

File: 9/2/00

**PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY**

PCG Leads meeting to be held on Friday 8 September 2000 at 1.45 at ~~Westlands~~ *E1*  
~~Medical Centre, Westlands Grove, Portchester~~ *Tinchdean*

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**AGENDA**

1. **Apologies for Absence**
2. **Minutes of the previous meeting**  
 To agree the minutes of the meeting held on 14 July 2000 **Attached**
3. **Matters arising**
- 3.1 Criteria for referral for community dentistry (3.3)  
 Update on a care pathways for DVT/cellulitis (6)
4. **Coronary Heart Disease – NSF** **Attached**
5. **Representation**  
 Research Ethic Committee **Attached**
6. **Any other business**
7. **Date of next meeting**

**Circulation – PCG Chairs and CEs/ CG and CHD leads**

8/9

# Portsmouth and South East Hampshire

Health Authority  
 Finchdean House, Milton Road  
 Portsmouth, PO3 6DP

## Portsea Island Primary Care Group

### PCG Leads

Notes of the Meeting held: Friday 14 July 2000

<b>Present:</b>	Dr Charles Lewis (chair)	✓ Sue Robson
	Dr Mike Johns	David Crawley
	Dr Gordon Somerville	Tracy Green
	Dr J Barton	John Kirtley

No	Discussion	Action
1.	<b>Apologies for Absence</b>	
	Apologies received from Dr John Hughes, Sheila Clark and Dr Mark Denman-Johnson.	
2.	<b>Minutes of the previous meeting</b>	
	With the correction of the spelling of Dr Mark Denman-Johnson's name, the notes of the meeting held 9 June were agreed as correct.	
3.	<b>Matters arising</b>	
3.1	<b>Dermatology</b>	
	Dr Mike Johns outlined the outcome of his discussions with Dr Bob Button. A revised rate of £50 per procedure would be offered to interested GPs. The Hospitals Trust would be writing to all GPs outlining the rates, service outline, quality standards and other arrangements and inviting expressions of interest to undertake this work. Enclosed with this letter would be an accompanying letter from the LMC setting out their views.	
	Lin Kennett had also agreed to provide activity and waiting list information across the PCGs that would be circulated once ready.	
3.2	<b>Dental</b>	

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Tracy Green reported from the OHAG meeting attended by Sheila Clark. The group was happy with the links established into PCGs and the commissioning process. The group had requested a PCG representative to future meetings. It was agreed that Sheila Clark would be this representative. Agreement had been given to running a poster campaign to promote oral health that would be funded from the communications budget held by the Health Authority. The Group had also discussed the development of a waiting list initiative for qualified GDPs to undertake Orthodontics work.

Dr Jane Barton highlighted the need to increase the numbers of NHS dentists and also to have clear criteria and guidelines. Sue Robson agreed to write to Alan Jones regarding the latest guidelines for both adults and children.

SR

### **3.3 Child Health Surveillance**

John Kirtley noted that a representative from the PCGs was requested for this group. It was agreed that Elizabeth Emms would undertake this role if there were no alternative offers within the next two weeks. In addition John Kirtley noted the offer from the group to attend individual PCG/GP discussions.

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## **4. Commissioning Group**

Sue Robson highlighted that the volume of work under consideration by the group was huge with many contentious issues being tackled. The Commissioning Group would be looking to the PCG leads group for support on some of these issues.

Sue highlighted the issues within Family History Breast Screening and noted a response was awaited from the Trust. Each PCG would need to pick up the implications locally.

The devolution of commissioning was noted to be almost completed with the transfer of resources and responsibilities now drawing to a close. Dr Mike Johns noted that he was now considering vulnerable people issues under OATs. John Kirtley noted that the formal date of transfer was 14 July 2000.

Dr Charles Lewis requested that any sensitive issues be raised with the PCG leads group so that the Chairs and Chief Executives of the PCGs were aware.

David Crawley highlighted an area of concern for the IOW relating to the relocation of cancer services at SUHT. It was noted this was not a significant issue for Portsmouth and South East Hampshire.

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**5. Portsmouth Hospitals****5.1 Feedback from PHT Strategic Advisory Board**

Sue Robson reported that this had not been a good meeting. Three service reviews had been presented to the meeting and there had been no opportunity for questions or discussion although many issues had been raised. The role of PCGs within the group was questioned and it was agreed that Sue Robson would check with Brendan Ward the status of the Strategic Exchange forums and then write to David Bawtree to note PCGs would not be attending the Strategic Advisory Board in future as the Health Authority would be reconvening the exchange meetings.

SR

**5.2 PFI Operational Policies**

Sue Robson had responded to the Trust on behalf of all PCGs regarding representation on these working groups. John Kirtley felt this was the one opportunity for GPs to influence future service models. It was agreed reports from the groups would be brought back to the group.

**5.3 Developments in medical services**

John Kirtley noted that the Trust had met with both Fareham and Gosport GPs to discuss medical services and the proposed reopening of 19 beds at Haslar staffed by the Trust. This would increase capacity within the district.

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**6. Update from PCGs**

Dr Mike Johns reported that he was undertaking an analysis of the care pathway for patients with DVT/Cellulitis with a view to managing patients in intermediate or community care rather than an acute setting. Mike agreed to bring back the results of his investigations once completed and the consequences known.

MJ

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**7. Any Other Business****7.1 IOW PCT**

David Crawley noted that he was meeting with SERO to discuss the PCT application and SERO would be presenting the proposal to ministers on the 24 July. The application document for the PCT was shared. David noted that he had undertaken 30 public meetings as part of the consultation and that a 90% positive response had been received from the LMC ballot.

**7.2 Cardiology**

David Crawley noted he was in discussions with PHT cardiology department regarding a joint cardiology department. Currently cardiology and cardiac surgery were provided from King Edward VII. Sue Robson agreed to copy the notes and papers for the recent cardiology review meeting to David for his information. The potential impact of the proposed Regents Park development was noted. A meeting involving Penny Humphris, John Hughes, Peter Howlett, John Watkins and others had been arranged to discuss the situation and to develop a strategy.

SR

### **7.3 Whole System Group**

Dr Mike Johns raised his concerns about being asked to consider and make decisions on large schemes being proposed during these meetings. Also concerns were raised that although PHT had not yet asked for funding for waiting lists, that they may will request funding later in the year and if we had committed the funds on other schemes this would cause financial difficulties for the health economy. John Kirtley raised concerns regarding the lack of clarity of funding for some schemes, which were being approved, and the potential impact on PCG plans.

With regards the bed management proposal John Kirtley agreed to respond to Nicky Pendleton and Liz Steel on behalf of all PCGs asking the group to relook at a cost neutral solution recycling existing funds.

JK

### **7.4 Dietetics**

Dr Charles Lewis noted he had been in discussions with Joan Munro regarding a potential specialist Macmillan dietetics nurse bid that would require funding from PCGs in three years time. Joan was planning to contact the other PCGs as well. It was agreed to consider this at a later meeting.

### **7.5 EMH Services**

Sue Robson noted that Brendan Ward had sent a neutral response to Dr Hardwick and that Max Millett had also responded asking for further information. It was noted the group might need to pick this issue up at a later meeting.

### **7.6 Access and Enhanced Services for Primary Care**

It was agreed that the extra funding would be split 80% to all PCGs pro rata to baseline and 20% split according to the pace of change model. Tracy Green agreed to inform Bob Weeks for allocation purposes.

TG

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**7.7 Teenage Pregnancies**

It was agreed that the allocation received for the district (£15,000 for co-ordinator and £50,000 for the district) would be the first call of funds for the nurse project officer being appointed (estimated £30,000 per annum cost). The balance would be held as a budget for the nurse project officer to work with PCGs for further developments of service to areas of need across the district. The specific allocation for the City would go directly to the City.

**7.8 Clinical Commissioning Issues Group**

Sue Robson requested agenda items for the next meeting due to be held 10 August 2000.

ALL

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**8. Date of Next Meeting**

It was agreed to cancel the next arranged date of 11 August 2000. The next meeting will be held 8 September 2000 from 1.45pm in Dr Somerville's practice.

ALL

### Cardiology NSF & Primary Care Standards 3&4

The NSF is extremely prescriptive both in terms of clinical standards expected of General Practice and the collation of data to demonstrate that these standards are being adhered to. The general advice for Primary Care and the information required over the next few years to support the NSF should be District-wide but much of the implementation in terms nursing developments, clinical governance and prescribing implications will fall to the individual PCGs.

The sooner GP practices begin to tackle any deficits of CHD management as laid out in the NSF the less likely we are to run into problems with inadequate data in forthcoming years.

However I feel we should be striving for achievable and clinically meaningful improvements in CHD care rather than embarking upon, what could be, a heavily bureaucratic process.

Milestone 1: "By October every practice should have clinical teams that meet at least once every quarter to plan and discuss the results of clinical audit....."

All practices should be aware of this by now and the PCGs need to discuss ways of encouraging this to happen.

Milestone 2: "By April 2001 every practice should have medical records and hospital correspondence ...in date order.....containing easily discernible drug therapy lists ....and a practice-based CHD register to provide structured care."

Date order medical records should be the norm in practices by now but exceptions may need some help in sorting out. Similarly most practices will have computer based prescribing systems but practices with poor record keeping may need some assistance.

The CHD register should consist, in STEP ONE of all patients with known cardiovascular disease. The LEAP project should provide a list of many of these patients and practices should be asked, as a minimum, to record the following as READ codes:

CHD	G3 [MI=G30]
PVD	G73
TIA	G65
CVA	G6
CABG /PTCA	792
LVD[HF]	G58
AF	G573

This would form the basis of their CHD register for secondary prevention and the other NSF requirements.

Work with Biochemistry may help to keep tabs on future patients admitted with MIs and we need to think about the possibility of patient held shared care cards and a standard discharge form for post-MI patients.

STEP TWO should be to add to the risk register all patients with hypertension diabetes and a significant family history of IHD using codes:

↑ BP	G20
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DM                    C10  
 FH IHD            12C [stem]

Both of these groups will need serum cholesterols measuring if not already done with a view to decreasing level to < 5.

STEP THREE should be to identify all patients at risk of CHD >30% in 10 years. It is suggested that we use the Joint British Society tables to assess this in order to ensure consistency across the District. The practices can be supplied with laminated hard copies or floppy discs to assess risk. Advice should be to assess using a default level for total cholesterol of 6.4 and 1.2 HDL-C for men and 1.4 HDL-C for women [this is used in EMIS]. Any risk of <15% does not require an absolute cholesterol as the alteration in risk from a raised level will rarely push the risk above the 30% threshold.

There is then a requirement to structure management of CHD patients – both with known disease and high risk. Although one of the options suggested by the NSF is specific clinics in order to achieve this we clearly cannot be prescriptive as far as practices are concerned. Nurse led clinics for primary prevention / screening would seem to be an obvious way forward but secondary prevention and follow up of secondary prevention /post MI patients would probably fit more neatly within the usual GP consultation mechanism.

The PCGs will need to have mechanisms in place to fund additional nursing time through PCIPs and will also need to manage the increase costs of statin / ACE prescribing etc. It would be helpful if, as part of the discussions around cardiology ‘unified budgets’, we can agree a preferred statin and ACE with the cardiologists in order to reduce overall financial risk.

Clinical governance will need to handle those practices that are not complying with primary and secondary prevention guidelines, or, more likely, can’t prove that they are!

Whatever mechanisms practices use to deal with their ‘at risk’ patients the following data will need to be recorded in an auditable way, either through MIQUEST or internal practice audit:

Smoking status	READ	137
Smoking advice		6791
Alcohol consumption		136
Alcohol advice		6792
Dietary history		1F
Dietary advice		6799
Exercise grading		138
Exercise advice		6798
BP level		246 / measurement
BMI		22K / measurement
Serum Cholesterol		44P / measurement
Salicylate prophylaxis		8B63
ACE inhibitor prescribing		
Statin prescribing		
Beta-blocker prescribing		
Warfarin prescribing in AF		

-as well as the codes already referred to.



The use of specific IHD templates on computer systems will make this much easier to collate and audit although persuading all GPs to work like this will be difficult if not impossible! We need to be sure that all the templates on the systems used by GPs have the relevant fields for the recording of the NSF information.

The benefit of specific clinics, especially nurse run, is that nurses are more likely to abide by a 'template' compared to GPs.

The measures necessary for the delivery of the heart failure standard are being dealt with separately but as a first step we should encourage GPs to record their HF patients in an auditable way and provide structured care for these patients. Further advice will follow from a subgroup led by Bob Logan.

Questions for the PCGs :

1. What measures do you envisage putting in place to encourage practices to have clinical audit meetings?
2. What measures can we put in place to ensure all GP records are in date order and with easily discernible drug lists?
3. Are you happy with the range of READ codes suggested for STEP ONE?
4. Are you happy that this forms the basis of a practice's CHD register?
5. Do you think input from Biochemistry will be helpful to ensure pick up of all post MI patients for clinical and rehab follow up?
6. What do you think of shared care cards for patients to encourage patient [and GP] compliance?
7. What measures can we put in place to ensure practices are compiling a CHD register?
8. Are you happy with the READ codes for STEP TWO?
9. Are you happy with the suggestion to encourage use of laminates or floppy discs for the assessment of risk using Joint British Society guidelines?
10. Are you happy with default levels in order to discourage widespread cholesterol testing?
11. How would the PCGs like to play the introduction of CHD clinics
  - a. For primary prevention?
  - b. For follow-up and secondary prevention?
12. Are you happy to run this with your PCIP process?
13. How do you want to 'risk manage' the potentially huge increase in prescribing costs?
14. How do you want to handle the overall 'clinical governance' issues for practices who appear to be failing to implement the NSF?
15. Are you happy with the READ codes suggested for the management of at risk patients?
16. Are you happy to encourage practices to use their computer templates to assimilate this data?
17. What do you envisage doing if practices do not comply?

Any further ideas!?

*JRH August 2000*

7. Minister  
PCG Leads  
8/9.

**NHS**  
**Executive**

**South East**

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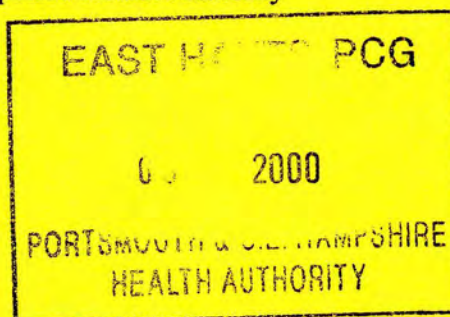
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30<sup>th</sup> June 2000

Dear Dr Hughes

**South Thames/South East Multi-Centre Research Ethics Committee**

I am writing to you in your capacity as Chairman of a Primary Care Group based in the South East Region.

The South Thames (soon to be known as the South East) Multi-Centre Research Ethics Committee (MREC) currently has two vacancies in its membership, one for a General Practitioner member and the other for a Pharmacist member.

MRECs were established by the Department of Health in 1997 to carry out the ethical review of research undertaken on NHS patients in five or more centres. There are currently eight committees, based in each of the NHS English Regions and comprising of up to 18 members drawn from the general public and from professions linked to health and social sciences.

The South Thames Committee meets monthly, in London, on the second Wednesday of each month. Meetings last between four and eight hours, dependant on the business and it is estimated that preparation time can be at least as long as the meeting itself. Members receive papers relating to new applications (currently a ceiling of ten per meeting) two weeks before each meeting and a further mailing relating to deferred applications in the

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INVESTOR IN PEOPLE

week before. Two members, normally one medically-qualified and one lay, lead the review and the Committee aims to come to a decision by consensus. Individual members may be asked by the Chairman or Administrator to help in preparing responses to particular points.

MREC members are encouraged to keep abreast of developments in medical ethics in general and research ethics in particular by attending conferences and courses on relevant themes. No remuneration is paid, but expenses are covered (including locum fees relating to the General Practitioner's attendance at the meetings).

I would be grateful if you would pass the above information onto any General Practitioners or Pharmacists within your Primary Group who may be interested in applying for either of these two vacancies.

If you require further information on how the MRECs work or require an information pack (including an application form) please do not hesitate to contact me on Code A

Code A

Yours sincerely

**Code A**

**Jane Martin**

**Administrator, South Thames MREC**