PORTSMOUTH & SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PCG Leads meeting

Notes of the meeting held on 8 September 2000

Present:	Dr J Hughes	Ms S Damerell-Kewell
	Dr J Barton	Dr G Sommerville
	Mr J Kirtley	Dr G De-Feu
	Dr A Patterson	Dr D Lynch
	Dr J Grocock	Dr T Wilkinson
	Dr C Lewis	Mrs S Robson
	Mrs S Clark	Mr D Crawley
	Dr J Harrison	Dr A Douglas
Apologies for absence:	Dr M Johns	Dr J Hogan

No.	Discussion	Action
1.	**Minutes of the previous meeting**	
	The minutes of the meeting held on 14 July were agreed.	
	Matters Arising	
	Community Dentistry – Mrs Robson had received a response from Alan Jones. He had confirmed that the criteria for referral to the service had not changed for some time. She would ask Dr Jorge for the details and circulate them.	**SR**
	Cellulitis – In Dr John's absence, to be carried forward to the next meeting	
2.	**Coronary Heart Disease NSF**	
	Dr Hughes thanked Clinical Governance and NSF lead clinicians for attending the meeting.	
	He noted that a local cardiac network was now set up with sub-groups working to deliver specific aspects of the framework. Each of the standards had a district-wide lead. It was clear the NSF not only required good clinical medicine but also required clinicians to prove they were practising appropriately.	
	He reported successful bids for central cash for:	
	• Rapid access chest pain clinic (increase to a 5 day a week service) • Thrombolysis in A&E to be piloted at QAH	
2.1	**READ Codes**	
	It was agreed sensible to await national directions before making contact with all practices to ensure they were coding data correctly.	**JH**
	It was unlikely that the national guidance would vary significantly from LEAP. Mr Crawley reported that PVD was a sub-set in the register on the IOW.	
	It was agreed that G2 rather than G20 would be used.	**JH**

It was confirmed that old coding does need to be re-READ coded but that work was being undertaken to provide an electronic fix through MIQUEST.

2.2 Possible use of Biochemistry

It was noted that the biochemistry computer systems were being used elsewhere in the country to trigger access to preventative and treatment services. E.g. raised cardiac enzymes automatically triggers a letter to the patient's GP and cardiac nurse to ensure the patient is identified for cardiac rehabilitation.

Dr Hughes was exploring the possibility of an automatic annual recall system being set up. He would keep those present up to date with progress. **JH**

2.3 Clinical Audit arrangements

F&G – developing standard audits for all practices to roll out. Funds are being made available to each practice for data collection. Practices are being offered facilitators for their audit meetings.
IOW - have invested in data entry and audit staff in practices. They are matching secondary care data with practice data to target appropriate patients. A questionnaire has been sent to each practice to identify what they are doing so that gaps can be identified.
Portsea – All practices being offered protected time for education with CHD being the first topic discussed (November). Practices are being assisted to set up registers and coders and data entry has been a priority for GMS investment.
EH – Audit of practice data about to be undertaken. Clinical Audit is one of the quality criteria set out in this year's prescribing incentive scheme.

2.4 CHD Registers

The difficulties and shortcomings of non-computerised records were discussed. It was agreed that only computerised registers would be acceptable. PCGs would formulate their reimbursement policies to ensure that only computerised registers were supported with staff time. **All PCGs**

2.5 Patient Held Records

It was noted that local experience of patient held records was not positive. It was agreed patients should be provided with information which made clear the services and standards of care which they should expect.

It was felt to be important for GPs to have access to blood tests arranged by secondary care clinicians. John Hughes agreed to pursue this with PHT. This was agreed to be a higher priority than biochemistry initiative discussed previously. **JH**

2.6 Joint British Society guidelines

It was agreed that these should be shared with practice. Individual judgement would still be necessary for patients who fell just outside the guidelines.

2.7 Default levels foe cholesterol testing

These were agreed as Chol 6.4 with HDL-C 1.2 for men and 1.4 for women.

2.8 CHD Clinics

Gosport PCG was proposing a central clinic for secondary prevention. This pilot would be watched with interest by other parts of the district.

2.9 Prescribing Costs

NSF implementation costs for prescribing had been estimated to be a further £2.5-3m within the district. Previous projected costs were proving to be accurate. Some additional non-specific funds had been made available to covering increasing prescribing costs in 2000/01. There would need to be further consideration in future SFF discussions.

Mr Crawley reported that the IOW was already high statin prescribers.

It was suggested that there might be merit in auditing patients on statins, not identified through LEAP.

2.10 Computer Templates

It was reported that Nicky Heyworth was working with computer software suppliers to try to ensure the availability of templates for all practices.

2.11 Cardiac Rehabilitation

It was agreed that the extension of cardiac rehabilitation to cover Fareham, Havant and Petersfield would be planned on a district-wide basis until complete coverage has been achieved.

3 Any other urgent business

To be transacted between the PCG Chief Executives. **SR/SC/JK**

4 Date of next PCG Leads meeting

13 October at 1.45 in F1 Finchdean house **PCG Leads**

Agenda items:

Cancer network – Mrs D Evans to attend
CAMHS/ADHD local service