. The funding shortfall would be taken from the SLA risk pool.

Escalation Policy (item 5.3)

Noted that this covered all providers.

Winter Pressures and Intermediate Care (item 7.1)

Noted that the outstanding issues for this year has been resolved. Funding issues for next year would be the subject of business cases as part of the SAFF process.

PHT monitoring process (item 7.3)

Noted a paper regarding the proposed process for performance management was being taken to the Executive Team.

PHCT Reviews (item 7.4)

Noted that the informal feedback from the reviews had been positive. There would be a wash up session in December when a review of the SLA would also be undertaken.

4. SAFF

4.1 Reporting Arrangements for PHT SLA Information

It was agreed that activity should be reported on a combined site basis for targets and actual and that financial monitoring should be excluded due to the complication of Haslar financing.

4.2 PHCT Proposal

It was agreed that differential tariffs would be used between PCGs as a result of the recosting exercise undertaken on the basis this reflected existing service costs to the individual localities.

4.3 2001/02 SLA negotiation arrangements

Pat Rimmer to set up meeting of SLA leads in December to take forward SLA negotiations for next year. As next years negotiations would be based on a wider health community the SLA leads needed to be redetermined. Linda Fuller and Bob Weeks agreed to pull together a schedule setting out the financial values by PCG (with revised PCG boundaries for the City and East Hampshire) and specialist services for all SLAs. OATs for either existing Health Authority would then be added where a

PR

LF/BW

SLA already existed with one partner. Decisions then would be taken as to the appropriate organisation to lead the negotiations firstly based on materiality and secondly on distribution of workload.

4.4 2001/02 OATs arrangements

Lin Kennett noted that there was a proposal to incorporate all specialist services OATs into SLAs. No formal guidance had yet been issued and Lin agreed to check out the status and implications of the SERO document and bring back to this group. LK

Work was ongoing to merge the IOW and PSEH OATs matrixes. Decisions regarding which OATs should be converted into SLAs had to be made by 1 December. It was agreed that Sue Pepper be asked to convene a group consisting of Linda Fuller, Pat Rimmer, Ben Gillett and Tracy Green to consider the results of the merged matrix before 1 December. Decisions would be made based on the £50,000 local limit and a reflection of the volume and type of activity for each provider over the financial limit. BW

4.5 Defining Specialist Services

Noted this had been superseded by a more recent version. In addition London Regional Office were undertaking further work on the definitions.

4.6 Financial Pressures for SAFF Finance sub group

The group brainstormed district wide commitments that needed to be incorporated into the SAFF process. Bob Weeks agreed to take into the SAFF finance sub group. BW

5. NICE/NSF

5.1 Hepatitis C

It was proposed that for 2000/01 those individuals meeting the criteria that could be treated this year at SUHT would be funded from the NICE/NSF reserve. The issue needed to be considered as a development for next years SAFF.

Pat Rimmer agreed to liase with Nick Hicks over the proposed process and to approach SUHT to identify all patients who meet the criteria. PR/NH

Tracy Green agreed to feedback the agreed process to Angie Becks in complaints as she needed to respond to complaints from MPs regarding this issue. TG

5.2 ADHD

Noted that PHCT are looking at GP specialists in this area. The PCG leads group is considering this.

5.3	**NICE/NSF Guidance** Paul Edmondson-Jones is updating proposals on process. The proposal will be used as the basis at the next meeting on the 5 December to prioritise the in year use of funding. The next meeting would confirm the process, prioritise available bids and agree process to quantify impact of those areas not yet quantified.	
6.	**Service and OAT Issues**	
6.1	**Beta Interferon** Lin Kennett reported that previously the Health Authority had only purchased a small number of specific patients. This had now been built into the SLA with SUHT. Pat Rimmer agreed to write to SUHT and PHT reminding them it was within the block agreement and that additional investment had been included in the agreement.	PR
6.2	**EPO** Noted that the Health Authority has £18k to transfer to PHT for admin and nursing time for EPO (contribution to overall costs for all purchasers of £58k). Lin Kennett to liase with Andrew Swinney with regards the SAVO. Noted there was a need to transfer funding for drug costs from primary care to the Trust and that the costs of the drugs would form part of the cost pressures considered in next years SAFF.	LK
6.3	**Renal Holiday Haemodialysis** Lin Kennett noted the guidance for Trusts to become responsible for purchasing these services. Lin agreed to discuss with PHT and to progress through the SAFF for 2001/02.	LK
7.	**Report back from Groups/projects**	
7.1	**Whole Systems Group** It was noted that the Executive Team was considering proposals for future performance management and this may lead to the reconfiguration or demise of this group.	
7.2	**Waiting List Taskforce** Jane Pike agreed to urgently reconvene a multi-agency waiting list group with membership from the Health Authority, PCGs and Portsmouth Hospitals Trust. It was agreed that the group would be linked into and reports into the monthly service review meetings with the Trust. Agreed that a Chair or Chief Executive	JP

of a PCG should chair the group. Jan Elliot and Mark Wagstaff would be the representatives from PHT. Jane Pike agreed to pull together a proposal and terms of reference and share with PCGs. JP

In addition Ann Bullen agreed to pull together and bring back to the District Commissioning Group a summary of this years expenditure and commitments against the waiting list risk reserve. AB

7.3 Demand Management Group

The DMG was meeting the following week and it would approve the current expenditure forecasts against the £313k DMG funds from 1999/2000.

Mike Johns noted he had discussed the future of the group with Penny Humphris.

8. Update from individual PCGs

Sue Robson noted she was meeting with GPs within East Hampshire and Orthopaedic Consultants to establish operational policies for a GP specialist role.

Tracy Green noted that the Low Vision Aids pilot within the City should commence from April with opticians undertaking the LVA assessments in conjunction with Social Services rehabilitation services.

9. Any Other Business

9.1 Hospice Free Money

Tracy Green agreed to write a paragraph for Nick Hicks regarding the developments at the Rowans and how capacity at the unit is hard to contain within existing resources. Nick would then send this to SERO to see if additional one off funding could be provided. TG NH

10. Date of Next Meeting

Next Meeting to be held Tuesday 5 December 2000 from 12 – 2pm in the small meeting room – lunch to be provided. ALL

Future dates for the new year are attached. ALL

Circulation: All present and apologies
Executive Team

\\FRODO\PORTSPCG\District Commissioning Group\211100 Commissioning Group notes.doc

Charles Lewis (Chair/Cx.

From: <Code A>
To: <Code A>; <Code A>; <Code A>; <Code A>
Sent: 24 November 2000 09:20
Subject: RE: Dermatology

Mike- thanks for this. I agree with you that we need to put a shot across the bows of the Trust. I suggest three things

1.add to yr letter
a)GPs should continue to refer as before and let their PCGs know if the Trust refuse to accept referrlas
b) we are aiming to meet with Trust to disucs this issue

2. A letter to Bronwen saying how unhappy you are with this, how it does not set a good tone for future relationships. Ask Bronwen to ask Wendy Greenish to arrange a meeting with PCG representatives (via you for EHants?me for F&G and Tracy? for PI). Unitl then GPs will continue to refer as before. I would copy to the new Divisional General Manager in General Medicine who I believe has just started at the Trust.

Pat

-----Original Message-----
From: s=johns;g=michael;ou1=THE SURGERY PO8 8DZ;o=NHS PORTSMOUTH AND SE HANTS HAGP;p=NHS NATIONAL;a=NHS;c=GB;
Sent: 23 November 2000 15:58
To: Patrick Rimmer; Tracy Green; Ben Gillett; p=NHS NATIONAL INT;a=NHS;c=GB;dda:RFC-822=charles(a)Code A
Subject: Dermatology

Tracy you may be unaware that the derm dpt have just sent a letter to all GPs which is just a slight rewording of the letter that Bronwent sent us to consider . I was on the verge of sending a reply but they beat us to it ! You may recall we were going to agree with the provisor that they got on and sorted out the cat 'C' project.

I strongly feel that some sort of rebuttal is necessary because otherwise we will be in a very weak nogotiating position having given something away for nothing. Also of course doing nothing sends out the wrong messages about letting providers declaring unilateral intention etc

I have drafted this letter which I was going to send to all GPs UNLESS I HEAR TO THE CONTRARY IN THE NEXT WEEK FROM SOMEONE

MIKE