

Portsmouth and

Mr John Kirtley  
Chief Executive  
Fareham & Gosport PCG

1 PR/RS/GE/ET  
2 file: Gen 12

**Portsea Island Primary Care Group**

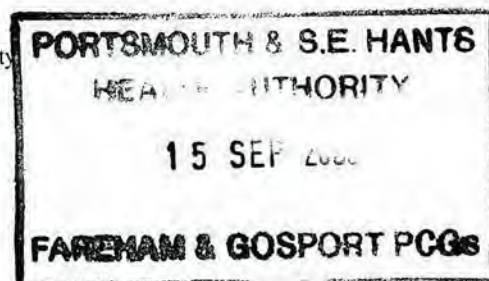
PART I ONLY

## A G E N D A

**Board Meeting : 20 September 2000, Lecture Theatre, Portsmouth College, Tangier Road, Portsmouth  
7.15 p.m.**

### PART I

No	Item	Lead/Paper	Attachments
1.	Apologies		
2.	Chairman's Report	C Lewis	
	Questions from the Public		
4.	Minutes of last meeting		White
5.	Matters Arising		
	5.1 PCT Proposal (for noting)		
	5.2 PCT Development Plan (for noting)		Blue
	5.3 Patient Conference Programme		Green
6.	PCG Development		
	6.1 IM&T Sub Group Minutes	J Douglas	White
7.	Health Improvement		
	7.1 Oral Health Strategy	N Torlot	Presentation
	7.2 HImP/HAZ Conference Report	J Charleworth	Yellow
	7.3 CHD Projects Summary	J Charlesworth	Salmon
8.	Commissioning Issues		
	8.1 Concise Commissioning Performance Report	J Douglas	Pink
	8.2 Commissioning & Performance Sub Group Minutes	A Swinney	White
9.	Finance Issues		
	9.1 Finance Report	T Green	Lilac
10.	Quality and Clinical Governance		
	10.1 Quality & Clinical Governance Sub Group Minutes	J York	White
	10.2 Clinical Governance Report & Plan	J York	Blue
	10.3 Communication and Public Involvement Sub Group Minutes	J York	
11.	Prescribing		
	11.1 Prescribing Sub Group Minutes	C Olford	White
	11.2 Prescribing Incentive Scheme 2000-2001	C Olford	Green
	11.3 End of Year Prescribing and Incentive Scheme 99/00	C Olford	Blue
12.	Date and venue for Next meeting		
	15 November 2000 at 7.15 p.m. in the Lecture Theatre, Portsmouth College		
13.	Resolution to exclude the Press and Public from the rest of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted		
14.	Refreshments and discussions with Public		



# PORTSEA ISLAND PRIMARY CARE GROUP

## PUBLIC BOARD MEETINGS DISTRIBUTION LIST

1 Alder K Miss	Prescribing Advisor	PI PCG	Part I and II
2 Bajric N Ms		Portsmouth	Ag & Mins Only
3 Barton J Dr	Chair	Gosport PCG	Part I Only
4 Barton J Mr	Chair, Copnor	Portsmouth Neighbourhood Forum	Ag & Mins Only
5 Bishop D Mr	Chief Executive	Portsmouth Hospitals Trust	Part I Only
6 Breton L Mr	Chair, North End	Portsmouth Neighbourhood Forum	Ag & Mins Only
7 Burgess M Mr	Chair, Anchorage Park	Portsmouth Neighbourhood Forum	Ag & Mins Only
8 Burkinshaw J Mrs	Chair, Milton	Portsmouth Neighbourhood Forum	Ag & Mins Only
9 Cameron-Davies R Mr	Chairman	Portsmouth LOC	Part I Only
10 Carr S Mr	Policy Implementation Mgr	Policy & Performance	Part I Only
11 Churchill D Mr		Old Portsmouth	Ag & Mins Only
12 Clark S Mrs	Chief Executive	PI PCG	Part I and II
13 Coles C Mr	Chair, Portsea	Portsmouth Neighbourhood Forum	Ag & Mins Only
14 Croker R Mr	PCG Link	Local Pharmaceutical Committee	Part 1 Only
15 Cullen J Mrs	Nurse Representative	PI PCG	Part I and II
16 Daley P Mrs	Community Librarian	Portsmouth City	Part I Only x 7
17 Doyle G Mr	Chair, West Southsea	Portsmouth Neighbourhood Forum	Ag & Mins Only
18 Durham Neil	Health Correspondent	Portsmouth Evening News	Part I Only
19 Dye N Mrs	Alzheimers Society	Portsmouth Branch	Ag & Mins Only
20 Fellows E Dr	Board Member	PI PCG	Part 1 and II
21 Francis P Mr	CHC	Community Health Council	Part I only
22 Fuller R Mr	Chair, Central Southsea	Portsmouth Neighbourhood Forum	Ag & Mins Only
23 Godden Janet	Non Exec Director	Oxfordshire Mental Healthcare Trust	Ag & Mins Only
24 Gowers P Mr	PCG Link	Local Dental Committee	Part 1 Only
25 Green T Miss	General Manager	PI PCG	Part I and II
26 Grummit C Dr	Head of HealthCare	Kingston Prison	Part I Only
27 Gurney N Mr	Chief Executive	Portsmouth City Council	Part I Only
28 Harris S Dr	GP Board Member	PI PCG	Part I and II
29 Hogan J Dr	Vice Chair	PI PCG	Part I and II
30 Hooper J Professor	Non Exec	PI PCG	Part I and II
31 Hudson P Mr	Chair, Buckland	Portsmouth Neighbourhood Forum	Ag & Mins Only
32 Hughes J Dr	Chair	East Hants PCG	Part I Only
33 Hutchinson R Mr	Social Services	Portsmouth City	Part I and II
34 Jackson M Cdr	Chair, Old Portsmouth	Portsmouth Neighbourhood Forum	Ag & Mins Only
35 Jones C Mrs	Chair, Stamshaw & Tipner	Portsmouth Neighbourhood Forum	Ag & Mins Only
36 Kirtley J Mr	Chief Executive	Fareham & Gosport PCG	Part I Only
37 Knight H Mr	PCG Link	Age Concern	Part 1 Only
38 Lewis C Dr	Chair	PI PCG	Part I and II
39 Lovell M Mrs	Chief Executive	Community Health Council	Part I Only
40 McKenning S Dr	Chairman	Portsmouth LMC	Part I Only
41 Millett M Mr	Chief Executive	Portsmouth HealthCare NHS Trust	Part I Only
42 Murray P Mr	Chair, South Somerstown	Portsmouth Neighbourhood Forum	Ag & Mins Only
43 Newcombe S Ms	Chief Executive	Portsmouth City Community Service	Part I Only
44 Olford C Dr	Vice Chair	PI PCG	Part I and II
45 Painter T Mr	Chair, Landport	Portsmouth Neighbourhood Forum	Ag & Mins Only
46 Plumb D S Mr	Secretary	Local Pharmaceutical Committee	Part 1 Only
47 Potter M Mrs	Lay Member	PI PCG	Part I and II
48 Robinson P Miss	Nurse Representative	PI PCG	Part I and II
49 Robson S Mrs	Chief Executive	East Hants PCG	Part I Only
50 Rose E Mr	Carers Association	Portsmouth & SE Hampshire Branch	Ag & Mins Only
51 Samuel R Mr	Policy & Performance	Portsmouth Health Authority	Part I Only
52 Shepherd T Mr	Chief Executive	Age Concern	Part 1 Only
53 Smith J Ms	Chair, Baffins	Portsmouth Neighbourhood Forum	Ag & Mins Only
54 Smithson M J Mr	Chair, North Somerstown	Portsmouth Neighbourhood Forum	Ag & Mins Only
55 Sommerville G Dr	Chair	Fareham PCG	Part I Only
56 Stone L Mrs	Link Officer	Fratton Neighbourhood Forum	Ag & Mins Only
57 Stratford M Mrs	Patient Participation Mgr	Public Health Department	Part 1 Only
58 Swinney A Mr	Service Dev Manager	PI PCG	Part I and II
59 Tarrant D Mrs	Service Dev Manager	PI PCG	Part I and II
60 Thornton J Dr	GP Board Member	PI PCG	Part I and II
61 Wainwright V Mr	East Southsea	Portsmouth Neighbourhood Forum	Ag & Mins Only
62 Wastall D Mr	Chief Executive	Isle of Wight Health Authority	Part I Only
63 Wellman J Mr	Chair, Eastney	Portsmouth Neighbourhood Forum	Ag & Mins Only
64 Widdecome Teresa	NHS Business Manager	Janssen-Cilag Ltd	Ag & Mins Only
65 Wilkinson T Dr	GP Board Member	PI PCG	Part I and II
66 Wright Joan	Practice Manager	Lake Road Surgery	Ag & Mins Only

## D R A F T

Portsmouth and South East Hampshire 

Health Authority

Finchdean House, Milton Road  
Portsmouth, PO3 6DP**Portsea Island Primary Care Group**

---

**Public Board Meeting****Notes of the Meeting held: Wednesday 14 June 2000 at Portsmouth College, Tangier Road, Portsmouth**

<b>Present:</b>	Dr Charles Lewis (Chair)	Penny Humphris
	Dr Jim Hogan	Julie Cullen
	Dr Colin Olford	Pauline Robinson
	Dr Tim Wilkinson	Professor Jean Hooper
	Dr Elizabeth Fellows	Marie Potter
	Dr Simon Harris	Sheila Clark
	Dr John Thornton	Rob Hutchinson
		Tracy Green (in attendance)

**No      Discussion**

---

**1.      Apologies for Absence**

There were no apologies for absence.

**2.      Chairman's Report**

Dr Charles Lewis welcomed everyone to the meeting. In particular Dr Charles Lewis welcomed Penny Humphris, Chief Executive of Portsmouth and South East Hampshire Health Authority who had joined the meeting for the main discussions of the evening regarding Primary Care Trust status.

The Board members introduced themselves to the members of the public. Dr Charles Lewis reminded members of the public how they could be involved and noted that he would open the meeting up to questions from the public for agenda item 5 in addition to being welcome to join Board members for coffee at the end of the meeting.

Dr Charles Lewis informed members of the Board that following the discussions at the last meeting regarding the PCG bid for Health Improvement Performance funds for Coronary Heart Disease, he could confirm that the PCG had been successful and had received £440,000 per annum for a three year period.

# D R A F T

## No      Discussion

---

### 3.      **Minutes of the previous meeting**

The Board considered the minutes of the previous meeting held on 12 April 2000.

**The Board approved the minutes as accurate and Dr Charles Lewis signed them.**

### 4.      **Matters Arising**

#### 4.1     **Questions from the Public**

No written questions had been received from the public.

#### 4.2     **Portsmouth Hospitals Trust Presentation**

Dr Charles Lewis reminded Board members that Portsmouth Hospitals NHS Trust had been invited to attend the meeting to undertake a presentation on waiting list and winter pressures. However due to staff sickness and vacancies the Trust had been unable to attend this meeting.

### 5.      **PCG Development**

#### 5.1     **Consideration of PCT status including summary of results from GP Survey**

Dr Charles Lewis explained that several local issues including the scenario plan, the proposed new health authority incorporating the Isle of Wight, the prospect of two other local PCGs moving to PCT status and the vision for the development of the community hospital had led the PCG to consider whether an early application for PCT status would be advantageous. This was considered at a Steering Group meeting of the PCG where the advantages and concerns were discussed.

Following the May Steering Group a confidential survey of all GPs within the PCG was undertaken to quantify what level of support there would be for an early application for PCT status. Dr Charles Lewis emphasised that this survey did not negate the formal LMC ballot that would be undertaken as part of any formal consultation.

Dr Charles Lewis summarised the outcome of the survey. 83% of GPs had responded. In answer to the question 'do you feel able to support the PCG Board in preparing a draft application for formal consultation for level 4 PCT status with effect from April 1<sup>st</sup> 2001?' 49% replied yes, 25% yes with reservations, 14% unsure and 12% responded no. Reservations expressed mainly concerned issues of timing and management resources that Dr Charles Lewis felt could be overcome. There was a 74% positive response supporting a PCT application in 2001.

Dr Charles Lewis concluded that there had been a very high response rate with a significant level of support, with a need to provide further information for some GPs.

In response to a question from Dr Colin Olford, Dr Charles Lewis stated that all practices had been reminded of the survey via fax and in addition Dr Lewis had

# D R A F T

## No      Discussion

---

personally phoned every practice. Dr Colin Olford noted that if non-responders were taken into account, then 61% of all GPs had responded positively.

Professor Jean Hooper stated that she hoped that the wider primary health care team would be involved should the application proceed. Sheila Clark responded that in addition to the formal Health Authority and Community Health Council consultation the PCG would use its established networks to discuss the application and share information.

Dr Colin Olford stated that the significant level of support surprised him and he felt this was a clear mandate to proceed with an early application.

Sheila Clark stressed that the amount of work involved in preparing an application should not be underestimated, however, with support from the Regional Office and the Health Authority it was believed that the PCG could continue to deliver on all aspects of its Business Plan.

**The PCG Board noted the considerable level of support for progressing to PCT status and the concerns to be addressed. The PCG Board formally approved the PCG to apply for PCT level four status from April 1<sup>st</sup> 2001.**

## 5.2      Draft Application for Primary Care Trust Status

Dr Charles Lewis explained that due to the tight timetable he had felt it appropriate to establish a PCT Development Planning Group in advance of the formal Board decision. This group was being chaired by Professor Jean Hooper and had representation from the PCG, Health Authority, Portsmouth HealthCare NHS Trust, Portsmouth Hospitals NHS Trust and Portsmouth City Council.

Sheila Clark noted that the group had requested the PCG write to all key partners to ask whether they would also support the PCG making an early application. Expressions of support had been received from many partners including Portsmouth Hospitals, Portsmouth HealthCare, Portsmouth City Council and its separate departments, the local PCGs, the Local Dental Committee and the local branch of UNISON. The CHC had also responded supporting the PCT drafting an application, which they would then undertake formal consultation on.

Dr Charles Lewis noted that East Hampshire PCG and Portsea Island PCG had agreed to work together on specific areas in conjunction with Portsmouth HealthCare NHS Trust.

Professor Jean Hooper noted the great willingness to share expertise and work between key partners and also the great amount of work already done by the PCG that would act as a foundation for the application.

Penny Humphris acknowledged that it would not be an easy time but felt that with the ground work and the enthusiasm from key partners PCT status was achievable and should be undertaken now in order to deliver the vision of the PCG as early as

# D R A F T

## No Discussion

---

possible.

Penny Humphris undertook a presentation to the Board setting out the process and timetable for establishment of a PCT for April 2001. It was noted that the Health Authority would be consulting on two PCT applications (East Hampshire and Portsmouth City) alongside the boundary review which proposed that those practices in Cosham should join with Portsea Island to form Portsmouth City PCT. There would be a three month period of consultation ending in late October, with public meetings being held by the Community Health Council in September. Ministerial decision was expected in December, which would allow PCTs to be established in January with an operational date from 1 April 2001.

In response to a question from Professor Jean Hooper, Penny Humphris responded that the PCT Chair would be the first appointment along with two non-executive members. The Health Authority would assist the Secretary of State with the selection process by placing local advertisements. The Health Authority was seeking clarification on what criteria for eligibility would be used.

Sheila Clark presented an outline of the proposed draft application document. Sheila Clark noted that although there was much guidance and criteria set out for the application, no template existed. A review had been undertaken of other PCT application documents to inform the draft under consideration.

Sheila Clark presented a summary of the different sections of the application covering: vision, improving health, shaping services, involving partners, service quality, making decisions, resources, involving and developing staff and involving the public.

Dr Charles Lewis opened the meeting up to questions from the public. Penny Humphris explained the nature of the relationship between the PCT Board and the PCT Executive Committee. The PCT Board was responsible for public accountability, strategic direction and would hold the Executive Committee to account. The Executive Committee would be responsible for the running of the operations of the PCT, bringing together commissioning and providing, and being accountable to the PCT Board. Penny Humphris noted that there would be clinical majority on the PCT Executive Committee.

In response to a question enquiring if the PCT would take on the capital asset of St Mary's Hospital, Sheila Clark responded that the transfer of assets to the PCT would probably be phased to reflect the services provided by the PCT. It was hoped to initially develop intermediate care facilities on the site and then further develop services. Dr Tim Wilkinson noted that you did not need to own the estate to achieve the vision of a community hospital.

Rob Hutchinson highlighted the PCG position of having high health needs but being underfunded. Sheila Clark noted the constraints on the Health Authority in achieving additional funding for the PCG as only a process of levelling up could be used. Sheila Clark also noted that some movements had already been achieved such as increased

# D R A F T

## No      Discussion

---

usage of services at Portsmouth Hospitals and the CHD funding. Penny Humphris acknowledged the difficult issues that existed and that the national formula changed annually. However the Health Authority was looking at a three year period to address pace of change issues. It was noted that should a new Health Authority be created that the Isle of Wight would bring with it a 6% over funding and that arrangements were being discussed with the Regional Office to try and protect Portsmouth and South East Hampshire funding for a three year period.

**The Board approved the draft application and delegated authority to the Chair to make any minor amendments required before the final submission to the Health Authority.**

### 6.      Commissioning Issues

#### 6.2      Commissioning Performance Report

Tracy Green presented the commissioning performance report for the 1999/2000 financial year covering activity, waiting list and quality issues.

Rob Hutchinson found the report most interesting and requested that in future information is included regarding the actions being taken to correct or investigate areas of poor performance.

Dr Colin Olford was pleased to see that clinics with waiting times over 13 weeks were decreasing but expressed concerns that other clinic waiting times were extending towards 13 weeks.

Dr Charles Lewis acknowledged that Portsmouth Hospitals NHS Trust had been discussing all these issues and were currently considering possible solutions.

Marie Potter asked if the targets set were unrealistic. Dr Charles Lewis noted that the targets were either nationally or regionally set. Marie Potter also asked whether it was possible to report how long patients suspected of cancer waited for treatment following the initial outpatient attendance.

**The Board noted the report.**

#### Commissioning and Performance Sub Group Minutes

### 6.3

Dr Charles Lewis drew the Board's attention to the prompt scheme, the progress on the commissioning projects and the five additional areas being considered for future inclusion in the performance report.

**The Board approved the minutes of the Commissioning and Performance Management Sub Group of 3 May 2000.**

# D R A F T

No	Discussion
----	------------

---

7.	<b>Primary Care Development</b>
----	---------------------------------

7.1	<b>IM&amp;T Sub Group Minutes</b>
-----	-----------------------------------

Dr Colin Olford noted the work of the various groups under the LIS that were working to form links with key partners.

**The Board approved the minutes of the IM&T sub group of 28 March 2000.**

8.	<b>Finance Issues</b>
----	-----------------------

8.1	<b>Financial Report</b>
-----	-------------------------

Tracy Green presented the financial report to the Board, The report was in two parts: presentation of the provisional 1999/2000 outturn and the initial financial programmes for the PCG for 2000/01.

It was noted that the PCG was reporting a year end underspend of £87,000 for 1999/2000. The final figures would not be known until the closure of the final accounts in August and would include the latest prescribing figures. Tracy Green noted however that the PCG had recently received the January prescribing figures that had shown a further improvement of £50,000.

Tracy Green explained that the initial financial programmes for the PCG did not include the resources contained within service agreements or funds associated with the further devolution of commissioning.

Rob Hutchinson raised the difficulties of recruitment and whether PCT status would help attract and retain staff within the City. Sheila Clark noted that historically there had been difficulties due to the complexity of the work as well as the total remuneration package. Pauline Robinson stated that proposals to mix clinical and managerial roles for trained nurses would make positions more attractive.

**The Board noted the provisional financial programme of the PCG for 1999/2000, noted the outstanding adjustments required to the 1999/2000 final accounts, approved the opening financial programmes of the PCG for 2000/01 and approved the proposed arrangements for remuneration outlined within the report.**

9.	<b>Quality and Clinical Governance</b>
----	--

9.1	<b>Quality and Clinical Governance Sub Group Minutes</b>
-----	--

Dr Jim Hogan highlighted the four ongoing projects: data project, diabetes project, nurse accreditation and TARGET.

**The Board approved the minutes of the Quality and Clinical Governance sub group of the 29 March 2000.**



# D R A F T

**No      Discussion**

---

**9.2      Communications and Public Involvement Sub Group Minutes**

Dr Charles Lewis noted the main areas of action following the patient conference.

**The Board approved the Communications and Public Involvement Sub Group Minutes of 22 May 2000.**

**9.3      Patient Conference Ideas for October**

Marie Potter reported that it was planned to cover three areas at the next planned conference: the future shape of health care, responses to local health needs, and the Health Improvement Programme and the impact on the public.

Marie Potter explained that it had been planned to be a one day event but after discussions with colleagues at Portsmouth City Council was now considering a two evening event in order to attract more working people. Dr Charles Lewis invited members of the public to share their views at the end of the meeting.

**11.      Prescribing**

**11.1    Prescribing Sub Group Minutes**

Dr Colin Olford noted that the group had met once more following this meeting to consider the individual practice budget appeals. 12 practices had appealed, some funding had been released, further information had been requested from some practices and a further review was planned for September. The group would now be considering the incentive scheme for 2000/01.

**The Board approved the Prescribing Sub Group Minutes of 4 May 2000.**

**12.      Date and Venue for Next Meeting**

The next public Board meeting will be held on Wednesday 20 September 2000 at 7.15pm in the Lecture Theatre, Portsmouth College, Tangier Road, Portsmouth.

**13.      Resolution to exclude the Press and Public**

Dr Charles Lewis read out the resolution to exclude the press and public. Press and public to be excluded from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

**Agenda Item No:**

**No: 5.1**

**PCT PROPOSAL**

**Background & Summary**

The PCT Consultation Documents became available on Monday 24 July. There will be four public meetings held to discuss the proposals. Representatives of the Health Authority, East Hants PCG, Portsea Island PCG and other local health and social care organisations will be presenters at these meetings and form the panel to which members of the public can ask questions about the proposals. The meetings are scheduled as follows:

Thursday 31 August 2000	7.00 p.m.	Wesley Centre, Fratton
Monday 4 September 2000	7.00 p.m.	Professional Centre, Cosham
Tuesday 5 September 2000	7.00 p.m.	Petersfield Library
Tuesday 3 October 2000	2.00 p.m.	Havant Civic Offices

If further copies of the consultation document are required, please contact Maria Smith on **Code A**

**Recommendations:**

The Board are asked to note this.

**Date: 11 September 2000**

**Paper Prepared by: Sheila Clark**

**Agenda Item No:****No: 5.2****PCT DEVELOPMENT PLAN****Background & Summary**

An up to date copy of the PCT Development plan is attached.

Updates have been made in **Section 2 - "Strengths and Weaknesses"**, where a number of weaknesses have now been updated or removed, these are:

- Section 2 - Improving Health - A protocol is being developed on the Health Needs indicator model (*Updated*)
- Section 3 - Shaping Services - Relationships with PHT services are greatly improved (*Removed*)
- Section 4 - Involving Partners - these are greatly improved with Portsmouth Hospitals Trust, Community Health Council and the LMC (*Removed*)
- Section 7 - Resourcing - only one Finance vacancy remains (*Updated*)
- Section 8 - Involving & Developing Staff - it was agreed to include the Community Trust in the bullet point of changing roles etc. (*Updated*)

Also included in the new document are dates when PCT Presentations have been set up for various service areas.

**Recommendations:**

The Board are asked to note this.

**Date: 11 September 2000****Paper Prepared by: Sheila Clark**

**PORTSMOUTH CITY PRIMARY CARE TRUST  
DEVELOPMENT PLAN**

**Version : 5 September 2000**

# PORTSMOUTH CITY PRIMARY CARE TRUST DEVELOPMENT PLAN

## Contents

1. **Introduction**
2. **An assessment of Current Strengths and Weaknesses :**
  - 2.1 Assessed strengths and weaknesses derived from draft application:
    - i. PCT Vision
    - ii. Improving Health
    - iii. Shaping Services
    - iv. Involving Partners
    - v. Improving Service Quality
    - vi. Making Decisions
    - vii. Resources
    - viii. Involving and Developing Staff
    - ix. Involving the Public
  - 2.2 Strengths and weaknesses derived from audit Commission checklist
  - 2.3 Strengths and weaknesses derived from HQS assessment
  - 2.4 Summary
3. **Supporting Information requirements**
4. **Action plans**

## 1. Introduction

This plan is a working document which draws together all the development needs required of the Primary Care Group and its partners to develop into a successful Primary Care Trust operating at level 4 from April 2001. It has been commissioned by the Portsmouth City Primary Care Trust development and planning group which is attended by senior representatives from:

- Portsea Island Primary Care Group
- Portsmouth Health care NHS Trust
- Portsmouth Hospitals NHS Trust
- Health Authority
- Social Services department
- Primary Care Group Nurse network

Professor Jean Hooper chairs the group. The plan is used by this group to check that progress is made in a timely way on all development needs. The information is also used to keep partners informed of developments and progress. The content of the plan itself will be amended as further guidance and information on best practice emerges.

HSC 1999/167 sets out the detail of Primary Care Trust application process. In approving an application to establish a Primary Care Trust the Secretary of State will want to be satisfied in four areas:

- The benefits of what will be achieved
- The degree of support for the proposal
- The perceived 'fitness' of the proposed organisation to deliver
- The impact on other organisations

This development plan draws heavily on the joint working groups established between Portsea Island Primary Care Group, East Hampshire Primary Care Group, Portsmouth Health Care NHS Trust and the Health Authority for specific tasks in order to minimise duplication of effort, to ensure local consistency and to avoid unnecessary disruption to services and staff. The main working groups are for Human Resources, IM&T, Estates, and Finance. The plan also has many references to a number of existing plans such as the Local Information Strategy (LIS), Portsea Island Primary Care Group business plan, the district scenario plan and the health improvement programme to ensure that all related plans and development timescales are co-ordinated.

There are three main parts to this plan

- An assessment of current strengths and weaknesses
- A list of additional information requirements set out by the NHS South East Regional Office
- A detailed action plan highlighting the main tasks and timescales.

## Portsmouth City Primary Care Trust Development Plan

**2.1 Strengths and Weaknesses Based on Draft Application Form**

STRENGTHS	WEAKNESSES
<b>1. VISION</b>	
<ul style="list-style-type: none"> <li>• Clear and documented</li> <li>• Based on recent history</li> <li>• Includes principles and collective aspirations</li> <li>• Involves partners (aHAZ)</li> </ul>	<ul style="list-style-type: none"> <li>• Boundary and new partners</li> <li>• Vision poorly linked into everyday operations and appreciated by all staff</li> <li>• Shortness of development timescales</li> </ul>
<b>2. IMPROVING HEALTH</b>	
<ul style="list-style-type: none"> <li>• Half time attachment of Public Health Consultant</li> <li>• Acclaimed HImP and action plans</li> <li>• aHAZ (and performance funds for chd)</li> <li>• Joint planning and working across traditional agency boundaries</li> </ul>	<ul style="list-style-type: none"> <li>• Unsophisticated health needs baseline information</li> <li>• Below equity funding</li> <li>• Acute Trust waiting lists position</li> <li>• Health needs indicator protocol being developed</li> </ul>
<b>3. SHAPING SERVICES</b>	
<ul style="list-style-type: none"> <li>• Integrated services plans and delivery for aspects of mental health, children and older person's services</li> <li>• GP and nurse involvement in service commissioning</li> <li>• Pooled arrangement for commissioning pilot savings</li> <li>• Development of a range of primary and community based services well under way</li> <li>• Involvement in district scenario planning</li> </ul>	<ul style="list-style-type: none"> <li>• Update of skills database in primary care needed and formal link to PCIP/ primary care development plans Primary Care priorities</li> <li>• Need to confirm range of services to be provided and phasing in plans</li> <li>• Greater range of practice base services and access to them needed</li> <li>• Lack of progress in refocusing district service models to reflect more local needs</li> </ul>

## Portsmouth City Primary Care Trust Development Plan

<b>4. INVOLVING PARTNERS</b>	
<ul style="list-style-type: none"> <li>• Good background in partnerships (especially Portsmouth Health Care Trust, Social Services Department, Public, GPs and nurses )</li> <li>• HImP experience</li> <li>• aHAZ projects and commitment</li> <li>• Local Ophthalmic Committee and Local Dental Committee</li> <li>• Newsletter</li> </ul>	<ul style="list-style-type: none"> <li>• Practice based staff – especially in Cosham practices</li> <li>• Pharmacists</li> </ul>
<b>5. IMPROVING SERVICE QUALITY</b>	
<ul style="list-style-type: none"> <li>• Clinical Governance foundation (information sharing, practice leads, baseline assessment, CG Plan including TARGET)</li> <li>• Quality requirements in agreement with providers</li> <li>• Systems for feedback from GPs/Users</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence-based protocols &amp; joint audits need expanding</li> <li>• Practice administration (Practice Manager issues)</li> <li>• Actions and incentives for primary care/commissioned services</li> <li>• PHT influence (lack of)</li> </ul>
<b>6. MAKING DECISIONS</b>	
<ul style="list-style-type: none"> <li>• Current democratic structure and subgroups</li> <li>• Financial control</li> <li>• Engaging clinicians</li> <li>• Current cohesive and open PCG Board</li> </ul>	<ul style="list-style-type: none"> <li>• Involving and clarifying roles for Practice Managers, LMC and CHC</li> <li>• Size of agenda and mechanisms for reporting back (eg delegation of powers)</li> </ul>
<b>7. RESOURCING</b>	
<ul style="list-style-type: none"> <li>• Balanced finance using unified budget</li> <li>• Progress on Partnerships in Action</li> <li>• Collaboration over commissioning savings</li> <li>• Management time and expertise available</li> </ul>	<ul style="list-style-type: none"> <li>• IT – pace of change and level of investment and practice development</li> <li>• Finance vacancy</li> <li>• Estates - expertise and clarify over transferring assets and responsibilities</li> <li>• Value for money of buying in services or providing then in house</li> <li>• Set up systems/agency arrangements etc to manage premises, payroll, supplies, IT, accounting, budgets and risk, and clinical governance support</li> </ul>



## Portsmouth City Primary Care Trust Development Plan

<b>8. INVOLVING AND DEVELOPING STAFF</b>	
<ul style="list-style-type: none"> <li>• “Working Together” collaboration and action plans</li> <li>• Existing policies</li> <li>• Infrastructure and progress in CPD and PDPs (including board members)</li> <li>• Team building and time out</li> <li>• Industrial relations</li> </ul>	<ul style="list-style-type: none"> <li>• Need for harmonisation of terms and conditions of employment</li> <li>• Need to promote best employment practice across organisations (esp primary care settings)</li> <li>• Greater clarity needed over which staff affected, detailed transfer arrangements/redeployment</li> <li>• Changing roles for current PCG &amp; Community Trust management team during transition</li> </ul>
<b>9. INVOLVING THE PUBLIC</b>	
<ul style="list-style-type: none"> <li>• Current programmes of work</li> </ul>	<ul style="list-style-type: none"> <li>• Engaging hard to reach groups</li> <li>• Follow ups</li> </ul>

## 2.2 Strengths and weaknesses derived from Audit Commission checklist

### CHECKLIST

Has your PCG ...

<b>Primary Care Development</b>		
1.	set up a database of skills available to each practice (including attached staff), current services, facilities and computerisation? <i>Available from Practice Based Survey Summer 1999 - to be updated Summer 2000, to inform redrafted PCIP and to set Primary Care Development priorities.</i>	✓
2.	projected future skill shortages and planned how these will be addressed? <i>Health economy wide work force plan includes GPs, All Community Nurses and Managers.</i>	✓
3.	agreed how to assess the cost-effectiveness of practice-based services and widen access to them? <i>Work completed for: Physiotherapy, Counselling, Vasectomies, ENT, Diabetic Retinal Monitoring.</i>	✓
4.	developed cover arrangements for practice nurses, to facilitate continuing education and continuity of patient care? <i>Practice Nurse Accreditation Scheme including backfill and cross practice cover arrangements.</i>	✓
<b>Commissioned services</b>		
5.	involved clinicians in service review meetings? <i>Through : Locality Board, Partnership Board, Major service specific reviews for Cancer, Cardiology, Diagnostics, Mental Health and also through regular service specific discussions with all major providers.</i>	✓
6.	investigated ways to improve the accuracy and timeliness of monitoring data <i>See regular Performance Monitoring Reports to Board and Commissioning Sub Groups. Prompt Scheme and provider based information discussion groups.</i>	✓
7.	started to develop primary care alternatives to secondary care referral for appropriate conditions, supported by referral protocols, training and audit? <i>These include Diabetes, Vasectomies, Back Pain, Dermatology, Specialist Community Nursing, Psychological Therapies.</i>	✓
<b>Partnership</b>		
8.	reviewed the scope for reorganising both community and social care around clusters of practices? <i>Constituency GP Leads, Nursing Network, Sure Start, Healthy Living Centres, Teenage Pregnancies</i>	✓
9.	agreed evidence-based protocols common to practice and community nursing, and a programme of joint audits? <i>Diabetes, Asthma, Leg Ulcers and Learning Disabilities.</i>	✓
10.	agreed how partnership enterprises will be evaluated? <i>Project by Project basis.</i>	✓

## Portsmouth City Primary Care Trust Development Plan

Has your PCG ...

<b>Economy</b>		
11.	supported practices with pharmaceutical advice and practical help in implementing prescribing changes? <i>5 Pharmaceutical Advisors working in practices led by the PCG Prescribing Advisor.</i>	✓
12.	agreed priorities for PCG prescribing advisers and for prescribing change? <i>D&amp;TC, Clinical Audit, Prescribing Sub Group Meetings, feedback from practices through monitoring practice visits.</i>	✓
13.	devised incentive schemes to reward care that is both high quality and economic, as part of an integrated package of clinical governance, audit, education, information and support? <i>Incentive Schemes in line with Guidance for Prescribing. Quality targets linked to key priorities.</i>	✓
<b>Quality</b>		
14.	ensured that all practices have their own clinical governance/quality leads? <i>Regular Clinical Governance Sub Group Meetings held.</i>	✓
15.	negotiated sharing of clinical audit findings and data on a named practice basis? <i>Information Sharing Protocol - all practices engaged.</i>	✓
16.	agreed minimum acceptable standards for practice administration, facilities and key clinical areas and the approach to be taken with any 'problem practices'? <i>Disabled Discrimination Act, HR Projects, Key clinical areas based on HImP, Clinical Governance Protocols and Education Initiatives.</i>	✓
17.	assessed the skills and training needs of PCG, community nursing, and practice staff, and drawn up skills development and training plans? <i>Organisational Development Plan. See No. 1 for approach needed in Primary Care. TARGET.</i>	✓
<b>Accountability and public involvement</b>		
18.	agreed measurable targets/milestones for PCG/clinical developments (including some that can be included in the PCGs accountability agreement with the health authority)? <i>See Business Plan and Accountability Agreement.</i>	✓
19.	developed a communications strategy? <i>See Business Plan</i>	✓
20.	planned how best to gather the views of stakeholders, service users and the local community on health needs and service options? <i>See Business Plan</i>	✓
21.	involved service users and local people in working groups? <i>See Business Plan</i>	✓

## Portsmouth City Primary Care Trust Development Plan

Has your PCG ...

<b>PCG management</b>		
22.	established shared PCG principles and values, a patch and cluster model of practice organisation, supported by good communication through news sheets, forums and meetings? <i>Developed from Commissioning Pilot, reviewed yearly for Business Plan and Application Document. Active infrastructure to engage and inform using Newsletter, Practice and Patient Leaflets, Health &amp; Social Services Directory, Steering Group Meetings, Nursing Network, Practice Managers Meetings, Management Team Meetings and Time Out, Corporate Team meetings etc.</i>	✓
23.	ensured that board members have clear lead responsibilities? <i>All have separate portfolios, objectives and personal development plans.</i>	✓
24.	considered how to develop practice manager roles? <i>Practice Managers Network</i>	✓
25.	attempted to involve service users, and also other local bodies that may be willing to offer the PCG their resources and experiences? <i>See Business Plan plus Citizens' Jury, Patient Conferences and representation on planning Board.</i>	✓
<b>Future development</b>		
26.	formed a clear view of the advantages and disadvantages of trust status in the local situation, including potential benefits for patients and service efficiency? <i>Application document based on agreed position with local partners.</i>	✓
27.	agreed how best to discuss options for the PCGs future with stakeholders (including the public and any service providers) and with other PCGs that could be affected? <i>Based on communication and consultation initiatives in development plan and working in partnership with East Hants PCG.</i>	✓
28.	ensured that strategies, structures and procedures, and commissioning decisions are developed in parallel with those of neighbouring PCGs, where appropriate? <i>PCG Chairs &amp; Chief Executives, PAN PCG Communication Group, PAN PCG Prescribing Group, Quality Partnerships, Scenario Plan, reciprocal commissioning arrangements.</i>	✓
29.	(potential PCTs) assessed the relative value for money of buying in services or providing them in-house? <i>See Development Plan.</i>	✗
30.	(shadow PCTs) set up systems, or agency arrangements, to manage premises, payroll, supplies, IT, accounting, budgets and risk, and clinical governance support? <i>See Development Plan.</i>	✗

### **2.3 Strengths and weaknesses from HQS assessment**

The HQS assessment conducted in January 2000 identified the following development needs for the Primary Care Group:

- prescribing budgets
- needs assessment systems (especially the use of primary care data)
- developing primary and community services and moving services from acute settings
- developing incentives for HCHS
- Clinical Governance programme of work based on education
- IM&T in primary care

All of these have been incorporated into the 2000/01 Primary Care Group Business Plan

### **2.4 Summary**

There are number of common threads to all three strengths and weaknesses assessments which require significant development.

These are:

- Service developments in primary and community settings
- The need to deliver health improvements in real terms
- Greater influence over hospital based services
- Resource issues (HR policies, Estates transfers, budget setting/equity, IM&T)
- The need for greater involvement and communications with partners

## Portsmouth City Primary Care Trust Development Plan

**3. Supporting information required by SERO**

Information required	Notes	
<b>APPLICATION DOCUMENT</b>		
Proposal document	Prepared by PCG, launched by HA	√
Update proposal consultation and produce application document(s)	SC/TG and development group	
Risk assessment and business plan for year 1 (including the preparatory period and key steps)	TG/IP	
Most current PCIP	1999/2003 PCIP already available - AS/DT to update	
Current PCG HIMP Objectives	2000/01 HA HIMP sets out current PCG objectives - IR to update	
Most recent Clinical Governance Annual report and action plan	JH/SC	
PCG self assessment against the Audit Commission Report recommendations	Development and planning group	√
Proposed PCT management costs	SC/TG/MS	
Demonstrate co-terminosity with the LA	HA Boundary review consultation process	√
Evidence of community staff involvement and inclusion in the consultation process	Joint PCT HR subcommittee and PCT consultations	
Evidence of the degree of GP support (1)	Results of pre-consultation survey and subsequent actions	√
Evidence of the degree of GP support (2)	By LMC confidential ballot BB to arrange	
Clear evidence of the clinical benefits of the proposal upon patient services	In proposal document, through individual service discussions and reflected in needs assessment input to final application - P. E-J.	
Evidence of progress in partnership working	In consultation document. Letters of support received. Through PCG Business Plan and performance against the plan. Communications /supplementary consultation plan.	√ √ √ √

#### 4. Action Plan

The action plan for the development of the Portsmouth City Primary Care Trust is split into six parts. In addition to the required actions set out within this document, the PCG will also continue the action as set out within its business plan and contribute to the action plans for the Local Information Strategy (LIS), the district scenario plans and the health improvement programme.

The six parts are:

- Actions arising from the analysis of strengths and weaknesses
- Corporate Governance and Primary Care Trust Board set up
- Shaping Services (by care group and pathway)
- Resources (summarising the four action plans from the sub groups for Human Resources, Estates, Finance and IM&T)
- Application Document and Supporting Information for NHSE
- Communications Strategy

##### 4.1 Actions arising from the analysis of strengths and weaknesses

(Not covered by existing plans or in sections 4.2 – 4.5 below)

Action	By whom	By when
4.1.1 Equity funding position – pursue pace of change arrangements with Health Authority	CL/TG/JH	31 Dec 2000
4.1.2 Waiting List position – agree action plans with Portsmouth Hospitals to rectify current problems in conjunction with waiting list taskforce using city wide profile	AS/CL	30 Sept 2000
4.1.3 Update skills database in primary care and link to primary care development plans to inform future PCIPs	JC/JH with AS/DT	31 Dec 2000

##### 4.2 Corporate Governance and Primary Care Trust Board set up

To follow – awaiting further national guidance and to include:

- Setting up of systems/agency arrangements to manage premise, payroll, supplies, IT, accounting, budgets, risk and clinical governance support
- “skills check” – to ensure that sufficient staff with appropriate skills are in place to deliver these requirements

##### 4.3 Reshaping Services (by care group and pathway)

Action	By whom	By when
4.3.1 Hold discussions with individual services, partner organisations and service users to determine those services to be transferred, preferred service model, when to transfer and to whom. Multi disciplinary teams preferred	SC/CL/PT/ PHCT/ PHT	15 Oct 2000 latest for all
• Community Nursing services (1) (PT - Strategy Group)	PT/SC PT/SC/CL	28/9 23/10
• Physiotherapy (1)		

## Portsmouth City Primary Care Trust Development Plan

Action	By whom	By when
• Occupational therapy (1)	SC/PT	26/9
• Child health (1)	SC/CL	4/9
• Child and adolescent mental health (1)	SC/CL	4/9
• Community dental services (3)	SC	19/9 & 7/11
• Podiatry (1)	SC/CL/PT	9/10
• Community rehabilitation (2)	SC/CL	10/7
• Health promotion (1)	SC/PT	21/9
• Elderly medicine and EMH (2)	PT/CL SC/PT	11/10 22/9
• AMH (2)	SC/PT	28/9
• Substance misuse (3)	PT/CL	6/10
• Speech and language therapy (2)	SC/PT	22/9
• Specialist family planning (3)	SC/PT/CL	4/10
• Palliative medicine (3)	SC/CL	13/9
• Inpatient rehabilitation (1)		
• Home Loans (Phys dis services) (2)	SC/PT	31/8
• Dietetics (2)	SC/PT	12/10
• Diabetes (1)		
• Dermatology (3)	SC/CL	29/9
• Rheumatology (3)		
• Other acute services (3)		
• Learning Disabilities (3)	SC/PT	26/9
• Psychology (3)	SC/PT	27/9
4.3.2 Agree arrangements and specific details of services to be transferred (linked to HR action plan)	SC/TG/PHCT/ PHT	31 Jan 2001
4.3.3 Formal transfer of services		1 April 2001

\*Numbers in brackets refer to timing based on level of discussions already held and urgency to resolve local aspects of service model: 1 = July, 2 = August, 3= September /October

#### 4.4 Resources

##### 4.4.1 Human Resources

See separate joint plan with EH PCG plus local work to follow

- Need to promote best employment practice across organisations including primary care
- Harmonisation of terms and conditions of employment
- Clarity over which staff are affected, with detailed transfer/redeployment arrangements
- Changing roles for current PCG management team during transition

##### 4.4.2 Estates

See separate joint plan with EH PCG plus local work to follow

- Joint meeting with city council (August 24<sup>th</sup>) to map potential for shared premises where integrated services are being developed.



**4.4.3 Finance**

See separate joint plan with EH PCG plus local work to precede

- Develop service agreement with PHCT for interim management accountancy support to PCG (operational asap)

**4.4.4 IM&T**

See separate joint plan with EH PCG for IM&T project

Final strategy/implementation plans to include:

- Pace of change and levels of investment and practice development

**4.5 Application Document and Supporting Information for NHSE**

Action	By whom	By when
4.5.1 Risk assessment and costed business plan for year 1	TG/IP	30 Sept 2000
4.5.2 Update to existing PCIP	TG/AS/DT	30 Sept 2000
4.5.3 Clinical Governance annual report and action plan	SC/JHogan	30 Sept 2000
4.5.4 Proposed PCT management costs and structure	TG/SC/MS	30 Sept 2000
4.5.5 Update to proposal and finalise application document following consultation	SC/TG	27 Oct 2000
4.5.6 Collation of all information required to build PCT application to SERO	TG/MS	27 Oct 2000

**4.6 Communications Strategy****Portsmouth City PCT Proposal – communications strategy**

1. **Purpose** : the purpose of this strategy is to ensure that all those who have an interest in the development of the PCT are adequately informed and involved in its development.
  
2. **Background** : During times of organisational change effective communications can minimise disruption and levels of insecurity. Where there are gaps in information or communication deficits rumour and misinformation can grow and become widespread. This brief strategy builds on current communication arrangements and sets out a plan for ensuring that all interested parties are up to date with developments and involved wherever appropriate in important decisions. In order to be as flexible as possible in reaching people the methods to be followed are multi media and include
  - Meetings with key staff groups and service providers
  - Formal and informal discussions with partner organisations
  - Newsletters
  - Information exchanges
  - Presentations to community groups
  - Public meetings
  - Website updates

Portsmouth City Primary Care Trust Development Plan

---

Communication is a two-way responsibility – it is not merely about disseminating information. We will make sure that key people are nominated to listen and respond to feedback promptly on an organisational basis. In addition the Chief Executive and administrator of the PCG will respond to requests via phone, letter or website.

### 3. Principles

- 3.1 We will communicate openly and in an even-handed manner.
- 3.2 We will use a variety of communication methods and events.
- 3.3 Wherever possible we will use and join with existing communications mechanisms.
- 3.4 We will ensure that information is timely and accurate.
- 3.5 We will respond positively to all requests for information and presentations.
- 3.6 We will involve staff, service users and partners in decisions which impinge on services.
- 3.7 We welcome feedback on the effectiveness of our communications and will have mechanisms in place to respond promptly to causes for concern.

### 4. Communications/ supplementary consultation plan :

The following will be consolidated into a programme of events, co-ordinated by the PCG administrator.

Group	Current arrangements to continue	To be arranged
1. Board/PCG infrastructure 1.1 Board members 1.2 GPs 1.3 Practice managers 1.4 Community Nurses	Sent copies of D&P meeting notes Chairman's update at Steering Group PCG updates at monthly meetings Board nurses update via network	Regular items on Board agenda (CL) Newsletter articles; representatives(") " (DT) " (JC)
2. Cosham practices	Nil	Invite practices to send reps to St. Group, PM and nurse network. (MS) Newsletter, Board papers lists etc. (MS)
3. PCT Practices	GP constituency reps. for PCG	Offer to visit (CL/SC/Board reps) Ballot (LMC) Locality discussions (MS/CL)
4. PHCT	City Communications group Information exchange Representation at D&P and SG	Service by service discussions(incl support services).(PT/CL/SC) JNC consultation group.(DF) User groups . (PT) Trouble shooting link (PT/SC/MS) Presentations on request (MS)
5. PHT	Clinical Issues Group Service review groups PFI task groups	Service by service discussions and presentations. (PT/SS/SC/MS) Trouble shooting link (SS)

## Portsmouth City Primary Care Trust Development Plan

Group	Current arrangements to continue	To be arranged
6. Public and patients	CHC/HA consultation programme PHCT user groups network	Patient conference (MP/JH/JY) Website updates (MS) Healthcheck articles (SG) Leaflet version of proposal (SG) Consult with citizen's panels (JY) Presentations to community groups as requested (CL/SC)
7. Other partners – PCC  Voluntary sector LRCs Other PCGs  HA  SERO	Newsletter , HIMP, Board meetings City Health strategy group, Joint planning groups, H&SCP, Whole systems group, SRB5 group etc Service by service and PCCS meetings Regular meetings PCG leads group, joint subgroups with EHPCG Fortnightly meetings, consultation programme. PCT development group	Local HIMP plans & HAZ launch (JC) Join H&SS subcommittee (SC) Trouble shooting link (SM) Presentation – Info. Officers group (SC)          Visit in September

#### 4.7 The NHS National Plan

The NHS National Plan will influence PCG/T development substantially with its emphasis on modernising services and investment. In particular we will need to pay attention to the following

- Ensuring that the modernisation agenda is emphasised during consultations with services and the public
- Cross referencing current practice and PCT aspirations which are endorsed by parts of the National Plan when drawing up the final application
- Ensuring that the areas we are currently “light” on are sufficiently developed to be included in the final application
  - (a) incentivising primary care (not just prescribing)
  - (b) addressing inequalities (HIMP, HAZ and PMS)
  - (c) integrating health and social care using new Health Act flexibilities.
- The publications “Improving Working Lives” and “Human Resources Performance Framework” are expected imminently and will influence the work of the joint HR subgroup.

**Agenda Item No:****No: 5.3****Public Conference 2000 – Draft Programmes****Background & Summary**

The dates for the Public Conferences have been agreed as:

Wednesday 1<sup>st</sup> November 2000, 9.00am – 1.00pm at Portsmouth Football Club (lunch included)

Wednesday 22<sup>nd</sup> November 2000, 6.00pm – 9.30pm at Portsmouth City Girls School (light refreshments at start)

A draft programme has been agreed and is attached for the Board to note.

**Recommendations:**

The Board are asked to note the draft programmes.

**Date: 12 September 2000****Paper Prepared by: Jo York**

**Portsea Island PCG Conference  
Your Health Services – One Year On  
What's New, What's Different?**

**Draft Programme  
Wednesday 1<sup>st</sup> November 2000  
Portsmouth Football Club**

- 9.15am Arrival/Coffee (10 minutes)
- 9.25am Welcome by Chair (5 minutes)
- 9.30am Introduction to the Day  
Session setting out the parameters and constraints set by Government  
Priorities for health improvement, partnership working, power balance  
- users/providers (10 minutes)
- 9.40am Presentation:- **“The Shape of Things to Come”**  
Modernisation/NHS Plan – what it means locally – including the  
development of St Mary’s as a community hospital and the strategy for Older  
People. (15 minutes)
- 9.55am Small Group Discussions  
Groups discuss the issues that are important to them, arising from the  
presentation. At the end of the session, each table will write down an  
issue/comment etc. which they feel is their highest priority. (40 minutes, inc 5  
minute comfort break)
- 10.35am Presentation:- **“The NHS Plan for YOUR heart”**  
The implications of NHS plan and the NSF on local coronary heart  
Services and the Coronary Heart Disease projects being developed through  
HAZ (15 minutes)
- 10.50am Small Group Discussions  
Groups discuss the issues that are important to them, arising from the  
presentation. At the end of the session, each table will write down an  
issue/comment etc. which they feel is the highest priority for the group. (40  
minutes, inc 5 minutes comfort break and possible fitness break)
- 11.30am Presentation: – **“The Missing One Million”**  
Moving diabetes into the community – development plans for diabetic  
services. (20 minutes)
- 11.50am Small Group Discussions and Interactive Session  
Full details not yet agreed, possible educative session (25 minutes, inc 5  
minute comfort break)
- 12.15pm PCG Action Plan and closing session  
Pulling together the major issues from each table throughout the day to form  
an action plan for PCB Board approval. (15 minutes)
- 12.30pm Lunch  
**Coffee will be available throughout the day and the groups can decide when to  
take any breaks in addition to the 5 minute comfort breaks**

**Portsea Island PCG Conference  
Your Health Services – One Year On  
What’s New, What’s Different?**

**Draft Programme  
Wednesday 22<sup>nd</sup> November 2000  
Portsmouth City Girls School**

- 6.00pm Arrival/Light Refreshments (25 minutes)
- 6.25pm Welcome by Chair (5 minutes)
- 6.30pm Introduction to the Day  
Session setting out the parameters and constraints set by Government  
Priorities for health improvement, partnership working, power balance  
- users/providers (10 minutes)
- 6.40pm Presentation:- **“The Shape of Things to Come”**  
Modernisation/NHS Plan – what it means locally – including the  
development of St Mary’s as a community hospital and the strategy for Older  
People. (15 minutes)
- 6.55pm Small Group Discussions  
Groups discuss the issues that are important to them, arising from the  
presentation. At the end of the session, each table will write down an  
issue/comment etc. which they feel is their highest priority. (40 minutes, inc 5  
minute comfort break)
- 7.35pm Presentation:- **“The NHS Plan for YOUR heart”**  
The implications of NHS plan and the NSF on local coronary heart  
Services and the Coronary Heart Disease projects being developed through  
HAZ (15 minutes)
- 7.50pm Small Group Discussions  
Groups discuss the issues that are important to them, arising from the  
presentation. At the end of the session, each table will write down an  
issue/comment etc. which they feel is the highest priority for the group. (40  
minutes, inc 5 minutes comfort break and possible fitness break)
- 8.30pm Presentation:- **“The Missing One Million”**  
Moving diabetes into the community – development plans for diabetic  
services. (20 minutes)
- 8.50pm Small Group Discussions and Interactive Session  
Full details not yet agreed, possible educative session (25 minutes, inc 5  
minute comfort break)
- 9.15pm PCG Action Plan and closing session  
Pulling together the major issues from each table throughout the day to form  
an action plan for PCB Board approval. (15 minutes)
- 9.30pm Close

**Coffee will be available throughout the day and the groups can decide when to  
take any breaks in addition to the 5 minute comfort breaks**

**Agenda Item No:****No: 6.1****IM&T****Background & Summary**

The committee for the IM&T Sub Group met on Tuesday 6 June 2000.  
A copy of the meeting notes are attached.

**Recommendations:**

The Board are asked to approve these minutes.

**Date: 12 September 2000****Paper Prepared by: Colin Olford**

Portsmouth and South East Hampshire **NHS**

Health Authority

Finchdean House, Milton Road  
Portsmouth, PO3 6DP

**Portsea Island Primary Care Group**

**IM&T Subgroup**

**Notes of the Meeting held on Tuesday 6 June 2000**

<b>Present:</b>	John-Jo Campbell	Barbara Dale
	Jeremy Douglas	Colin Olford (Chair)
	Andrew Scott Brown	Dick Tyrrell

No	Discussion	Action
----	------------	--------

**1. Apologies for Absence & Practice Manager Representation**

Apologies were received from Jennie Bennett and Marcus Saunders.

It was agreed that practice manager representation would be helpful and that the Practice Managers Meeting should be invited to select a nominee. *Post Meeting Note: An invitation was made at the meeting of 9 June, but no new member was forthcoming.*

JD

**2. Minutes of the Last Meeting**

These were accepted as a true record

**3. Matters Arising**

**Direct Bookings**

Nine practices were now involved in the pilot, 7 of which were from PIPCG:

Torex and Microtest sites were therefore represented, an EMIS site was also being piloted outside the PCG boundary. It was acknowledged that some practices had been unable to take part due to their stand alone not working

**Accessing Portsmouth Hospital's Server**

Problems relating to the pathology system, the 'love bug' virus precautions, and the unreliability of the exchange server had led to a patchy service recently. Service response times were



discussed, along with communications with practices which was acknowledged as an issue to be addressed.

JJC

#### **BT Invoices and Consultation with Practices**

Some practices had wrongly received large invoices from BT. There was also no prior notification of new IT staff arranging to visit practices, and there was concern that practices using Office 2000 would only be offered training on Office 1998. It was agreed that communication with practices needed to be addressed and JJC confirmed that a newsletter was to be sent out.

JJC

#### **NHSNet Connections Update**

Microtest practices were up and running and EMIS practices should all be connected by the end of June. Negotiation with Torex regarding pricing was nearing a successful conclusion.

#### **4 Coding**

It was agreed that Colin, Dick and Marcus should be asked to produce a diabetes template. The template development should utilise user input, including nurses. It should be achieved over the next couple of months and could help to progress the PRIMIS work. A district wide version may be appropriate following testing.

CO/RT/MS

#### **5 PCG IT Software Options**

The Phoenix project at Yorkshire (Airedale) was discussed with reference to the 'launch meeting' and 'ITinsight' articles available at <http://www.revdoc.demon.co.uk/articles/>. It was welcomed.

Chris Tite at Portsmouth HealthCare Trust would be leading the district wide debate and reviewing options. Issues would include the level of consensus and the appropriate size of incremental steps. Jeremy would share the Phoenix information with other PCGs. John-Jo would investigate how the cost of a single major investment could be spread across financial years taking into account future capital and maintenance savings.

JD

JJC

#### **6 Reimbursement Policy**

##### **NHSNet Equipment in the Second Year**

Practices in PIPCG had requested information on the reimbursement level for second year NHSNet hardware maintenance. John-Jo was not able to assure the meeting that this maintenance would be available at a district level. He would discuss reimbursement from GMS with PCGs in the light of PCGs' reimbursement policies. At the moment no hardware maintenance is paid at 100% from GMS. *[Post Meeting Note: One PIPCG practice has now refused to accept new NHSNet*

JJC

*hardware on account of a lack of commitment to pay 100% maintenance.]*

### **Back-up Tapes Advice**

Useful tape backup information had recently been issued, and Jeremy agreed to contact David Tones to source the advice to pass on to practices. It was agreed that reimbursement should be provided to practices for backup tapes as part of normal ongoing maintenance costs. (To be included in next year's IT reimbursement policy).

JD

JD

## **7 Feedback from the LIS Programme Boards**

The Processes and Protocols Programme Board had received:

- plans for an information sharing protocol from Portsmouth's Adult Mental Health Team.
- a Prology presentation that gave rise to questions regarding the length of time required for GP consultations and the training required.
- An opportunity for a joint post (PCG/Health Authority) PRIMIS facilitator for 18 months.
- Adult Mental Health's interest in a wider coding basket, although coding progress was less marked in child and family therapy.

## **8 Any Other Business**

Unsuccessful IT bids from the March Board Meeting were received and their priority for funding ranked using the PCG Reimbursement Policy criteria.

## **9 Date of Next Meeting**

It was agreed to move the proposed date back one week. **The date was therefore changed** and is now:-

**12 September 2000 12.30 – 14.00**

Please note earlier finish time

Venue as before: F1 Meeting Room Finchdean House

ALL

(Following Meeting: 21 November 2000 12.30 – 14.30, F1)

**Agenda Item No:****No: 7.1****ORAL HEALTH PROMOTION FOR PORTSMOUTH & SOUTH EAST HANTS****Background & Summary**

A 10 minute presentation will be given by Nick Torlot and Kedi Mulcock from Portsmouth HealthCare NHS Trust, Dental Department, Gosport Health Centre, outlining:

- Oral Health Background
- Who is Working Where?
- Funding
- Contracting Issues
- Priorities for Portsmouth City/Portsmouth & South East Hants
- Achievements
- Questions and Answers

**Recommendations:**

The Board is asked to note the presentation

**Date: 12 September 2000****Paper Prepared by: Nick Torlot and Kedi Mulcock**

**Agenda Item No:****No: 7.2****Portsmouth City Health Improvement Programme: Priorities for 2001 – 2004  
(incorporating Health Action Zone Conference Report)****Background & Summary**

The Portsmouth and South East Hampshire Health Improvement Programme 2000-2003 (HImP) was finalised in March 2000.

In recognition of the evolution of locality-based Primary Care Groups and Trusts, it was agreed that each Primary Care Group (PCG), in liaison with their respective Local Authority and other stakeholders, would develop locality-based HImPs during 2000/2001. These HImPs should identify priorities for health improvement for their locality and state what action will be taken to address them.

The development of the Portsmouth City HImP began at the Portsmouth City Health Action Zone Conference and HImP Strategic Exchange on the 19<sup>th</sup> July 2000.

This paper:

- Feeds back main issues from the HAZ Conference and HImP Strategic Exchange
- Identifies HImP priorities for Portsmouth City
- Summarises next steps in the development of the Portsmouth City HImP

**Recommendations:**

- The PCG Board endorses the Portsmouth City HImP priorities identified in this paper
- The PCG Board notes the feedback generated by the Portsmouth City Health Action Zone Conference and Strategic Exchange

**Date:           Friday, 08 September 2000****Paper Prepared by:****Innes Richens  
General Manager  
(Health Improvement)****Jackie Charlesworth  
HAZ Projects Manager**

## PORTSEA ISLAND PRIMARY CARE GROUP

### Portsmouth City Health Improvement Programme: Priorities for 2001 – 2004

#### 1 Introduction

The Portsmouth and South East Hampshire Health Improvement Programme 2000-2003 (HImP) was finalised in March 2000. It represents a comprehensive strategy for tackling health inequalities, improving health and modernising healthcare services within the Health Authority district.

In recognition of the evolution of locality-based Primary Care Groups and Trusts, it was agreed early in 2000 that each Primary Care Group (PCG), in liaison with their respective Local Authority and other stakeholders, would develop locality-based HImPs during 2000/2001. These HImPs should identify priorities for health improvement for their locality and state what action will be taken to address them.

The development of the Portsmouth City HImP began at the Portsmouth City Health Action Zone Conference and HImP Strategic Exchange on the 19<sup>th</sup> July 2000. The Health Action Zone (HAZ) will be particularly valuable in HImP development and delivery, as it will retain a focus on inequalities, innovation and new approaches to complex issues.

This paper:

- Feeds back main issues from the HAZ Conference and HImP Strategic Exchange
- Identifies HImP priorities for Portsmouth City
- Summarises next steps in the development of the Portsmouth City HImP

#### 2 Health Action Zone: Conference Report

The Health Action Zone launch conference and Portsmouth City Strategic Exchange took place at the Hilton Hotel, Portsmouth on Wednesday 19<sup>th</sup> July 2000.

Approximately 60 people attended the HAZ conference from a variety of organisations across the City including representatives from Social Services, the Local Authority, local NHS Trusts, the PCG Board and management team amongst others.

The purpose of the conference was threefold, namely:

- to launch the Portsmouth City Health Action Zone
- to encourage delegates to consider the potential benefits to Portsmouth City of having health action zone status
- to use delegate feedback to develop the Portsmouth City Health Action Zone

The presentation made by a team from Manchester, Salford & Trafford Health Action Zone about what health action zones were and what they could do generated a great deal of interest and debate from delegates.

Delegates were encouraged to think of the HAZ as:

- an opportunity to work differently and innovatively to reduce health inequalities, particularly in deprived communities
- a vehicle for working jointly across agencies and traditional boundaries

The question put to delegates in the workshop session was “What do you think the potential benefits are to Portsmouth of being a Health Action Zone?” The main themes that emerged from this session were:

- Encouraging individuals and organisations to think differently about what they do and how they do it
- Empowering individuals and organisations to break down traditional boundaries and blocks to joint working
- Enabling organisations to shape and deliver 'seamless' services

## **2.1 How do we do this?**

Workshop participants were also asked to identify how these benefits of HAZ status could be achieved:

- Joint working is essential and should involve whole organisations
- Use existing structures, and rationalise strategies/plans
- Strip out processes and 'hoops' to overcome traditional boundaries and blocks to effective joint working
- Acknowledge each organisation's contribution to the health and well-being agenda
- Work closely with local communities to enable them to take part fully in shaping and delivering services.

As a result of the conference, the Health Action Zone Steering Group will be expanded to include representation from a variety of organisations and departments within the City who have a role to play in health improvement. The above conference outcomes will be used to shape the Terms of Reference for this group and determine the future direction of the Portsmouth City HAZ.

## **3 Portsmouth City HImP Strategic Exchange**

The Portsmouth City HImP Strategic Exchange took place following the HAZ launch on the 19<sup>th</sup> July. It was an opportunity for chief executives and senior managers of key organisations to exchange ideas, compare and discuss priorities, identify overlaps and gaps and agree those priorities where joint working between organisations would bring about health improvement and reduce inequalities in health in Portsmouth City. These priorities have informed the development of the locality HImP.

Twenty people attended the exchange. Following the workshops that took place, the top themes for joint working were:

- Inequalities
- Promoting healthy lifestyles
- Community capacity building
- Promoting independence
- Education

People attending the Strategic Exchange felt that other key organisations that should be included in development of the locality HImP are:

- Employers/local businesses
- Voluntary sector
- Criminal justice system
- Ambulance service

- The people of Portsmouth City
- Employment Service
- Benefits Agency

The outcomes of the Strategic Exchange will be included in the Portsmouth City Health Improvement Programme that is currently being developed by the Primary Care Group and the Portsmouth City Health Strategy Group.

#### 4 Portsmouth City HImP Priorities for 2001 - 2004

The Portsmouth City HImP priorities are summarised in **Attachment A**. They are based upon:

- The two year consultation and development of the district HImP and its existing priorities (this includes national 'givens')
- Priorities of organisations within Portsmouth City where they have an impact on the health of local people; this includes Portsmouth City Council's Community Plan
- Issues highlighted at the Portsmouth City Health Action Zone Conference and Strategic Exchange which was held in July of this year
- The recently published NHS National Plan

The list of priorities for the Portsmouth City HImP is exceptionally comprehensive. It should be noted that:

- The majority of these priorities already form part of the business or corporate plans of stake-holder organisations; this does not represent a list of 'new' issues to be tackled
- Many of these priorities are not for the Portsea Island Primary Care Group to implement alone. In the majority of cases, where the PCG is clearly the lead organisation for implementation, action is already underway and the priority has been incorporated into its Business Plan.
- Many of the priorities aiming to reduce inequalities in health will be tackled by using the new approach to joint planning and flexibilities of the Health Action Zone
- Implementation and progress monitoring of the HImP, although led by the PCG, will be achieved via joint working with local communities, the City Council, NHS Trusts, Health Authority, the independent and voluntary sector and other key stakeholders in Portsmouth City

#### 4 Next Steps

The HImP priorities given here are still in draft form. The PCG will review these in partnership with Portsmouth City Council and other local stakeholders in order to:

- Assess whether each priority has an existing action plan in place

- Develop a detailed Portsmouth City HImP by the end of November 2000, based on these priorities, which lays out more clearly the actions individual organisations will take on these priorities over the next three years

## **5 Recommendations**

- The PCG Board endorses the Portsmouth City HImP priorities identified in this paper
- The PCG Board notes the feedback generated by the Portsmouth City Health Action Zone Conference and Strategic Exchange

Innes Richens  
**General Manager (Health Improvement)**  
Portsea Island Primary Care Group  
Thursday, 07 September 2000

Jackie Charlesworth  
**HAZ Projects Manager**



## Attachment A

## PORTSMOUTH CITY HEALTH IMPROVEMENT PROGRAMME

Priorities 2001 - 2004

## Tackling Inequalities in Health

Priority	Source
Access <ul style="list-style-type: none"> <li>• Access to Healthcare services by vulnerable and socially excluded groups</li> <li>• Access to and availability of :               <ul style="list-style-type: none"> <li>• GPs and primary care in deprived wards</li> <li>• NHS dentistry</li> <li>• Optical services</li> <li>• Community nursing</li> <li>• Immunisation</li> <li>• Screening</li> </ul> </li> </ul>	PCG Business Plan PSEH HImP PSEH Annual Public Health Report PCC City Health Plan NHS National Plan
Health and Lifestyles <ul style="list-style-type: none"> <li>• Teenage pregnancy/perinatal mortality: deprived wards</li> <li>• Diet: men and young people, deprived wards, access to fruit by children</li> <li>• Smoking: women aged 16-29, deprived wards</li> <li>• Alcohol use: men 16-29, deprived wards</li> <li>• Mental health: higher levels in Portsmouth City</li> <li>• Stress: higher levels in Portsmouth City</li> <li>• Coronary Heart Disease: deprived wards, access to effective treatments lowest in deprived wards</li> <li>• Asthma: deprived wards, under 15s, variable admission patterns between GP surgeries</li> <li>• Accidents: deprived wards, falls in older people</li> <li>• Exercise: people over 65, deprived wards</li> <li>• Sun behaviour: sun protection amongst men, deprived wards</li> <li>• Health needs assessment for Portsmouth City</li> </ul>	PCG Business Plan PSEH HImP PCC City Health Plan PSEH Lifestyles Survey PSEH Annual Public Health Report NHS National Plan
Neighbourhoods and Community Development <ul style="list-style-type: none"> <li>• Portsea</li> <li>• Landport</li> <li>• Buckland</li> <li>• Somerstown</li> <li>• Paulsgrove</li> <li>• Healthy Living Centres and programmes</li> <li>• Community development programmes</li> </ul>	PCC Community Plan PCG Business Plan PSEH HImP
Employment and Economy <ul style="list-style-type: none"> <li>• Support disadvantaged groups access training and jobs and tackle discrimination</li> </ul>	PCC Community Plan
Education <ul style="list-style-type: none"> <li>• Pre-school and low income families (Sure Start)</li> <li>• Truancy and exclusion</li> <li>• Retainment of children from low income families</li> </ul>	PCC Community Plan Acheson Report
Crime <ul style="list-style-type: none"> <li>• Focus on deprived communities</li> </ul>	Acheson Report
Housing <ul style="list-style-type: none"> <li>• Vulnerable groups</li> <li>• Homeless</li> <li>• Fuel poverty</li> </ul>	PCC Community Plan Acheson Report
Environment and Transport <ul style="list-style-type: none"> <li>• Older people</li> <li>• Schoolchildren</li> </ul>	Acheson Report
Reduce Poverty <ul style="list-style-type: none"> <li>• Deprived areas</li> </ul>	PCC Community Plan PCC City Health Plan PSEH HImP

## Attachment A

## Tackling the Determinants of Health

Priority	Source
Employment and Economy <ul style="list-style-type: none"> <li>• Skills training programmes</li> <li>• New Deal</li> <li>• Redevelopment of key sites and Regeneration</li> <li>• Expand local businesses, attract new ones</li> <li>• Workplace health/stress</li> </ul>	PCC Community Plan PCG Business Plan
Education <ul style="list-style-type: none"> <li>• Under 5s</li> <li>• Parents as main educators</li> <li>• Support schools around reading and maths (literacy and numeracy) and educational attainment</li> <li>• Stay on rates in 16 year olds</li> <li>• Further/higher education</li> <li>• Lifelong learning</li> </ul>	PCC Community Plan Acheson Report
Crime <ul style="list-style-type: none"> <li>• Violent crime, domestic and racial violence</li> <li>• Anti-social behaviour</li> <li>• Crime by children and young people</li> <li>• Support for victims of crime</li> <li>• Reduce fear of crime</li> </ul>	PCC Community Plan
Housing <ul style="list-style-type: none"> <li>• Private sector housing</li> <li>• Council houses</li> <li>• Ensure future housing provision responds to people's needs</li> <li>• Housing costs</li> <li>• Social housing</li> <li>• Home energy</li> </ul>	PCC Community Plan Acheson Report
Environment and Transport <ul style="list-style-type: none"> <li>• Alternatives to car use</li> <li>• Clean up contaminated sites/ get vacant sites used</li> <li>• Recycling</li> <li>• Energy efficiency of homes</li> <li>• Design of new buildings</li> <li>• Regenerate the 5 main shopping areas</li> <li>• Noise complaints</li> <li>• Involvement in improving the environment</li> </ul>	PCC Community Plan Acheson Report

## Promoting Health and Preventing Ill Health

Priority	Source
Coronary Heart Disease and Stroke <ul style="list-style-type: none"> <li>• Smoking:</li> <li>• Diet</li> <li>• Physical activity</li> <li>• Alcohol use</li> <li>• National Service Framework for CHD</li> </ul>	PCG Business Plan PSEH HimP PCC City Health Plan PCC Community Plan NHS National Plan
Mental Health <ul style="list-style-type: none"> <li>• National Service Framework/ Portsmouth City Locality Implementation Plan – prevention objectives</li> <li>• Suicides</li> </ul>	PCG Business Plan, PSEH HimP PCC City Health Plan PCC Community Plan
Diabetes <ul style="list-style-type: none"> <li>• National Service Framework (March 2000)</li> </ul>	PCG Business Plan PSEH HimP
Cancers <ul style="list-style-type: none"> <li>• Smoking, diet, exercise, lifestyles (as above)</li> <li>• Skin cancer/sun behaviour</li> </ul>	PCG Business Plan, PSEH HimP

## Attachment A

Asthma <ul style="list-style-type: none"> <li>Internal and external air quality</li> <li>Education</li> </ul>	PCG Business Plan, PSEH HImP
Accidents <ul style="list-style-type: none"> <li>Home</li> <li>Workplace</li> <li>Roads and Road safety</li> <li>A&amp;E and Primary Care data collection</li> </ul>	PCG Business Plan PSEH HImP
Teenage Pregnancy/ Perinatal Mortality <ul style="list-style-type: none"> <li>Support district-wide work</li> </ul>	PSEH HImP

## Modernising Health and Social Services

Priority	Source
Promoting Independence: modernising services for: <ul style="list-style-type: none"> <li>Older people</li> <li>People with physical disabilities</li> <li>People with learning disabilities (support district)</li> <li>Substance misuse: (support Drug Action Team)</li> <li>Mental health <ul style="list-style-type: none"> <li>Adult Mental Health</li> <li>Older people with mental health problems</li> <li>Children and adolescent mental health</li> </ul> </li> <li>Children and families</li> <li>Carers</li> </ul>	PCG Business Plan PSEH HImP PCC Community Plan NHS National Plan
NHS Services (General) <ul style="list-style-type: none"> <li>Community hospital for Portsmouth City</li> <li>Capital and estates</li> <li>Cleanliness and food standards</li> <li>Community nursing and community services</li> <li>Joint review and collaborative commissioning mechanisms</li> <li>Clinical Governance and Quality</li> <li>Human Resources, Workforce Planning and Organisational Development</li> </ul>	PCG Business Plan PSEH HImP NHS National Plan
Primary Care Services: <ul style="list-style-type: none"> <li>Staff training</li> <li>Staff relief</li> <li>IT</li> <li>Premises</li> <li>Prescribing</li> <li>Access</li> <li>Secondary care in primary care (physio, counselling etc)</li> </ul>	PCG Business Plan NHS National Plan
Asthma Services <ul style="list-style-type: none"> <li>Long term Service Level Agreements</li> <li>Care and audit pathways</li> <li>Use of prophylaxis, transition to CFC inhalers</li> </ul>	PCG Business Plan
Teenage Pregnancy/ Perinatal Mortality Services <ul style="list-style-type: none"> <li>Support district-wide work</li> </ul>	PSEH HImP
Coronary Heart Disease and Stroke Services <ul style="list-style-type: none"> <li>National Service Framework for CHD services</li> <li>Community and rehabilitation services for stroke</li> </ul>	PSEH HimP NHS National Plan
Cancer Services <ul style="list-style-type: none"> <li>Clinic distribution and access, referral</li> <li>Palliative care</li> <li>Screening</li> </ul>	PSEH HimP NHS National Plan
Waiting Lists <ul style="list-style-type: none"> <li>Waiting lists and times</li> <li>Outpatient appointments and access</li> <li>Primary care appointments and access</li> </ul>	PCG Business Plan PSEH HimP NHS National Plan

## Attachment A

Priority	Source
Kingston Prison HImP <ul style="list-style-type: none"> <li>• Complete needs assessment and action plan</li> <li>• Mental health services for prisoners</li> </ul>	PSEH HImP NHS National Plan
Provision of healthcare services for residents of Gosport and South Fareham <ul style="list-style-type: none"> <li>• Support ongoing consultation, and development as appropriate</li> </ul>	PSEH HImP
PCG to PCT <ul style="list-style-type: none"> <li>• Develop proposal with key stakeholders</li> </ul>	PCG Business Plan

Innes Richens

**General Manager (Health Improvement)**

Portsea Island Primary Care Group

Tuesday, 05 September 2000

h/innes/portseaislandpcg/Ports City HImP Priorities 2001.02\_List.doc

**Agenda Item No:****No: 7.3****Coronary Heart Disease Projects Update****Background & Summary**

The purpose of this paper is to keep Board Members informed of progress to date on the family of 8 CHD projects funded from the HImP Performance Fund. The main messages are:

1. A great deal of headway has been made on 7 of the projects due to close collaboration between the PCG, Social Services, various local authority departments, colleagues in the SRB team, members of the public, local Trusts and primary care.
2. One of the projects, the 'Healthy Heart Bus Tour' will not take place this year, as a very similar piece of work is currently being planned by the Healthy Workplace Alliance. The new HAZ Steering Group will be asked to recommend a suitable project that can replace this piece of work.
3. Discussions are currently taking place regarding evaluation of the projects, and it is hoped that this will be carried out by a sub-group of the revised Portsmouth Health Strategy Group.
4. There will be an underspend on the project budget this financial year and a significant proportion of this will be used to support the prescribing implications of implementing LEAP report recommendations.

**Recommendations:**

That the PCG Board note progress on the projects.

**Date:** 6<sup>th</sup> September 2000**Paper** Jackie Charlesworth, HAZ Projects Manager

## Health Action Zone Update Coronary Heart Disease Projects

The purpose of this paper is to keep Board Members informed of progress to date on the family of 8 CHD projects funded from the HImP Performance Fund. The main messages are:

1. A great deal of headway has been made on 7 of the projects due to close collaboration between the PCG, Social Services, various local authority departments, colleagues in the SRB team, members of the public, local Trusts and primary care.
2. One of the projects, the 'Healthy Heart Bus Tour' will not take place this year, as a very similar piece of work is currently being planned by the Healthy Workplace Alliance. The new HAZ Steering Group will be asked to recommend a suitable project that can replace this piece of work.
3. Discussions are currently taking place regarding evaluation of the projects, and it is hoped that this will be carried out by a sub-group of the revised Portsmouth Health Strategy Group.
4. There will be an underspend on the project budget this financial year and a significant proportion of this will be used to support the prescribing implications of implementing LEAP report recommendations.

The projects are outlined below:

1. **The Good Grub Challenge** A multi-agency group is currently being formed to brainstorm ideas about this healthy eating promotion, and the group will meet by the end of September. A series of cookery competitions will be arranged covering different geographical areas, age ranges, ethnic groups and a local school, The City of Portsmouth Girls School has offered the use of their domestic science unit as a base for the competitions to take place in. The main event will be a 'cook-off' between two teams led by local 'celebrity' chefs, and hosted by a person well known by City residents. The final event will be held at the John Pounds Centre, Portsea. Various outcome measures will be built into the event, and results of these will be used to inform future work on healthy eating issues.
2. **Secondary Prevention** This project has a number of component parts, namely:

### **Thrombolytic therapy service – A & E Dept**

Dr John Hughes and Dr Elizabeth Jorge have discussed the proposed service with Lin Kennett (PHT) and agreed a 52 week pilot to provide a service at QAH, Monday – Friday, 9am – 5pm. The pilot will be audited after this period to gauge effectiveness and the service will then be reviewed alongside other scenarios for the service.

### **Nurse led heart clinics in primary care**

A small group is currently being formed to discuss work that has been undertaken in other parts of the country in relation to cardiac rehabilitation programmes linked to the British Heart Foundation 'Heart Manual'. The purpose of this discussion will be to determine whether this service would be viable in Portsmouth.

### **Implementation of LEAP Reports**

Individual GP practices are now receiving their LEAP reports and will be able to determine the likely impact of implementing the findings. It has been agreed with the PCG Prescribing Adviser that a proportion of the underspend in this years' CHD/HAZ budget will be used to support the cost of prescribing statins.

### **3. Exercise for Older People**

A number of schemes have been put in to place. Funding for 'Armchair Aerobics' via the EXTEND scheme has been provided at one GP practice and it is hoped to roll this out to other practices who would be interested in setting up a similar scheme. Discussions are taking place with Social Services with regard to offering the service to residents in sheltered housing and develop alternative exercise (such as dancing) to older peoples groups in the City.

### **4. Stress Free City Initiative**

A city-wide pilot project is currently being developed which is aimed at reducing levels of stress in the city by helping people to recognise, manage and prevent future occurrences of dysfunctional stress. The target group is anyone who lives and/or works in the city of Portsmouth. The project is being driven by a multi-agency steering group.

### **5. Walking Bus**

Discussions have taken place between the PCG, City Engineers Department and Social Services to develop a way forward with this project. A number of schools have previously been involved in research undertaken by the City Engineers Department regarding the feasibility of setting up a scheme in Portsmouth, and the results of this research are in the process of being followed up.

### **6. Community Conservation**

In order to promote messages about exercise, healthy eating and adopting healthier lifestyles in as wide a variety of forms as possible, community conservation projects are being developed in Portsmouth. One such scheme that is being supported by the PCG is a community garden in Landport. The garden will be cultivated using organic gardening methods together with recycling and composting facilities, a 'garden buddy' scheme and support and advice for people to develop their own gardens. It is hoped to develop similar schemes in various parts of the City.

### **7. Improved Access to Exercise**

Working closely with Social Services a variety of schemes are being developed to facilitate easier access to exercise for minority ethnic groups in the City. One example of a scheme that has been approved is Tai Chi for older people in the

Chinese community. It is also proposed to look at issues of access in relation to different geographical areas in the City.

**8. Healthy Heart Bus Tour**

The Healthy Workplace Alliance is a multi-disciplinary, multi-agency group that looks at issues relating to health in the workplace. One project that the group will be piloting this year is a healthy heart bus tour. Outcomes of the pilot will be made available to the PCG, and in order not to duplicate effort we will no longer be pursuing our own healthy heart bus tour. The newly formed HAZ Steering Group will be asked to generate a project to replace this scheme.

If there is any aspect of this work that you would like to discuss please do not hesitate to contact me.

**Jackie Charlesworth**  
**HAZ Projects Manager**



**Agenda Item No:****No: 8.1****Interim Commissioning And Performance Report****Background & Summary**

Waiting lists for in patient and day case treatment and outpatient waits greater than 13 weeks are both above target. This report focuses on the action being taken to improve waiting lists and times, and includes the PCG's proposal for intermediate care.

Part Two gives feedback on progress to develop commissioning information following suggestions from the Board and the Commissioning Subgroup.

A full report incorporating service level agreement data will be provided for the November Board Meeting.

**Recommendations:**

The Board is asked to note this report

**Date:** 06 September 2000**Paper Prepared by:** Jeremy Douglas, Information Analyst

**PORTSEA ISLAND PRIMARY CARE GROUP**  
**INTERIM COMMISSIONING AND PERFORMANCE REPORT**  
**For the September Formal Board Meeting – 20 September 2000**

**Introduction**

Part One of this interim report gives details of waiting lists and times and action being taken to improve them, and feedback on intermediate care planning - winter pressures. Part Two shows what information is becoming available in response to suggestions by the Board and the Commissioning Subgroup. A full Commissioning Performance Report will be provided at the November Board meeting.

The report is structured as follows:

- 1 PART ONE**
  - 1.1 Waiting time for first outpatient appointment - 13 week wait standard
  - 1.2 Waiting time for outpatient appointment – cancer waiting times
  - 1.3 Waiting lists/times for inpatient and daycase treatment – progress against profile
  - 1.4 Winter pressures - update on intermediate care proposals
  
- 2 PART TWO (Developing Information)**
  - 2.1 Hospital cancellations
  - 2.2 ITU capacity
  - 2.3 Patient tracking
  
- 3 Conclusion**

## 1 PART ONE

### 1.1 Waiting time for first outpatient appointment - 13 Week Wait Standard

The number of Portsmouth and South East Hampshire residents waiting 13 weeks or longer for a first outpatient appointment was 5030 as at end of July 2000. Of this total, 4893 people were waiting to be seen at Portsmouth Hospitals Trust. PCG specific figures are not yet available.

Table 1 below shows that although this was less than the previous month, it is now above our target, as the monthly profile reduces to meet the national target for March 2001. The underlying trend is an increase since April 2000.

Table 1 Number of GP referrals not yet seen at end of month waiting 13 weeks and over

	<b>Profile</b>	<b>13 WEEKS AND OVER</b>	<b>Variance</b>	<b>% Variance</b>
April	5503	4252	-1251	-29.4
May	5390	4715	-675	-14.3
June	5277	5281	4	0.1
July	4940	5030	90	1.8
August	4613			

Portsmouth Hospitals Trust is now reporting on a weekly basis to the South East Regional office and Simon Jupp has been seconded from Region to work with the Trust 2 days a week. An Outpatient group has been established with input from each PCG. The group will report through the Waiting List Task Force.

The Trust is aiming to see an additional 1500 patients during September to achieve its target of 4195. This may involve delaying follow-ups and seeing new patients instead. The Trust is also checking administrative processes against best practice guidelines. In the meantime the Trust continues to validate waiting lists, starting with the longest waiters.

From the Primary/Community Care end, several 'Demand Management' projects are at various stages of development, which when up and running should reduce the demand on secondary care outpatient services. These include:

**Back Pain:** District-wide scheme going live on 1 October and involving specialist physiotherapy treatment and triage.

**Glaucoma Monitoring:** Community monitoring of stable glaucoma patients by optometrists. Planned to start in October.

**Diabetic Retinopathy:** Testing by community optometrist. Scheme is up and running.

**Orthopaedics:** Specialist Physiotherapy triage of knee conditions.

**Bone Densitometry:** GP direct access.

**Rapid Access Prostate Clinic:** Should be incorporated in to direct booking pilot.

Other longer-term projects include; dermatology minor operations, an orthodontic waiting list initiative and the possible increased use of specialist GPs.

## 1.2 Waiting time for outpatient appointment – cancer waiting times

The cancer two weeks wait standard states that 100% of patients should be given an appointment within two weeks of an urgent GP referral, this referral being received within 24 hours. This standard was extended from 1 July to include upper and lower gastro-intestinal tract cancers. Appendix One provides tables and trend graphs for each condition monitored at a district-wide level until the end of Quarter 1, (or July 2000 for monthly data).

Most patients are being seen within 14 days of the referral being received at the hospital, although there is a consistently longer wait for patients with a lower gastro-intestinal cancer. There was a sharp rise in July in the number of referrals received after 24 hours for patients with lung cancer.

### Summary by Condition

1.2.2 Breast Cancer: The standard is being met on 98% of urgent referrals received within 24 hours. However 21% referrals in quarter 1 were received by the Trust more than 24 hours after the decision to refer (58 patients).

1.2.3 Lung Cancer: The standard is being achieved in 95% of referrals, however in July 56% referrals were received after 24 hours (24 patients).

1.2.4 Haematological Cancers: There were 2 urgent referrals for haematological cancers both were seen within two weeks. A referral for one patient was received after 24 hours.

1.2.5 Upper Gastro-Intestinal Cancers: The standard is being met for 95% of referrals.

1.2.6 Lower Gastro-intestinal Cancers: Only one of 44 referrals received within 24 hours was seen within 14 days (2%) and 16 referrals were received by the Trust after 24 hours (27%).

1.2.7 Skin Cancers: In July the dermatology department saw 10 patients (31%) within 14 days.

1.2.8 Gynaecology Cancers: In July 16 out of 21 patients (76%) referred within 24 hours were seen within 14 days. However, 48% of all referrals were referred after 24 hours.

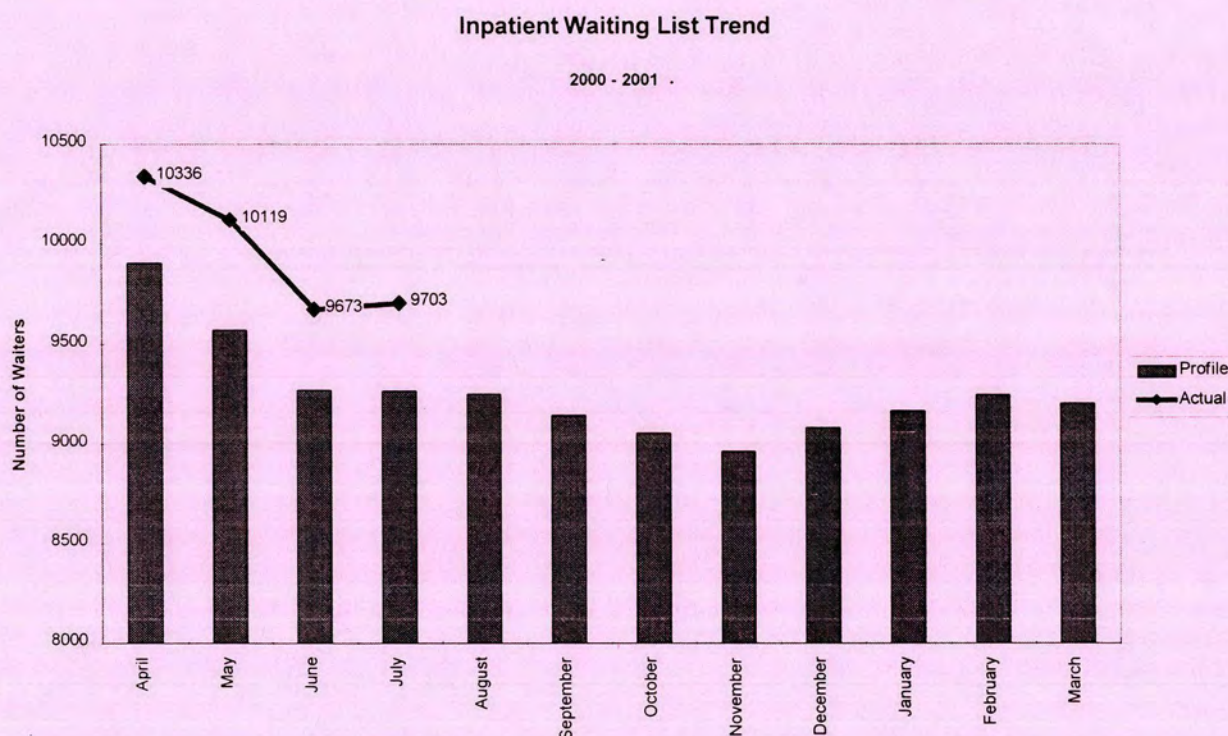
### Waits for Treatment following Diagnosis

Please refer to section 2.3 of this paper for a progress report.

### 1.3 Waiting lists/times for inpatient and daycase treatment – progress against profile

At the end of July the number of people waiting for treatment district-wide was 9703. This represented a reduction of 375 on the number waiting this time last year, but the current profile is a challenging 9262.

Figure One: District Waiting List against Profile



#### 1.3.1 All Providers

Table 2 shows that, as at 31 July 2000, the all provider target of 9262 for inpatient and daycase waiting lists was exceeded by 4.76%

Table 2 Number of Patients Waiting for Treatment by Provider 31 JULY 2000

Trust	Profile	Actual	Variance	Variance %
Portsmouth Hospitals	8133	8519	386	+ 4.7%
Portsmouth HealthCare	35	1	-34	- 97.1%
Southampton University Hosps	598	637	39	+ 6.5%
Other	496	546	50	+ 10.1%
<b>Totals</b>	<b>9262</b>	<b>9703</b>	<b>441</b>	<b>+ 4.76%</b>

#### 1.3.2 Portsmouth Hospitals Trust

Portsmouth Hospitals are now required to report to the Regional Office on a weekly basis. As a result more recent figures are available for the Trust and these include Royal Hospital Haslar performance with the profile increased accordingly.

As at 1 September there were 9119 patients on Portsmouth Hospitals' waiting list, 2.7% above the target of 8879.

Portsmouth Hospitals Waiting List Task force meets on a weekly basis and recent issues affecting waiting list performance have included:

- The Trust remaining on 'Red alert' until the middle of May, with significant numbers of medical patients occupying elective beds. Medical outliers have lead to cancelled procedures and specialties being unable to deliver waiting list reductions as planned.
- Staffing difficulties, with Hospital Sterilisation and Disinfection Unit (HSDU) and theatres particularly affected
- Sterilisation of equipment

Particular areas of concern and resulting management action include:

**Orthopaedics** (12% above target at 1/9/00)

- A training programme has started in Hospital Sterilisation and Disinfection Unit (HSDU) and additional experienced staff have been transferred from St Mary's to Queen Alexandra Hospital
- Meanwhile Trust have been asked to focus on intermediate cases
- Service review is planned for September
- Funding for 50 additional cases at BUPA/King Edward VII has been provided
- The Trust and Haslar are working to ensure the best utilisation of available capacity with some cases transferring to Haslar on a planned basis.

**Ophthalmology** (11.9% above target at 1/9/00)

- Additional 163 cases purchased from King Edward VII, using Portsmouth Hospitals Consultants
- New SHOs should be trained for minor operations by the end of September
- Plans to integrate care of cataract patients to make full use of the capacity of the new procedure suites
- Recovery plan requested from the Trust

**Gastroenterology** (26.3% above target at 1/9/00)

- Haslar numbers have increased
- Un-sedated lists beginning in September which should reduce list size to target

### 1.3.3 Portsea Island PCG Inpatient Waiting Lists

Of the 9,703 patients waiting for inpatient/daycase treatment district-wide at the end of July, 9,599 were to receive services commissioned by PCGs, and 2,533 of these (26.4%) were Portsea Island patients. Table 3 shows providers' relative performance for Portsea Island patients over the last three Quarters.

Table 3 Portsea Island - Inpatient Waiting Numbers by Provider

PROVIDER	Q3 - Dec	Q4 - March	Q1 - June	July 2000
Portsmouth Hospitals With Haslar	2247	2421	2403	2350
Southampton UHT	79	81	70	78
Salisbury	63	74	77	74
Brompton & Harefield	23	24	11	8
Others	21	22	23	23
<b>TOTAL</b>	<b>2433</b>	<b>2622</b>	<b>2584</b>	<b>2533</b>

The comparisons show a reduction of 53 patients waiting for treatment at Portsmouth Hospitals in July, although the June figure was 217 higher than the same Quarter period in 1999.

Portsea Island PCGs overall waiting list target for 31 March 2001 is 2457. The PCG will require a reduction of 165 (6.3%) on last March's total, although our first quarter figure shows a rise of 217 (9.2%) compared with June 1999.

#### **1.3.4 Waiting Times for Treatment**

No patients have waited longer than 18 months for treatment, although the target of 15 months maximum wait from 30 September 1999 was breached for 30 patients district-wide, 6 of whom were from Portsea Island. The number waiting more than 12 months was 249; this was 55 more than the profile target of 194.

13 patients waited longer than 12 months for CABG treatment, 3 of these were waiting between 15 and 17 weeks. One Portsea Island patient was amongst these 3 but was admitted for treatment in August.

#### **1.4 Winter pressures - intermediate care proposals**

An update by Debbie Tarrant, Service Development Manager

The P.C.G. has been successful in attracting funding to establish a 12 bedded intermediate care facility on St. Mary's Hospital site. This will form phase one of the Portsmouth City Community Hospital. The unit, which will be known as the Rembrandt Unit, will accept post acute patients over 65 whose condition is known and stable but who require further nursing and therapeutic input in order to increase functionality prior to discharge. The unit will be nurse-led and have a full complement of rehabilitation staff that will link to the community team. The contract for medical cover for the unit has been awarded to the Robinson practice and this will involve daily 'ward rounds' to manage routine care and 24 hour cover for emergencies. The Clinical Manager has now been appointed and the rest of the team is currently being recruited. A commissioning group has been set up to oversee the refurbishment and equipping of the unit which will be situated on the ground floor of the Exton block.

The Chief Executives on the Whole Systems Group will be asked to consider the remainder of the PCG's proposals for investment in intermediate care for 2000/2001 at a meeting on 21 September. The proposals include:

- A Rapid Response Assessment Service
- Early Supported Discharge
- Enhanced Care at Home Incorporating CAPS
- A Portsmouth City Community Rehabilitation Service

The schemes are part of Portsmouth City's proposals for integrated care for older peoples and have been developed in partnership between the PCG, Portsmouth City Council Social Services Department, Portsmouth HealthCare NHS Trust and Portsmouth Hospital NHS Trust.

The aims of the schemes are to:

- Prevent disability and promote independence
- Avoid inappropriate admissions and re-admissions to hospital and care
- Improve the quality of care
- Ensure optimal and appropriate length of stay in hospital
- Facilitate timely and appropriate discharge

Proposals are based on local pilot projects (e.g. CAPS, Community Rehabilitation Team), evidence of similar projects elsewhere in the country (e.g. Rotherham and Manchester), and reports of schemes in the Kings Fund report on intermediate care. Support for the development of community rehabilitation services is strongly encouraged in the recent Audit Commission report "The Way To Go Home: Rehabilitation and Remedial Services for Older People". The proposals complement and support other initiatives including the Rembrandt Unit, extended Social Services out of hours, and additional geriatrician time.

In addition, all four PCGs in the district have agreed funding to establish a Patient Access Service (Bed Management System) within Portsmouth Hospitals. The objectives of the Service are:

- To optimise bed capacity and ensure that patients coming into hospital as emergencies are admitted to a bed appropriate to their clinical need and that the majority of elective patients are admitted as planned.
- To contain acute activity within Queen Alexandra Hospital, St Mary's Hospital and Haslar and safeguard the 'open door' policy for emergency admissions.

All beds covered by the Service will be considered as a corporate resource and not 'owned' by any single specialty. All ward nurses will therefore be expected to maintain basic core nursing skills.

It should be noted that the Service will not be able to provide a single point of contact for referrers wishing to admit patients to acute adult or elderly beds, and will not include management of obstetric, paediatric, acute psychiatric, GP or community hospital beds.



## 2 PART TWO: - Development of Commissioning Information

### 2.1 Hospital cancellations

The PCG's Commissioning Subgroup has expressed concern at the number of patients that appear to have had their appointment cancelled by the hospital.

230 patients from Portsea Island PCG had their admission cancelled by Portsmouth Hospitals NHS Trust in the first Quarter (April to June 2000). This number excludes 63 cancellations identified as patient-related. Seven Specialties cancelled more than 10 patients.

Table 4 Portsea Island Patients Cancelled Pre-admission by Portsmouth Hospitals Trust

Specialty	Number of Cancelled Patients
Anaesthetics (Pain Management)	56
Ear Nose and Throat	25
General Surgery	36
Orthopaedics	35
Urology	27
Oral Surgery	16
Ophthalmology	13

The most common reason provided for the cancellation was 'Other' (104). Reasons given included 'consultant availability' (40) and 'other urgent operation took place' (31).

The number of patients cancelled from each practice ranged from 1 to 23.

Portsmouth Hospitals Trust are planning to escalate the policy for reducing cancelled patients which involves improving resource flow between specialties.

### 2.2 ITU capacity

Information on the capacity of ITU has been sought since the February Board meeting. There were concerns that ITU bed capacity may lead to the cancellation of operations and to patients being transferred to alternative providers. The number of cancelled operations due to a lack of ITU beds is available from Quarter 3 1998/9 and is shown in Table 5:

Table 5 Cancelled operations due to no ITU Beds

Quarter	Total number cancellations	Cancellations due to ITU
Q3 1998/9	101	1
Q4 1998/9	104	8
Q1 1999/0	95	7
Q2 1999/0	99	0
Q3 1999/0	153	0
Q4 1999/0	251	10
Q1 2000/1	158	0

Latest figures show that there were 44 cancelled operations in June this year but that none were attributed to a lack of ITU beds.

Data on occupied bed days in ITU and on transfers to other providers has also been requested.

## 2.3 Patient tracking

Patients admitted for treatment have normally waited both for an outpatient appointment and then subsequently for an admission date. Tracking patients from the receipt of the referral through to the date of admission for treatment should help provide an average delay from a patient's perspective. The PCG Commissioning Subgroup has therefore requested a pilot to ascertain how easily information can be obtained, initially looking at hip and knee replacements and cataract surgery. In addition, the PCG Board at its June meeting asked whether it was possible to report how long patients suspected of cancer waited for treatment following the initial consultation, this is to be piloted initially for patients with breast, lung and lower bowel disease.

There were 523 Portsea Island patients on Portsmouth Hospitals NHS Trust's Orthopaedic waiting list at the end of April 2000. Only 39% of these waits had been coded with an operative procedure so that out of the total 523 patients, 71 were identified as waiting for hip replacement and 51 for knee replacement. There were further reasons why patients could not be included in our sample for tracking, mainly related to the patient's ongoing condition, (please refer to Appendix Two for full details). The final sample of patients with a treatment date was just 6 patients waiting for a knee operation and 8 for a hip operation. Patients treated for cataracts do not always receive an outpatient appointment before joining a waiting list; in these cases the date of referral receipt is not entered on the database used for tracking.

Initial attempts to track delays experienced by patients with cancer beyond their first consultation were complicated due to the length of time treatment can take, and the resulting number of similar episodes identified for the same patient. It is now proposed that patient records are sorted according to their referral date, and that a new database query is written to enable this.

## 3 Conclusion

Outpatient waits greater than 13 weeks are above the set profile (+ 1.8%) and the waiting list numbers (+ 4.76%) are also resulting in management action. The PCG's waiting list target will require a reduction on last March's total, although our first quarter figure shows a 9% rise compared with the same period last year. The PCG's intermediate care proposals should help ensure that the majority of elective patients are admitted as planned this winter.

As we seek to develop commissioning information we have encountered difficulties in collating information that is not usually requested. Ongoing work should help uncover the extent to which tracking patient experience can be achieved through relatively simple measures, such as improved coding or the writing of new database queries, or to more structural changes in the way information is collected and stored.

Contributors

<b>Jeremy Douglas</b>	<b>Information Analyst</b>
<b>Andrew Swinney</b>	<b>Service Development Manager</b>
<b>Debbie Tarrant</b>	<b>Service Development Manager</b>

Thursday, 07 September 2000

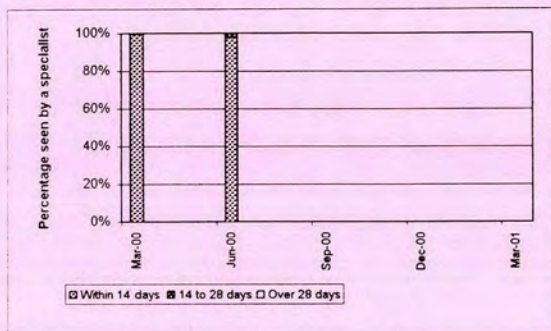
G:\BOARD\September 2000\200900InterimPerformance report.doc

PIPCG INTERIM COMMISSIONING PERFORMANCE REPORT  
APPENDIX ONE

**Portsmouth and South East Hampshire Health Authority**  
All Patients referred to Portsmouth Hospitals Trust including Royal Hospital Haslar

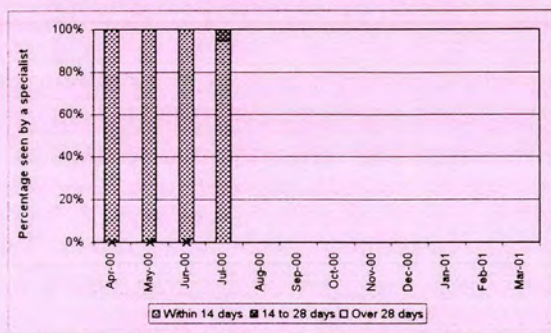
**Cancer Two Week Wait Standard:** 100% of patients should be given an appointment within two weeks of an urgent GP referral, this referral being received within 24 hours.

**Breast Cancer**  
Two week standard applies



	Urgent received within 24 hours	Urgent referrals seen		Urgent received after 24 hours	% urgent received after 24 hours
		Within 14 days %	15 days and over %		
Mar-00	295	294	100%	36	11%
Jun-00	224	219	98%	58	21%
Sep-00					
Dec-00					
Mar-01					

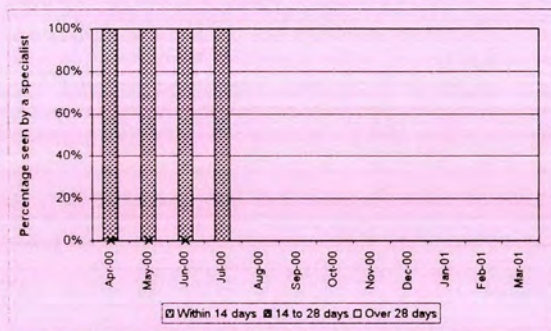
**Lung cancers**  
Shadow monitoring from February 2000



Two week standard applies from April 2000

	Urgent received within 24 hours	Urgent referrals seen		Urgent received after 24 hours	% urgent received after 24 hours
		Within 14 days %	15 days and over %		
Apr-00	14	14	100%	20	59%
May-00	13	13	100%	16	55%
Jun-00	25	25	100%	10	29%
Jul-00	19	18	95%	24	56%
Aug-00					
Sep-00					
Oct-00					
Nov-00					
Dec-00					
Jan-01					
Feb-01					
Mar-01					

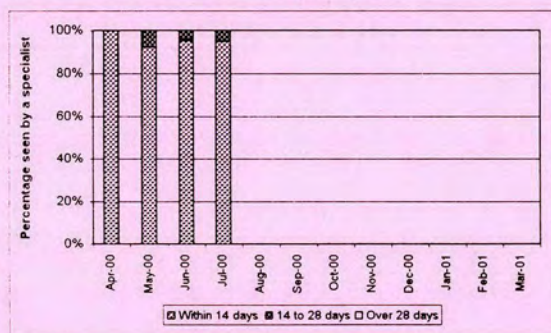
**Haematological Malignancies including Leukaemias**  
Shadow monitoring from February 2000



Two week standard applies from April 2000

	Urgent received within 24 hours	Urgent referrals seen		Urgent received after 24 hours	% urgent received after 24 hours
		Within 14 days %	15 days and over %		
Apr-00	1	1	100%	0	0%
May-00	2	2	100%	0	0%
Jun-00	5	5	100%	1	17%
Jul-00	2	2	100%	1	33%
Aug-00					
Sep-00					
Oct-00					
Nov-00					
Dec-00					
Jan-01					
Feb-01					
Mar-01					

**Upper gastro-intestinal cancers**  
Shadow monitoring from April 2000

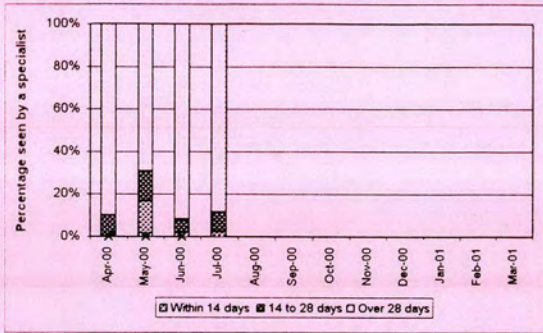


Two week standard applies from July 2000

	Urgent received within 24 hours	Urgent referrals seen		Urgent received after 24 hours	% urgent received after 24 hours
		Within 14 days %	15 days and over %		
Apr-00	14	14	100%	6	30%
May-00	13	12	92%	2	13%
Jun-00	21	20	95%	4	16%
Jul-00	20	19	95%	2	9%
Aug-00					
Sep-00					
Oct-00					
Nov-00					
Dec-00					
Jan-01					
Feb-01					
Mar-01					

PIPCG INTERIM COMMISSIONING PERFORMANCE REPORT  
APPENDIX ONE

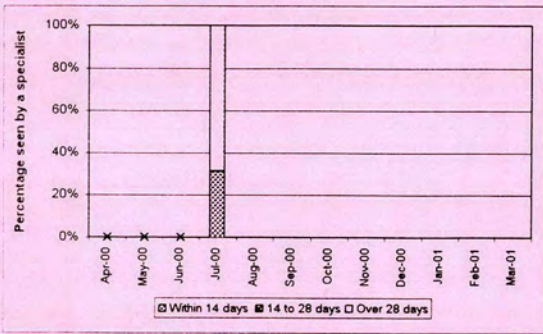
**Lower gastro-intestinal cancers  
Shadow monitoring from April 2000**



**Two week standard applies from July 2000**

	Urgent received within 24 hours	Urgent referrals seen		Urgent received after 24 hours	% urgent received after 24 hours
		Within 14 days %	15 days and over %		
Apr-00	50	0	0%	50	100%
May-00	59	10	17%	49	83%
Jun-00	50	1	2%	49	98%
Jul-00	44	1	2%	43	98%
Aug-00					
Sep-00					
Oct-00					
Nov-00					
Dec-00					
Jan-01					
Feb-01					
Mar-01					

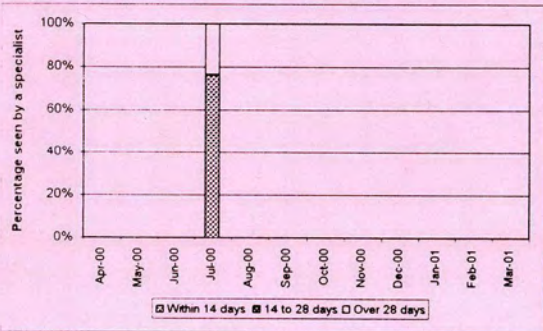
**Skin  
Shadow monitoring from July 2000**



**Two week standard applies from October 2000**

	Urgent received within 24 hours	Urgent referrals seen		Urgent received after 24 hours	% urgent received after 24 hours
		Within 14 days %	15 days and over %		
Apr-00					
May-00					
Jun-00					
Jul-00	32	10	31%	22	69%
Aug-00					
Sep-00					
Oct-00					
Nov-00					
Dec-00					
Jan-01					
Feb-01					
Mar-01					

**Gynaecological Cancers  
Shadow monitoring from July 2000**



**Two week standard applies from October 2000**

	Urgent received within 24 hours	Urgent referrals seen		Urgent received after 24 hours	% urgent received after 24 hours
		Within 14 days %	15 days and over %		
Apr-00					
May-00					
Jun-00					
Jul-00	21	16	76%	5	24%
Aug-00					
Sep-00					
Oct-00					
Nov-00					
Dec-00					
Jan-01					
Feb-01					
Mar-01					

**APPENDIX TWO**  
**PORTSMOUTH HOSPITALS NHS TRUST**  
**PATIENTS WAITING FOR HIPS AND KNEE REPLACEMENTS**  
**TAKEN FROM APRIL 2000 WAITING LIST CD'S**  
**SUMMARY**

Total Orthopaedic Waiting List for Portsea	523	
Total Number of Operative Procedure Codes Missing	321	61%
	<b>KNEES</b>	<b>HIPS</b>
Total number with Op Codes for Portsea	51	71
	<b>TO BE REMOVED</b>	
Patients with Consultant Referrals	3	11
A & E Referrals	1	0
Self Referral	0	1
Patients Suspended	2	2
Waiting Lists Cancelled	3	1
Patients deciding they will go private	3	0
Patients with No Referral details	4	2
Patient had Operation cancelled then added to W/List the following year	0	1
Patients that have been referred year's ago ( as far back as 1996 ) and have had continuing O/Pats appointments until they are ready to be added to the W/List	12	21
<b>Total to be removed</b>	<b>28</b>	<b>39</b>
	<b>REMAINING PATIENTS</b>	
Number of the above patients treatment completed	23	32
	6	8

**Agenda Item No:****No: 8.2****COMMISSIONING AND PERFORMANCE MANAGEMENT****Background & Summary**

The committee for the Commissioning And Performance Management Sub Group met on Wednesday 12 July 2000. A copy of the meeting notes are attached.

**Recommendations:**

The Board are asked to approve these minutes.

**Date: 12 September 2000****Paper Prepared by: Charles Lewis**

# Portsmouth and South East Hampshire

Health Authority

Finchdean House, Milton Road  
Portsmouth, PO3 6DP

## Portsea Island Primary Care Group

### Commissioning and Performance Management Sub-Group

Notes of the Meeting held: 12 July 2000

**Present:** Charles Lewis (Chair)  
Jeremy Douglas  
Tracy Green  
Andrew Swinney

No	Discussion	Action
----	------------	--------

#### 1. Apologies for Absence

Debbie Tarrant, Tim Wilkinson.

#### 2. Matters Arising

- **Future Chairmanship**

CL informed the group that from the 4 October Meeting Tim Wilkinson would be Chairing.

- **Prompt Card Scheme**

JD reported that he was expecting delivery of the cards in the week commencing 17 July and that they would be then be sent out to practices with a covering explanatory letter.

The Group agreed to review the scheme as and when PCT status was achieved.

JD

JD

#### 3. Trust Review Updates

- **Portsmouth Hospitals Trust**

- Activity targets currently being profiled by PCG and reporting should be available on the Extranet within a few months.
- Trust achieved overall waiting list target as at end of June but missed HA target by about 100 cases. Improvement due to list validation and sub-contracts with other providers
- Outpatient Improvement Plan progress report due shortly

No	Discussion	Action
----	------------	--------

- Direct Booking Project Plan signed up to by PCGs but with an understanding that pick up costs would be considered by PCGs not automatically assumed. Gynaecology and Urology would be the first specialties to pilot direct booking, in the first instance by consultants booking daycase procedures whilst patients are in outpatient appointments.

- **Portsmouth HealthCare Trust**

- Review meeting on Physical Disability and Palliative Care to take place on 19 July.

- **Others**

- AS reported that London provider service level agreements for 2000/01, managed by Portsea PCG on behalf of the District, were now all agreed.

#### 4. District Commissioning Group

- **Family History Breast Screening Service**

District position is that PHT should restart the.

AS to liaise with Liz Nails and with GPs over change in service.

AS

- **Morbid Obesity**

Batch of morbid obesity cases had been purchased to clear the list.

- **Bone anchored hearing aid service**

Noted as a specialist service and therefore commissioned by the HA.

#### 5. Commissioning Update

- **Portsea Back Pain Service**

Due to rising set up costs and perceived lack of back patients by primary care physiotherapy, it was looking more likely that patients would be seen by Dr Tanner at the Oving Clinic rather than setting up a clinic in Portsea.

AS to:

AS

- convene a meeting with Christine Heyward to run through options
- receive feedback and costs from John Tanner
- check SFIs re. tendering requirement

AS reported that Derek Pounder, Anaesthetist at the Trust, had contacted several Portsea GPs to express concern over the proposed scheme.



No	Discussion	Action
	<ul style="list-style-type: none"> <li>• <b>Dermatology</b> Project being led by Lin Kennet (PHT) and Mike Johns (EHPCG). Letter to be sent to GPs to establish interest in carrying out minor ops, although this will include reference to the LMCs non-support of the proposed fee.</li> <li>• <b>Glaucoma</b> AS meeting with Mike Jeffrey and Mark Esbester on 19/7 to finalise protocols and arrange optometrist training days.</li> <li>• <b>Low Vision Aids</b> Meeting being arranged to progress.</li> <li>• <b>OATs</b> Numbers for OATs for Plastic at Salisbury have increased which may lead to increased waiting lists and funding issues in the future. <span style="border: 1px solid black; border-radius: 50%; padding: 2px;">?</span></li> <li>• <b>CHD</b> Tim Wilkinson to give an update at Steering Group on 19/7.</li> <li>• <b>Intermediate Care Beds</b> Whole systems Group to consider Portsea bid for up to 15 beds on E2. (Post meeting note – bid approved - £568K revenue (on assumption of 11 beds) and for PCG to meet Capital costs).</li> </ul>	
6.	<p><b>Commissioning Performance Report</b></p> <ul style="list-style-type: none"> <li>• Comments on 1<sup>st</sup> Quarter Report received included: <ul style="list-style-type: none"> <li>- need more information on actions</li> <li>- report on cancer waits for treatment, after diagnosis</li> </ul> </li> <li>• Group agreed that next main Report would go to the November Board with an interim report going to the September Board Meeting, to include updates on: <ul style="list-style-type: none"> <li>- Intermediate Care Beds/Winter Pressures</li> <li>- Waiting lists (actual v. profile)</li> <li>- cancer waits for treatment, after diagnosis</li> <li>- Outpatient Plan - report against targets</li> <li>- Demand management Group Projects</li> </ul> </li> <li>• Additions to main report: <ul style="list-style-type: none"> <li>- Conversion ratios – unavailable routinely</li> <li>- ITU Bed Occupancy – OBD data available</li> <li>- Number of surgical cancellations due to lack of ITU beds</li> </ul> </li> </ul>	<p>TW</p> <p>JD</p>

No	Discussion	Action
	<ul style="list-style-type: none"> <li>- JD to follow-up with Sue D-K and Jane Lowe</li> <li>- Readmission rate – this is a High Level Performance Indicator (HLPI) with Portsmouth ranking 85 of 89 HAs – but skewed by LOS of 1<sup>st</sup> admission</li> <li>- JD working on cancellations and DNAs, by specialty</li> </ul>	<b>JD</b>
<b>7.</b>	<b>Date of Next Meeting</b>	
	4 October 2000 at 12.00 in F1 Meeting Room.	<b>ALL</b>

**Distribution:**

Those present and apologies  
 Maria Smith (for Board papers)

G:\Comm & Perf Sub Group\minutes 12 July 2000.doc

**Agenda Item No:****9.1****Finance Report for the Period ended 31 July 2000****Background and Summary:**

The attached report sets out the financial position of the Primary Care Group against its devolved budgets for the first four months of the new financial year (2000/2001).

The report covers all elements of the financial programmes of the PCG.

Budgets for the PCG are not yet complete and the PCG is awaiting notification from the Health Authority of its budgets for 2000/01 in several areas.

No prescribing information has yet been received for 2000/01.

The PCG is reporting an overall underspend of £31,000 (0%) at the end of July 2000.

**Recommendations:**

The Board are asked to :

- note the report
- approve the latest financial programmes as summarised in appendix 1.

**Date** 27 August 2000**Paper Prepared by :** Tracy Green, General Manager

## PORTSEA ISLAND PRIMARY CARE GROUP

### FINANCIAL POSITION AS AT 31 JULY 2000

#### 1 Overview

This report presents the performance of the PCG against its financial programmes for the period April to July 2000. This follows the approval of the initial financial programmes for the PCG by the PCG Board at its public meeting held in June.

The financial programmes for 2000/01 are still not complete and the PCG is awaiting notification from the Health Authority of its budgets for 2000/01 in several areas. These are highlighted below for each of the main programmes.

As at the 31 July 2000, the overall budgetary position is an underspend of £31,000 (0%) against the current devolved budget to the PCG. It remains too early in the financial year to draw any conclusions about a projected year end outturn on the basis of these figures.

Programme £000s	Annual Budget	Financial Position April – July 2000			
		Budget	Expenditure	Variance	Variance %
HCHS	126,467	41,844	41,845	(1)	0
GMS/Primary Care	2,843	846	849	(3)	0
Prescribing	13,652	4,372	4,372	0	0
Management	563	187	154	33	7
Other	124	27	25	2	0
Reserves	236	0	0	0	0
<b>TOTAL</b>	<b>143,885</b>	<b>47,276</b>	<b>47,245</b>	<b>31</b>	<b>0</b>

Note: ( ) Brackets indicate an overspend

Further analysis within programme heading is provided at appendix 1.

#### 2 Hospital and Community Health Services (HCHS)

A £1,000 overspend is reported against the Hospital and Community Health Services budget. This position includes some overspending and underspending areas.

The phasing of the budget for primary care projects do not reflect the expenditure incurred to date and therefore an overspend of £8,000 is shown against this programme area. The phasing of these budgets will be amended to greater reflect expected expenditure patterns for future reports.

The private provider budget is also showing an overspend. This reflects the overperformance of one of the service agreements with a private provider. This has been raised with the provider and corrective action requested to bring this service agreement in line with the available funding.

The ECR budget for referrals to private providers is showing an underspend of £9,000. However this is a volatile budget due to the unpredictable nature of activity charged against it.

The financial programmes for 2000/01 are still not complete. Outstanding adjustments are anticipated in respect of:

- Allocation of service level agreement budgets based on the PCG share of the 2000/01 agreements – the current devolved budget to the PCG reflects the district wide values for the six service agreements the PCG currently manages on behalf of the entire district (including Portsmouth Hospitals NHS Trust)
- Allocation of additional budgets in respect of the further devolution of commissioning from the Health Authority – most notably budgets for continuing care, joint finance and voluntary organisation payments
- Teenage Pregnancy funding from the NHSE for the City

It is hoped that these adjustments will be made in time for the August and September reports, although some of the adjustments are pending agreement with NHS providers.

The PCGs have agreed to work collaboratively in managing financial risks for this financial year in three areas within HCHS : waiting lists, service agreements and continuing care. The continuing care budget has historically been underfunded by the Health Authority, with overspends in previous years being covered by Health Authority general reserves and slippage from other programme areas. Discussions are currently taking place as to how this will be managed in 2000/01. Continuing Care will be an area of high financial risk for the PCG.

### **3 GMS and Primary Care Modernisation Funds**

The reported position as at the end of July is a £3,000 overspend (0%). The financial programmes reflect the first two phases of primary care investment for the financial year, with a third phase to be considered during September.

There remains an uncommitted financial reserve of £100,000 that will be reduced once the third phase of bids has been considered.

The DDRB funding received last year and not utilised has been carried forward to this financial year. Payments have now been arranged against the carry forward of £14,000.

The PCG is anticipating the receipt of its share of the 'Access and Enhanced Services in Primary Care' national funds. The agreed pace of change formula has been used for the allocation of 20% of this funding and the PCG is to receive the sum of £219,100.

The funding may be used for three purposes:

- Offer fast and convenient patient access to GPs and primary care professionals
- Extend the range of services provided in the primary care setting, addressing those where locally there are the longest waits
- Support the development of intermediate care

The PCG is currently considering the best uses of these funds in support of its business and primary care investment plans.

#### **4 Prescribing**

The delays in the receipt of prescribing information from the Prescription Pricing Agency (PPA) remain from last year and therefore no actual data has yet been received for the 2000/01 financial year. Therefore the finance report shows an assumed break-even position. However, as the PCG is only too aware, prescribing is an area of high financial risk for the PCG and therefore close monitoring will be required.

#### **5 Management Budget**

The management budget reflects the revised management team structure following the further devolution of commissioning. As there has been vacancies within this structure for the first four months of the financial year an underspend is reported of £33,000 (18%). The PCG is anticipating funding from the NHSE and the Health Authority for the development of the proposed Portsmouth City PCT.

#### **6 Other Programmes and Reserves**

This area relates to the funding programmed for clinical governance, prescribing support and the aHAZ project. An underspend of £2,000 (7%) is currently reported against these areas. Clinical governance expenditure is anticipated to be heavy in the last six months of the year to reflect the timing of the TARGET pilot.

The PCG's general reserve stands at £236,000 and will provide for future service and primary care developments, prescribing pressures and act as risk reserve for high risk areas such as prescribing and continuing care.

#### **7 Conclusion**

It is too early to make firm conclusions as to the likely financial position for the PCG for 2000/01 particularly in light of the absence of prescribing data and final HCHS budgets. However the overall financial position as reflected in this report is satisfactory as at 31 July 2000. The position will need to be carefully monitored and managed, but at this stage there does not appear to be any major areas of concern.

The PCG Board is asked to:

- Note the financial position
- Approve the latest financial programmes as summarised in Appendix 1

Tracy Green  
**General Manager**

27 August 2000

**PORTSEA ISLAND PRIMARY GROUP****FINANCIAL POSITION AS AT 31 JULY 2000**

<b>BUDGET HEADING</b>	<b>FINANCIAL PROGRAMME</b>	<b>YTD BUDGET</b>	<b>% OF BUDGET</b>	<b>YTD EXPENDITURE</b>	<b>YTD VARIANCE</b>	<b>% VARIANCE</b>	<b>FORECAST OUTTURN</b>
<b>£000's</b>	<b>£000's</b>	<b>£000's</b>	<b>%</b>	<b>£000's</b>	<b>£000's</b>	<b>%</b>	<b>£000's</b>
<b>HCHS</b>							
NHS Service Level Agreements	125270	41757	33	41757	0	0	0
Private Providers	63	21	33	23	-2	-10	0
ECR'S	52	17	33	8	9	53	0
Primary Care Projects	642	49	8	57	-8	-16	0
Coronary Heart Disease Project	440	0	0	0	0	0	0
<b>TOTAL HCHS</b>	<b>126467</b>	<b>41844</b>	<b>33</b>	<b>41845</b>	<b>-1</b>	<b>0</b>	<b>0</b>
<b>GMS &amp; PRIMARY CARE MODERNISATION FUND</b>							
Practice Staff	2374	782	33	784	-2	0	0
Premises Improvements	5	0	0	0	0	0	0
Premises - Cost Rents	145	48	33	48	0	0	0
Computing	191	16	8	17	-1	-6	0
DDRB	28	0	0	0	0	0	0
Reserves	100	0	0	0	0	0	0
<b>TOTAL GMS</b>	<b>2843</b>	<b>846</b>	<b>30</b>	<b>849</b>	<b>-3</b>	<b>0</b>	<b>0</b>
<b>PRESCRIBING</b>							
Practice Prescribing	13260	4372	33	4372	0	0	0
Contingency Reserves	392	0	0	0	0	0	0
<b>TOTAL PRESCRIBING</b>	<b>13652</b>	<b>4372</b>	<b>33</b>	<b>4372</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>MANAGEMENT BUDGETS</b>	<b>563</b>	<b>187</b>	<b>33</b>	<b>154</b>	<b>33</b>	<b>18</b>	<b>0</b>
<b>OTHER PROJECTS</b>							
Clinical Governance	73	3	4	2	1	33	0
Prescribing Support	40	13	33	11	2	15	0
aHaz Project	11	11	100	12	-1	-9	0
<b>TOTAL OTHER PROJECTS</b>	<b>124</b>	<b>27</b>	<b>22</b>	<b>25</b>	<b>2</b>	<b>7</b>	<b>0</b>
<b>RESERVES</b>	<b>236</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>GRAND TOTAL</b>	<b>143885</b>	<b>47276</b>	<b>33</b>	<b>47245</b>	<b>31</b>	<b>0</b>	<b>0</b>

**Agenda Item No:****No: 10.1****QUALITY & CLINICAL GOVERNANCE SUB GROUP****Background & Summary**

The committee for Quality & Clinical Governance Sub Group met on Wednesday 28 June 2000. A copy of the meeting notes are attached.

**Recommendations:**

The Board are asked to approve these minutes.

**Date: 12 September 2000****Paper Prepared by: Jim Hogan**



Portsmouth and South East Hampshire 

Health Authority

Finchdean House, Milton Road  
Portsmouth, PO3 6DP

**Portsea Island Primary Care Group**

---

**Quality and Clinical Governance Sub Group**

Notes of the Meeting held: 28 June 2000

---

<b>Present:</b>	Charles Lewis	Jean Hooper
	Pauline Robinson	Aileen MacNaughton
	Simon Harris	Mary Stratford
	Jim Hogan	Sue Damarell-Kewell
	John Thornton	Julie Cullen
	Anne White	Elizabeth Fellows
	Marie Potter	Lin Kneller

No	Discussion	Action
1.	<b>Apologies for Absence</b>  Sheila Clark Jo York Tim Wilkinson Kathy Primrose	
2.	<b>Minutes of the meeting held on 29 March 2000</b>  The minutes were agreed subject to the following alteration:  4.3. should read "a paper prepared by Julie Cullen was outlined....."	
3.	<b>Matter arising:</b>	
3.1	<b>Coding Project</b>  Jim Hogan gave an update on the progress on the coding/IT project. Anne Cuppage, the research consultant, was due to send the letters out to individual practices within the next week and the final report will follow on from that.	
3.2	<b>Target Update</b>  Jim outlined progress so far.	

In reply to a query from Jean Hooper, Jim stated that although it was hoped that eventually all practice staff would have the opportunity to join in, the situation on staff employed by the HealthCare Trust was still not clear and would have to be negotiated.

It was reported that news about the scheme was already being shared but a formal information campaign would begin shortly. Stuart Jamieson was keen for a slot on mental health but as the initial programme was already agreed this would be included at a later date.

Simon Harris was uncertain about the relationship with established postgraduate medical education and was concerned about overlaps and clashes. Anne White replied that all major events will continue to run and it was noted that there will need to be some consultation between the Deanery and the PCG to co-ordinate plans.

### **3.3 Practice Nurse Roadshow**

Julie Cullen gave an update on the success of the nursing roadshow and it was noted that another event was planned for 5 July. The uptake had been good and Julie was intending to copyright the learning development packs and publish as soon as possible.

JC

### **4. Clinical Governance Report**

Jim briefly reported on the presentation given to the clinical governance leads who had been impressed with progress to date and the proposed 'Target' development.

### **5. PDA Report (Pat Doorbar Associates)**

Mary Stratford introduced this item which was a report on a recent public survey. There were interesting findings, mainly concentrating on topics such as preference for particular doctors, waiting times, access, communications. The group were asked to look at the recommendations and comment as appropriate. It was agreed that this report could highlight issues suitable for input from Target.

All

### **6. Patients Charter Returns**

Sue Damarell-Kewell went through the latest figures. There was a lengthy discussion around cancelled out patient appointments and operations which should be re-scheduled to take place within the following four weeks but because appointments were booked so far ahead this was not happening. It was felt that this problem could be compounded by the use of the fast track

cancer forms. Sue will circulate copies of the full return with the meeting notes and will be happy to answer any queries.

SD-K

## 7. **Prompt Update**

Jeremy joined the meeting to share information about the relaunch of the Prompt scheme. The exact format of the card has still be decided but it will probably be A5 sized which will need to be folded and put in the internal post. The cards will shortly be printed and distributed and it was hoped that this scheme, once up and running, will provide a useful two way communication process between Primary Care and the Trusts.

JD

## 8. **Patients Conference**

Marie and Jean gave a report on progress so far. There will be two events, one on 1 November in the morning, at Portsmouth Football Club and the other an evening event at Portsmouth Girls School, date still to be arranged. The format agreed so far includes the use of themed tables to include diabetes, asthma, maternity services, amongst others. A social worker will be present and the services of facilitators will be obtained. It was envisaged that there will be group work discussion with feedback plus the opportunity and encouragement to make comments, suggestions and ask questions.

## 9. **Any other business**

**Caldicott** - There was a brief discussion on data protection. Jeremy informed the meeting that it is planned to offer training on Caldicott to appropriate people.

**Information Sharing Protocols** - Jeremy reported on current work that was taking place on developing these protocols. Jeremy also referred to an article about this in the latest edition of the Portsea Island newsletter.

**SIMPLE** - there was some discussion on the value of this data and the way in which it was presented, which does not always make it easy to follow.

## 10. **Date of Next Meeting**

Wednesday 4 October, 12.30 to 2 p.m., venue to be arranged.

**Agenda Item No:****No: 10.2****CLINICAL GOVERNANCE REPORT****Background & Summary**

The attached report details current progress in addressing the agreed Clinical Governance priorities for 2000/2001.

The priority areas are; TARGET, Diabetes, Information Sharing, Needs Assessment and Continuing Professional Development for Nurses.

**Recommendations:**

The Board is asked to note the report

**Date:**

31 August 2000

**Paper Prepared by:**

Jo York, Quality and Communications Manager

## **PORTSEA ISLAND PRIMARY CARE GROUP**

### **Clinical Governance Report**

#### **1.0 Introduction**

The following report provides details of progress to date on the PCG's Clinical Governance priority areas agreed for 2000/2001. These are TARGET, Diabetes, Information Sharing, Needs Assessment and Continuing Professional Development for Nurses.

#### **2.0 TARGET (Time for Audit, Review, Guidelines, Education and Training)**

The pilot project is well underway, Dr Jane Bell and Dr David Raw have been appointed as joint GP leads and Dr Ann White will be carrying out the evaluation of the pilot. There has been considerable interest from pharmaceutical companies to provide the funding required for each event, (£1500.00) which covers costs of venue and refreshments.

Dates and topics have now been selected for each of the five events. These are:

- 8 November – Coronary Heart disease
- 6 December – Asthma
- 24 January – Communication
- 28 February – PLPs / PDPs
- 28 March – Diabetes

Educational events will be held for all practice staff. Events on Coronary Heart Disease and Asthma will have separate sessions for admin and clerical staff. We are currently involved in discussions with practice managers to determine whether these will be individual events within practices or joint events for several practices. It is likely that there will be a combination of the two, to satisfy the requirements of all practices. The sessions on Communication and PLPs/PDPs will be joint sessions for all members of the practice. It is hoped that the Diabetes session will involve district and community nurses.

Newsletters have been sent to all practices, providing details of the events and the programme, and also to staff within the Trusts, Social Services and Portsmouth City Council, as well as CHC. A letter has been sent to consultants within both Trusts and initial responses have all been positive. Formal invitations will be sent to all practices towards the end of September.

An official press release is scheduled for 20 September and this will be followed by a public education campaign. Posters and leaflets will be available in a variety of places across the City, and extra provision has been made to inform vulnerable groups.

#### **3.0 Information Sharing**

##### **3.1 Clinical Coding**

Anne Cuppage has completed the work identifying existing practice information and data systems, incorporating read coding. A letter has been sent to each practice regarding their specific development needs. Generic requirements identified within the report are as follows:

- A modular education and training programme is required across the PCG for all GP systems
- Development of guidelines and clinical templates for core morbidities
- Need for additional support for clinical coding

#### *Education and Training*

The Quality and Communication Manager will liaise with the IM&T sub group and the Clinical Information Facilitator (due to start in October 2000) to co-ordinate the training programme. It is anticipated that the training will be a mixture of on and off site, perhaps in co-operation with Portsmouth Hospitals Trust.

#### *Guidelines and Templates*

It is anticipated that this will be tackled through the TARGET programme.

#### *Clinical Coding Support*

The PCG has accepted GMS bids for clinical coding support in practices. Where practices have stated that they required assistance in filling these posts, the PCG hopes to establish a pool of coders that can be used across practices.

Please see appendix one for a copy of the Executive Summary of the Clinical Coding Report.

### **3.2 *LEAP – Secondary Prevention of Coronary Heart Disease, Linking Evidence and Practice***

8 practices within the PCG have now completed the audit programme, The programme is ongoing in 15 practices, and 2 practices are yet to start the project. The Health Authority Clinical Governance Lead is compiling an aggregated report for the PCG.

## **4.0 Needs assessment**

There is concern that the PCG currently has no mechanism for ensuring that development money is allocated according to need, and that little evaluation work is completed to identify the quality and effectiveness of any changes made. A small working group will be established, made up of the PCG's new Public Health Consultant, Paul Edmondson-Jones, the Quality and Communications Manager and the Service Development Managers, to identify possibilities for resolving this issue. The Public Health Consultant will also be preparing a research paper, identifying needs indicators.

## **5.0 Diabetes**

The guidelines for the DRIVE project (Diabetes Risk factor Intervention to reduce Vascular Events) have been sent out, and an initial audit meeting was held at the beginning of September.

A nurse practitioner has recently been appointed to help introduce DRIVE into the practices and to set up a clinic for newly diagnosed type 2 patients. This will allow early targeting of patients, enabling them to gain early access to dieticians and podiatrists so helping them to manage the disease more effectively. Sue Craddock, Diabetes nurse specialist, is doing some work to revamp the Diabetes service on the Island.

## **6.0 Nursing Continuing Professional Development (CPD)**

The roadshows for distributing the CPD folders were extremely well received and an additional roadshow to those planned was also held. The practice nurse trainers are now offering surgery visits to those nurses who were unable to attend the roadshows to ensure all nurses receive the folder.

The CPD folder is designed as a working tool and will be evaluated in year. Updates will be included as and when necessary. A session has been included in the nurse induction programme to ensure all new nurses receive a copy.

Copyright has been applied for and it is hoped that the folder will be published.

## **7.0 Conclusions**

The Board is asked to note the progress made against this year's Clinical Governance priorities.

Jo York  
Quality and Communications manager  
29/08/00

G:\Q & CG\CG update to Board 2508.doc

**PORTSEA ISLAND PRIMARY CARE GROUP**

**CLINICAL CODING FOR DIABETES, MENTAL HEALTH  
ASTHMA, AND CORONARY HEART DISEASE**

**Executive Summary**

The move towards a primary care led NHS, the increasing role of GPs in health care commissioning and the ongoing development of primary care groups reinforce the need for general practices to obtain and interpret information.

The aim of the present study:

- To provide a PCG wide snap shot of the current stage of development of clinical coding specifically for ischaemic heart disease, asthma, mental health and diabetes.
- To support the clinical coding of historical data for diabetes and ischaemic heart disease and prospective coding for asthma and mental health.

A series of visits was undertaken to all practices:

- To assess progress with coding for historical data for ischaemic heart disease and diabetes
- To assess progress with coding for prospective data for mental health and asthma

All twenty five practices within the PCG were visited. General Practitioners were involved in twenty two of the visits. Attitudes were extremely positive and practices were very open about provision of information.

**Clinical Coding**

The average rate of direct entry at consultation is 20% with a range of 0 - 100%. The problems identified by GPs with direct entry at consultation were:

- pressure on clinical time
- lack of training
- new unfamiliar GP systems
- intrusion on doctor/patient relationship

**Clinical coding for core morbidities**

- **Asthma**

A number of practices have identified a need for PCG guidelines for the definition of asthma and COPD to improve the accuracy and reliability of reporting.



- **Ischaemic Heart Disease**

Practices have also identified a need for support to code electronically the LEAP data. The LEAP project is complete in eight practices, ongoing on fifteen practices and not yet started in two practices.

- **Mental Health**

The majority of practices agreed in principle to code the severely mentally ill patients. However, there are a number of issues relating to coding morbidities such as anxiety and depression which the PCG accepts needs a wider debate. A needs assessment may be needed in primary care to provide a short snapshot of the prevalence and management of the less severe end of the psychological morbidity which will give us data to inform service development.

- **Diabetes**

The clinical guidelines and standards for the management of diabetes which will address some of the issues raised were launched on 29 June.

## **Recommendations**

The following recommendations are proposed:

- Consider a single GP system for use across the district with standardised clinical templates (this however may not be a feasible option - therefore the following alternative recommendations are proposed:
- Support the development of clinical templates or protocols for all core morbidities specifically for asthma, diabetes, ischaemic heart disease and mental health.
- Establish a modular training programme across the PCG for all GP systems.
- Encourage all practices to establish standards for capturing data on core morbidities manually and inputting it subsequently where individual practitioners do not wish to participate in the collection of core data at consultation.
- Agree PCG guidelines for the definition of asthma to improve the accuracy and reliability of reporting.
- Acknowledge that mental health is a more difficult condition on which to record data than the other core morbidities and therefore needs a wider debate.
- Carry out regular audit of data quality within primary care. Unless data quality is audited regularly, problems with incompleteness and inconsistency of recording will continue.
- Support practices with bids for support with clinical coding.

Anne Cuppage  
Research Consultant

**Agenda Item No:****No: 10.3****COMMUNICATIONS AND PUBLIC INVOLVEMENT****Background & Summary**

The committee for Communications and Public Involvement Sub Group have not met since the last meeting therefore nothing new to report. A meeting will be scheduled for some time in October.

**Recommendations:**

The Board are asked to note this.

**Date: 04 September 2000****Paper Prepared by: Jo York**

**Agenda Item No:****No: 11.1****PRESCRIBING****Background & Summary**

The Prescribing Sub Group met on the following dates:

Thursday 8 June 2000  
Thursday 22 June 2000  
Thursday 29 June 2000  
Tuesday 2 August 2000

A copy of the meeting notes are attached.

**Recommendations:**

The Board are asked to approve these minutes.

**Date: 04 September 2000**

**Paper Prepared by: Kathryn Alder/Colin Olford**

# Portsmouth and South East Hampshire

Health Authority

Finchdean House, Milton Road  
Portsmouth, PO3 6DP

## Portsea Island Primary Care Group

### Prescribing Sub Group Meeting

Notes of the Meeting held: Thursday 8 June 2000

**Present:** Colin Olford (Chair) Tim Wilkinson John Thornton Kathryn Alder  
Helen Harris Elizabeth Fellow Simon Harris

No	Discussion	Action
1.	Apologies for Absence Liz Phillipou Vicki Turner	

#### Minutes of the last meeting

There were two amendments to the last minutes.

Page two bullet point reading, Review all patients with IHD, should have read Review **new** patients. Also item 5. Regarding the incentive scheme and John Thornton's suggestion of setting the same target for all practices that should be linked to the average PCG growth rate. This should have indicated a growth rate within a range.

#### Declaration of interests

There were no interests to declare within the group.

#### Matters arising

#### Summary of Letters (Budgets 2000/2001)

The group discussed about how to deal with disinvestment

- Keep and use
- Achieve a saving

---

All members then went on to discuss the letters sent in from GP practices regarding their bids. It was decided to agree some basic principles. Although initially the group thought LEAP should play a part in the bids, it was agreed LEAP should not be funded via the biddable pot. This at least in part should be found from the overall uplift and disinvestment. Any money remaining from the biddable pot would be used to help support the funding of lipid lowering drugs as appropriate. There was also some discussion as to whether the pot would be used to fund patients on one drug or a group of drugs. It was agreed that funding would be given where a practice had indicated a justified need unique to that practice. Funding would **not** be given for Leap or other prescribing issues common to all practices in the PCG.

Letters had been received from 12 practices and these were discussed in turn.

Two Practices: would be asked to do an audit on specific data in six months time and then funding may be allocated to these practices based on the results of these audits.

Two practices had both indicated a specific need for additional money for their diabetics. This was discussed and Kathryn agreed to investigate this further to feedback at the next meeting.

A total of £24,538 was allocated to the practices and a total of £92,161 would be held as a separate pot for part funding Lipid Lowering drugs. The actual amounts that would be made available to practices for Lipid Lowering drugs would be determined when all the practice baseline audits have been completed.

On discussion of the letters certain issues were raised regarding prescribing of specialist drugs. The practice had requested funding for a patient on a range of drugs including methadone. It was agreed that Kingsway House usually carried out methadone prescribing and that this avenue should be discussed with the practice. There was also some discussion over renal drugs EPO and mycophenolate. It was agreed to support funding for mycophenolate for this year and wait for the outcome of discussions with the Trust regarding EPO for next year.

The meeting closed at 3.05pm

**Date of the next meeting**

**Thursday 13 June 12.30 at Chichester Road Surgery**

Portsmouth and South East Hampshire 

Health Authority

Finchdean House, Milton Road  
Portsmouth, PO3 6DP

**Portsea Island Primary Care Group**

**PCG Prescribing Sub-Group**

Notes of the Meeting held: **Thursday 22 June 2000 12.30pm Chichester Road Surgery**

**Present:** Colin Olford Kathryn Alder Elizabeth Fellows Helen Harris Simon Harris  
John Thornton Tim Wilkinson

No	Discussion	Action
	<b>Apologies for absence</b>	
1.	Liz Phillipou Vicky Turner	
2.	<b>Declaration of interests</b>	
	There were no interests to declare	
3.	<b>Minutes of the last meeting</b>	
	The minutes of the last meeting were agreed as a correct record	
4.	<b>Matters arising</b>	
	<b>Incentive Scheme 2000/2001</b>	
	Kathryn tabled the Age Sex bands for GP practices within Portsmouth and Southeast Hampshire Health Authority and looked at Diabetic prescribing.	
	Tim pointed out that the practice was prescribing for All Saints Hostel. The group agreed it would be useful if they could ask the practice how All Saints Hostel has affected their prescribing. Kathryn agreed to look into the matter.	

---

### **Practice Bids**

All the members of the group agreed the practice bids as discussed at the last meeting.

The practice would be asked for feed back on COPD Audit

### **6. Quality Targets**

The group discussed quality targets all agreed that they should be linked with disinvestments and Clinical Governance. The group agreed to look into setting individual targets for NSAIDs for all within the PCG.

#### **Disinvestment Targets**

The group discussed what savings would be made in making drug changes. The following targets were discussed:

- Ulcer Healing drugs (Review all high dose patients on PPIs, setting a target for individual practices).
- ACES
- Bisoprolol
- NSAIDs

For Ulcer healing the group discussed:

- a) Set PCG wide target
- b) The choice of PPI (Kathryn agreed to consult Katie Hovenden on this matter ) KA
- c) Omeprazole 20mg switch to low dose PPI
- c) % reduction in dose 80/20

#### **Leap, Diabetes**

The group agreed that they should form part of the incentive scheme

#### **Nursing Homes and Residential Homes**

The group agreed that this would not be part of the incentive scheme. A letter would be sent to out to all practices with the READ codes for nursing and residential homes, explaining it would be in their best interests to use the codes as they provide vital data for next year's prescribing budgets.

#### **Post meeting note.**

##### **Hepatitis B Vaccine.**

Colin bought up the subject of Hep B and the expenditure of the PCG being £30,000. It was felt that a large part of this would be down to inappropriate use.

---

---

Kathryn agreed to look into the matter and investigate as a Possible Quality Target.

KA

**Meeting closed 2.00pm**

**Date of the next meeting to be arranged**

---



# Portsmouth and South East Hampshire

Health Authority

Finchdean House, Milton Road  
Portsmouth, PO3 6DP

## Portsea Island Primary Care Group

### Prescribing Sub-Group Meeting

Notes of the Meeting held: Thursday 29 June Chichester Road Surgery

**Present:** Colin Olford (Chair) Kathryn Alder John Thornton  
Simon Harris Elizabeth Fellows Helen Harris

No	Discussion	Action
1.	<b>Apologies for Absence</b> Tim Wilkinson	

#### Declaration of interests

The group had no interests to declare.

#### Hepatitis B

The group discussed the need for a policy to be developed for the Hepatitis B vaccinations. The LMC have reproduced an information sheet from West Sussex, which had been sent out to all practices in the latest Health Authority PIGLET. The group felt that the following areas needed further investigation and clarification:

- reasons why the patient was vaccinated, as there appeared to be a lot of inappropriate use
- whether a script was given or not
- charging for vaccinations

(Some of these issues would possibly be addressed by the Hepatitis B quality target)

#### Incentive Scheme 2000/2001

#### Quality Targets

Kathryn tabled the Quality Targets for the group. The group then discussed their individual choices for quality targets.

---

## Leap

After much discussion it was agreed that practices would be asked to do the following :

- a) Ensure that they have an up-to-date chronic disease management register for all patients with IHD. These should be READ coded on the computer using the code G3 (or G4 for practices with 4 –byte codes).
- b) From the Practice Leap Report and action plan, identify and review the following groups of patients:
  - All IHD patients requiring a baseline cholesterol level measurement
  - Patients with a total cholesterol of 5.01 or above who may benefit from Lipid Lowering therapy
  - Patients who may benefit from receiving anti-platelet therapy

## Diabetics Audit

Practices to complete Level 1 and 2 of the LDSAG form for a proportion of their diabetics.

The group then concluded that practices would be asked to achieve four out of five quality targets - three **compulsory targets**:

- Leap Project
- Diabetes Audit
- Ulcer Healing Drugs

Plus **one** other from:

- Hepatitis B audit
- ACE inhibitors

Simon suggested that practices could be given a choice and asked to decide their own quality targets. It was felt that for this year it was possibly too late to do this but this idea could be investigated for next year's scheme.

## Weightings of quality targets

The group then discussed the % weightings for quality targets. It was agreed that diabetes and Leap should have larger % weightings. There was mixed opinion as to whether practices should be allowed to keep any, or a proportion of their savings if they did not hit any of their quality targets. It was agreed that :

- quality targets would be linked to practices managing their growth
- practices would not be allowed to keep any of their savings if they did not hit any quality targets.

- 
- The % weightings for the quality targets would be :

40% Leap

40% Diabetics

10% Ulcer healing

10% Hepatitis B or ACES

In the situation where a practice managed its growth but overspent, the maximum payment would be £1,00 per partner for achieving all four quality targets and the % weightings for quality targets not achieved would be the same as above.

### **AOB**

John explained the situation with practice

CO,KA

It was agreed to write back to the practice agreeing to a meeting at the PCG offices on either the 1st or 3<sup>rd</sup> August

The meeting closed at 2.10pm

Portsmouth and South East Hampshire 

Health Authority

Finchdean House, Milton Road  
Portsmouth, PO3 6DP

**Portsea Island Primary Care Group**

**Prescribing Sub-Group Meeting**

**Notes of the Meeting held: Tuesday 1<sup>st</sup> August Chichester Road Surgery**

**Present:** Colin Olford (Chair) Kathryn Alder John Thornton Liz Phillipou  
Elizabeth Fellows Tim Wilkinson

No	Discussion	Action
1.	<b>Apologies for Absence</b>  Simon Harris Helen Harris	
2.	<b>Declaration of interests</b>  The group had no interests to declare	
	<b>Correction of minutes of 29<sup>th</sup> June meeting</b>	
	Patients with a total cholesterol of 5.01 or above should read above 5.00	
3.	<b>Incentive Scheme 2000/2001</b>  Kathryn updated the group - 4 practices have returned their replies, but the deadline is 7 <sup>th</sup> August. Practices, who have not returned their replies after this date, will be chased up by phone.	HH
4.	<b>Prescribing Day</b>  The group discussed the plan for the prescribing day. It was agreed that it should be a half-day supported by PGEA. The aim would to invite people for lunch at 12.30pm, start at 1.00pm and aim to finish around 3.30pm-4.00pm. A date was provisionally booked for Tuesday 17 <sup>th</sup> October. Kathryn agreed to confirm with Jim when the Target sessions were being held in November and enquire about the availability of the Professional Centre at Cosham as a suitable venue. All Portsea Island GPs would be invited. In addition the Cosham practices, prescribing support pharmacists and Katie Hovenden would be invited. The objectives of the day were agreed as:	KA

- 
- Sharing prescribing ideas and information
  - Promotion of good quality, cost effective prescribing

There was some discussion around the content of the day. It was agreed that after the welcome and introduction, there should be some sort of PCG update on end of year performance and incentive scheme outcomes. The group then discussed John's idea of using Dr Bernie Shevlin as an outside speaker to talk about the variations in prescribing costs and growth and the possible links to GP behaviour. The group then discussed the need for the speaker's talk to tie in with the rest of the day. It was suggested that the two BMJ articles by Avery on prescribing costs should form the basis and that the contents of the speaker's talk would be to be confirmed prior to the day. John confirmed that he was a very entertaining speaker and would most likely help with the group work. Kathryn agreed to contact him and to confirm with Sheila funding for the day. The group then discussed the idea of inviting community pharmacists in Portsea Island. It was agreed that Liz would feed this back to the LPC. The group work was then discussed. Eventually it was decided to focus it around the incentive scheme quality targets:

KA

- Lipid Lowering Drugs
- ACES
- Ulcer Healing drugs
- Hepatitis B
- and also Antibiotics

EP

It was suggested that the groups would be given graphs indicating costs and volume for the therapeutic areas, with some background information, some questions to get the groups taking about the possible range in costs for each group and some ideas for changing drugs, reducing costs and improving quality. Each member of the subgroup agreed to look at a therapeutic area and develop some questions for the groupwork. There was some debate as to who would facilitate the groups and it was agreed to use a mixture of GPs and pharmacists. Other questions about the group work included:

ALL

- whether information should be anonymised or not as the majority of practices had agreed.
- how big the groups should be and whether individuals should remain in their constituency groups or not

It was agreed these points would be clarified nearer the time when the total numbers are known. The meeting closed at 2.20pm.

**A date was set for the next meeting on Tuesday 3<sup>rd</sup> October**

**Agenda Item No:**

**PART I : 11.2**

**PORTSEA ISLAND PCG - Practice Prescribing Incentive Scheme  
2000/2001**

**Background and Summary:**

The attached document contains information regarding the:

- principles
- financial framework
- quality targets

for the Practice Prescribing Incentive Scheme for 2000/2001.

The principles of the scheme are based on the guidance indicated in HSC1998/228.

The maximum total payment made to any practice will be £45,000 to invest in their GP service as indicated in Paragraph 85 i.e. practices will be entitled to the first £10,000 of their savings and the remainder up to a maximum of £70,000, will be split 50/50 between the practice and the PCG. Incentive payments will be linked to four quality targets. The total incentive payment will be dependent on the number of quality targets achieved by each practice. Practices that fail to hit any quality targets will not be entitled to any incentive payment. The full details are indicated in the attached paper.

Practices will be asked to achieve **four** out of five quality targets. These are **three** compulsory targets:

- Leap Project
- Diabetes Audit
- Ulcer Healing Drugs

Plus **one** other from:

- Hepatitis B audit
- ACE inhibitors

**Recommendations:** The PCG Board are asked to note this.

**Date: 8 August 2000**

**Paper prepared by: Kathryn Alder**

## Northsea Island PCG Prescribing Incentive Scheme 2000/2001

### 1 Principles of Incentive Scheme 2000/2001

The principles of the scheme are based on the guidance indicated in HSC1998/228.

The maximum total payment made to any practice will be £45,000 to invest in their GP services as indicated in Paragraph 85 i.e. practices will be entitled to the first £10,000 of their savings and the remainder up to a maximum of £70,000, will be split 50/50 between the practice and the PCG.

### 2 Quality Targets

Incentive payments will be linked to **four** quality targets. Practices will be asked to achieve **four** out of five quality targets. Further information about the quality targets is detailed in appendix A.

These are **three** compulsory targets:

- Leap Project
- Diabetes Audit
- Ulcer Healing Drugs

Plus **one** other from:

- Hepatitis B audit
- ACE inhibitors

### 3 Financial framework for Incentive Scheme 2000/2001

#### Practices that come within budget at the end of the year

a) Practices that come within budget **and achieve all four quality targets** will be entitled to maximum payment as indicated in Paragraph 85.

b) Practices that come within budget and achieve one or more of the quality targets will be entitled to a percentage of their maximum payment dependant on the number of quality targets achieved. Payments will be reduced by % weighting for each quality target not achieved. In recognition that the Leap and Diabetes targets involve a greater amount of work for the practice, there will be different % weightings for the quality targets. Leap and Diabetes will each have a 40% weighting and Ulcer Healing drugs, Hepatitis B and ACEs will each have a 10% weighting. However, in the situation where the payment under Paragraph 85 would be a small amount i.e. less than £1,000 per partner, practices will be entitled to £800 (£400 per target) per partner for Leap and Diabetes and £200 (£100 per target) for Ulcer Healing drugs and ACEs or Hepatitis B. Hence the minimum payment for achieving all four quality targets and coming within budget will be £1,000 per partner.

#### Worked example 1

4 partner practice underspends at end of year by £14,000

i) Hits all four quality targets

Payment to practice under Paragraph 85, £10,000 + £2,000 =£12,000

ii) Achieves Leap and Diabetes - 2 out of 4 quality targets

Payment to practice = £9,600 (20% reduction)

**Worked example 2**

4 partner practice underspends at end of year by £1,000

i) Hits all four quality targets

Payment to practice =£1,000 per partner or £4,000 in total.

ii) Achieves Diabetes and one other (not Leap) - 2 out of 4 quality targets (50% reduction)

Payment to practice =£500 per partner of £2,000 in total.

c) Practices that come within budget and **do not** achieve any quality targets will **not** be entitled to any incentive payment.

**Practices that fail to come within budget at the end of the year**

a) Practices that are unable to contain their prescribing costs within budget, but improve their budgetary performance by an agreed amount, will be entitled to an incentive payment if they achieve one or more of the quality targets. An improvement in budgetary performance will be measured by a reduction in true growth rate of prescribing costs and by reviewing the practice's end of year position and their growth rate at March 2001.

In this case practices would be entitled to a payment of £800 (£400 per target) per partner for Leap and Diabetes and £200 (£100 per target) for Ulcer Healing drugs and ACEs or Hepatitis B.

**Worked example 3**

3 partner practice exceeds indicative budget by £6,000, but has reduced true growth in prescribing costs from 8% per annum to 4% per annum.

Achieves 3 out of 4 - Diabetes, Leap and Ulcer Healing drugs

Payment to practice = £900 per partner or £2,700 in total.

b) Practices that fail to come within budget and do not improve their budgetary performance by managing their growth will **not** be entitled to **any** incentive payment, even if one or more of the quality targets were achieved.

**4 Financial Implications**

The PCG has set practice budgets, conscious of the potential significant financial implications of this year's incentive scheme and kept a reserve of £300,000 to offset this risk. If potential payments exceed funds available to the PCG, the deficit will need to be met from a top-slice of next year's allocation. Practices will also have the option after the results of the 2000/2001 incentive scheme have been finalised to decline to receive all or part of their incentive payments.



## Appendix A-Quality Targets

Practices will have to achieve **four** out of five quality targets. The **three** compulsory targets are Leap, Diabetes and Ulcer Healing drugs.

### 1. Follow up of baseline audit of LEAP, Secondary Prevention of CHD Project

As part of the 1999/2000 incentive scheme practices were asked to establish a disease register and agree to participate in the baseline audit either with the help of clinical audit staff or independently as a practice. Some practices are still undergoing this process, but it is anticipated that all baseline audits should be completed by the end of September 2000.

Practices will receive feedback from the audit in two ways:

- A Practice Report
- Practice meeting with one of the Health Authority's Clinical Effectiveness staff to discuss the report and develop an action plan for the practice.

For the 2000/20001 incentive scheme, practices will have to complete the following:

- a) Ensure that they have an up-to-date chronic disease management register for all patients with IHD. These should be READ coded on the computer using the code G3 (or G4 for practices with 4 -byte codes).
- b) From the Practice Leap Report and action plan, identify and review the following groups of patients:
  - All IHD patients requiring a baseline cholesterol level measurement
  - Patients with a total cholesterol of 5.01 or above who may benefit from Lipid Lowering therapy
  - Patients who may benefit from receiving anti-platelet therapy

Individual practice information for the above groups of patients is available from the Clinical Effectiveness Team at the Health Authority. Practices who require this information should contact Kathryn at the PCG offices.

**To qualify for payment, practices will have to complete a practice action plan for implementation of Leap using the attached form. A copy of the form is attached with your practice targets. The action plan involves writing a brief summary on how the practice plans to implement the findings of Leap. Practices will also have to provide information by carrying out searches on the computer during January 2001- March 2001 to identify numbers of the following groups of patients:**

- **Total no of IHD patients produced by searching on the computer using G3 (or G4) READ code**
- **Total no. of IHD patients on aspirin**
- **Total no. of IHD patients on Lipid Lowering drugs**

**All the required information should be completed on the enclosed Leap Action Plan and returned to Kathryn at the PCG offices by March 31<sup>st</sup> 2001.**

Many practices are concerned about the cost implications of implementing Leap and the impact of this on their prescribing budget. As a result of this a contingency of approx. £90,000 has been set aside to help support the funding of Lipid Lowering therapy and additional money may also be available from the HAZ CHD bid. Therefore it is likely that practices will receive further additional funding for Leap, after the completion of the baseline audit in all PCG practices by the end of September 2000. This year's incentive scheme also targets some key areas where practices can make savings, which in turn could be used to help implement Leap.

## **2. Diabetes audit**

The new diabetic "DRIVE" guidelines and standards were launched at the end of June. All practices should have received copies of these. For the incentive scheme practices will be asked to participate in the baseline diabetes audit using the Local Diabetes Services Advisory Group (LDSAG) form. The Clinical Effectiveness team will shortly be sending out sufficient numbers of forms to all practices. The form consists of three audit levels. Practices will be asked to complete at least levels 1 and 2 of the audit for at least 60% of their diabetics between July 2000 and 31st March 2001. The forms can be filled out as part of the annual diabetic reviews carried out by practices. Level 3 can also be completed by practices if they feel this is part of the review process. Practices will be required, as part of the Drive project to complete all 3 levels by March 2002 for **all** their diabetics and this is likely to form part of the incentive scheme for next year. (This year we are asking for at least 60% as some diabetics may have already been seen prior to the launch of the standards).

**In order to qualify for payment practices will have to complete a minimum of levels 1 and 2 of the LDSAG audit for at least 60% of their registered diabetics between July 2000 and 31<sup>st</sup> March 2001.**

## **3. Ulcer Healing Drugs**

Ulcer Healing drugs were part of 98/99 incentive scheme and linked in with ACID-P audit launched in October 1997. Spend on Ulcer Healing drugs has increased by £28,355 compared to last year. This is largely due to the increase of PPIs, in particular omeprazole 20mg. These drugs are being reviewed as part of the District formulary and we have now received guidance by NICE. PPIs also form part of the Health Authority and PCG disinvestment plan. The approx. annual savings to the PCG by just reviewing PPIs are in excess of £160,00. Savings by reducing costs in Ulcer Healing drugs could then be used to help fund other key therapeutic areas e.g. initiating Lipid Lowering therapy.

**To qualify for an incentive payment practices will have to achieve a target aimed at reducing their current spend on Ulcer Healing drugs.**

Practices can help reduce costs on ulcer healing drugs by:

- a) Reviewing all patients on long term ulcer healing drugs
  - have all patients had a confirmed diagnosis?
  - can drug treatment be stopped or dose reduced
  - can any be given H Pylori eradication

- b) In particular reviewing all patients on long term high dose PPIs, can any be:
- stepped down to maintenance dose
  - given pulsating doses (5 out of 7 days)
  - switched to a more cost effective PPI

Ranitidine is currently the most cost effective H2 antagonist and the price is likely to fall further over the coming year. Lansoprazole 15mg and rabeprazole 10mg are the cheapest PPIs at £12.98. Current prices of all Ulcer Healing drugs are shown in the enclosed bar charts. Please note prices are subject to change over the coming year.

**4. Practices will also have to achieve one other quality target:**

**EITHER** ACE Inhibitors

**OR** Hepatitis B audit

**a) ACE Inhibitors**

Last year ACEs were reviewed as part of the District formulary. Formulary recommendations were Ramipril and Quinapril (most cost effective once a day preparations), Enalapril (patent expired in 2000 and decrease in price) and Captopril. Current expenditure on non-formulary ACEs for the PCG is approx. £167,334. This is approx. 24% of the total current expenditure for ACEs. The leading cost non-formulary ACEs are Lisinopril, Fosinopril and Perindopril. Estimated annual savings for the PCG by changing 50% of patients on non-formulary ACEs to formulary ACEs is approx. £30,931.

**To qualify for payment practices will have to achieve a % target aimed at increasing their current spend of formulary ACEs.**

Practices could increase current expenditure of formulary ACEs by:

- Reviewing existing patients on non-formulary ACEs and where appropriate switching to a formulary ACEs
- Ensuring all new patients requiring an ACE are put onto a formulary ACEs.

Current prices for all ACEs are shown in the enclosed bar charts. Please note prices are subject to change, price of enalapril may continue to fall over the coming year.

**b) Hepatitis B vaccination**

This was featured in the latest PIGLET. Current annual PCG expenditure for Hepatitis B is approx. £33,126. Requests for Hepatitis B appear to be on the increase and whilst some of these are justified some appear to be for use in non-risk groups. The PCG would like to investigate this further by carrying out a baseline audit on current use of Hepatitis B.

The main risk groups are identified in the “green book”- “Immunisation against Infection” and the BNF. They include:

- health care workers who have direct contact with patients' blood or blood stained body fluids or patients' tissues
- staff and residents of residential accommodation for those with severe learning disabilities
- occupational risk groups e.g. morticians, embalmers
- prison service staff and inmates
- long term travellers to areas of high prevalence of Hepatitis B
- babies born to mothers who are chronic carriers of Hepatitis B ,or to mothers who have had acute Hepatitis B during pregnancy
- patients with chronic renal failure
- haemophiliacs
- parenteral drug misusers
- close family contacts of a case or carrier
- individuals who change sexual partners frequently
- families adopting children from countries with a high prevalence of Hepatitis B

Immunisation may also be considered appropriate for members of the police, ambulance, fire and rescue occupation, although, the incidence of infection is not apparently greater in these groups compared to the general population.

**In order to qualify for payment practices will have to complete a data collection form on patients given Hepatitis B vaccination for a six month period from 1st October 2000 until 31st March 2001 indicating the reason why the vaccine was given and whether a prescription was written. All forms should be returned to Kathryn at the PCG offices by 20th June 2001.**

A copy of the form is detailed in attached with the practice targets.

## Appendix B- Leap Action Plan

**PORTSEA ISLAND PCG PRESCRIBING INCENTIVE  
SCHEME 2000/2001  
LEAP ACTION PLAN**

To qualify for payment, practices will have to complete this action plan and carry out searches on the computer during January 2001- March 2001 to identify numbers of the following groups of patients:

- Total no. of IHD patients produced by searching on the computer using G3 (or G4) READ code
- Total no. of IHD patients on aspirin
- Total no. of IHD patients on Lipid Lowering drugs

All the required information should be completed on the attached Leap Action Plan and returned to Kathryn at the PCG offices by March 31<sup>st</sup> 2001.

Date:

Practice Name:

**a) Baseline audit information**

Please complete the following table:

Date		Total no
	Total no of IHD patients ( from baseline audit)	
	Total no of IHD patients requiring baseline cholesterol measurement	
	Total no of IHD patients with a total cholesterol of 5.01 or above who may benefit from Lipid Lowering Therapy	
	Total no of IHD patients who may benefit from taking anti-platelet therapy	

This information will be available from your practice Leap Report. All practices should receive copies of their report by October 2000. Further information is also available from the Clinical Effectiveness Team at the Health Authority, please contact Kathryn at the PCG offices for further details.

**b) Implementation of findings of Leap Report**

Practice to write a brief summary on how they plan to implement the findings of the Leap Report and in particular identify and review the three groups of patients:

- All IHD patients requiring a baseline cholesterol level measurement
- Patients with a total cholesterol of 5.01 or above who may benefit from Lipid Lowering therapy
- Patients who may benefit from receiving anti-platelet therapy

The brief report should include details of:

**WHO**

Who was involved in carrying out the implementation

- GPs
- Practice nurses
- Practice Manager
- Practice Staff
- Clinical Effectiveness audit staff

**HOW**

- a) How the process for review was agreed by the practice
  - Practice meeting
  - Meeting with Clinical Effectiveness Team
- b) The method agreed by the practice for identifying and reviewing patients:
  - CHD Clinics
  - Medication review
  - Recall system
  - Letters to patients
  - Using computer screen message and / or messages in notes to highlight patients
- c) The method agreed for data input
  - READ coding of all IHD patients
- d) Prescribing policy
  - Choice of statins
  - Patients over 75

**WHEN**

The practice's timescale for implementation

## PRACTICE ACTION PLAN

### c) Follow up of baseline audit

Practices as a result of implementation should be able to provide up to date data on their IHD patients. We would be grateful if you could complete the following searches on your practice computer during January 2001 – March 2001 to provide information on the numbers of patients in the following table:

Date of search	Search Type	Total no of patients
	Total no of IHD patients produced by searching on the computer using G3 (or G4) READ code	
	Total no. of IHD patients on aspirin	
	Total no. of IHD patients on Lipid Lowering drugs	

**Please complete the Leap Action Plan and returned to Kathryn at the PCG offices by March 31<sup>st</sup> 2001.**

**Appendix C- Hepatitis B Audit form****PORTSEA ISLAND PCG PRESCRIBING INCENTIVE  
SCHEME 2000/2001  
HEPATITIS B AUDIT****Background and Information**

This was featured in the latest PIGLET (copy attached). Current annual PCG expenditure for Hepatitis B is approx. £33,126. Requests for Hepatitis B appear to be on the increase and whilst some of these are justified some appear to be for use in non-risk groups. The PCG would like to investigate this further by carrying out a baseline audit on current use of Hepatitis B.

The main risk groups are identified in the "green book"- "Immunisation against Infection" and the BNF. They include:

- health care workers who have direct contact with patients' blood or blood stained body fluids or patients' tissues
- staff and residents of residential accommodation for those with severe learning disabilities
- occupational risk groups e.g. morticians, embalmers
- prison service staff and inmates
- long term travellers to areas of high prevalence of Hepatitis B
- babies born to mothers who are chronic carriers of Hepatitis B ,or to mothers who have had acute Hepatitis B during pregnancy
- patients with chronic renal failure
- haemophiliacs
- parenteral drug misusers
- close family contacts of a case or carrier
- individuals who change sexual partners frequently
- families adopting children from countries with a high prevalence of Hepatitis B

Immunisation may also be considered appropriate for members of the police, ambulance, fire and rescue occupation, although, the incidence of infection is not apparently greater in these groups compared to the general population.

**In order to qualify for payment practices will have to complete the attached data collection form on patients given Hepatitis B vaccination for a six month period from 1st October 2000 until 31st March 2001 indicating the reason why the vaccine was given and whether a prescription was written. All forms should be returned to Kathryn at the PCG offices by 20th June 2001.**

Practice Name:



**PORTSEA ISLAND PCG HEPATITS B AUDIT COLLECTION FORM**

**PRACTICE NAME:**

Date	Patient ID no or initials	Vaccine given e.g. Hepatitis B, Hepatitis B booster, Twinrix ( Hep A and B), Twinrix ( Hep A and B)booster	Reason for vaccination: <ul style="list-style-type: none"> <li>• health care workers</li> <li>• staff and residents of residential accommodation for those with severe learning disabilities</li> <li>• occupational risk groups e.g. morticians, embalmers,</li> <li>• prison service staff and inmates</li> <li>• long term travellers</li> <li>• babies born to mothers who are chronic carriers of Hepatitis B ,or to mothers who have had acute Hepatitis B during pregnancy</li> <li>• patients with chronic renal failure</li> <li>• haemophiliacs</li> <li>• parenteral drug misusers</li> <li>• close family contacts of a case or carrier</li> <li>• individuals who change sexual partners frequently</li> <li>• families adopting children from countries with a high prevalence of Hepatitis B</li> <li>• Other (please specify)</li> </ul>	Prescription issued yes/ no (Y/N)
e.g. 1.11.00	23	Hep B	Prison service staff	N

**Agenda Item No:**

**PART I : 11.3**

**PORTSEA ISLAND PCG – INITIAL ANALYSIS OF END OF  
YEAR PRESCRIBING FIGURES AND INCENTIVE  
SCHEME**

**Background and Summary:**

From the March PPA Prescribing figures, Portsea Island PCG is predicted to overspend by £519,510.

This figure needs to be adjusted for any changes in list sizes and expensive drugs, contingency reserves and additional generic funding, to give the final end of year outturn. The PCG Prescribing Advisor is currently working on these adjustments and practices should receive notification of their final outturns and the results of their performance in the 1999/2000 Incentive Scheme by the end of September 2000.

The overspend, (taking into account for additional generics money and contingencies) is £41,897.

Total incentive payments to practices are £140,157.

13 practices will receive incentive payments.

11 practices hit all 4 quality targets

4 practices achieved their budget and all 4 quality targets.

**Recommendations:**

The PCG Board is asked to note this report.

**Date: 18 August 2000**

**Paper prepared by: Kathryn Alder**