NHE000455-0001

File: 4-12

PORTSMOUTH & S.E. HANTS
HEALTH AUTHORITY
20 NOV 2000
FAREHAM & GOSPORT PCGs

PORTSMOUTH & SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

Notes of the PCG Leads meeting held on 10 November 2000

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

John Kirtley
Lead Director
Fareham/Gosport Primary Care Groups
Unit 100 / Fareham Reach
166 Fareham Road
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No.	Discussion	Action
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**

	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.