Portsmouth and South East Hampshire Health Authority

File: 9 & 12

PORTSEA ISLAND PRIMARY CARE GROUP

AGENDA

Board Meeting : 12 April 2000, Lecture Theatre, Portsmouth College, Tangier Road, Portsmouth at 7.15 p.m.

PART I

No	Item		Lead/Paper	Attachments
1.	Apologies			
2.	Chairman's Report		C Lewis	
	2.1	Review of 1999 Business Plan	C Lewis/S Clark	Yellow
3.	Minutes of last meeting			White
4.	Matters Arising			
	4.1	Questions from the Public		
	4.2	Terms of Reference/Terms of Office	S Clark	Verbal
	4.3	PHT - June Board	S Clark	Verbal
5.	PCG Development			
	5.1	Business Plan for 2000/01	C Lewis/S Clark	Cream
6.	Health Improvement			
	6.1	Housing	H Keates	White
	6.2	CHD Proposal		Grey
7.	Commissioning Issues			
	7.1	St Mary's Hospital	D Tarrant/A Swinney	Blue
	7.2	Commissioning & Performance Sub Group Minutes		White
8.	Primary Care Development			
	8.1	Asylum Seekers	D Tarrant	Pink
9.	Finance Issues			
	9.1	Finance Report	T Green	Green
	9.2	2000/2001 SaFF	T Green	Lilac
10.	Quality and Clinical Governance			
	10.1	Public Involvement	M Potter	Grey
	10.2	Prompt		Cream
	10.3	Communication and Public Involvement Sub Group Minutes		White
11.	Prescribing			
	11.1	Budget Setting Process	C Olford	Salmon
	11.2	Prescribing Expenditure Report		Yellow
	11.3	Prescribing Sub Group Minutes		White
12.	Date and venue for Next meeting 14 June 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			

PORTSMOUTH & S.E. HANTS HEALTH AUTHORITY
- 7 APR 2000
FAREHAM & GOSPORT PCGs

Mr John Kirtley
Chief Executive
Fareham & Gosport PCG

PORTSEA ISLAND PRIMARY CARE GROUP

PUBLIC BOARD MEETINGS

DISTRIBUTION LIST

1	Alder K Miss	Pharmaceutical Adviser	PI PCG	Part I and II
2	Bajric N Ms		Portsmouth	Ag & Mins Only
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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	Clark S Mrs	Chief Executive	PI PCG	Part I and II
12	Coles C Mr	Chair, Portsea	Portsmouth Neighbourhood Forum	Ag & Mins Only
13	Croker R Mr	PCG Link	Local Pharmaceutical Committee	Part 1 Only
14	Cullen J Mrs	Nurse Representative	PI PCG	Part I and II
15	Daley P Mrs	Community Librarian	Portsmouth City	Part I Only
16	Doyle G Mr	Chair, West Southsea	Portsmouth Neighbourhood Forum	Ag & Mins Only
17	Durham Neil	Health Correspondent	Portsmouth Evening News	Part I Only
18	Fellows E Dr	GP Board Member	PI PCG	Part I and II
19	Francis P Mr	CHC	Community Health Council	Part 1 Only
20	Fuller R Mr	Chair, Central Southsea	Portsmouth Neighbourhood Forum	Ag & Mins Only
21	Gowers P Mr	PCG Link	Local Dental Committee	Part 1 Only
22	Green T Miss	Finance & Info Mgr	PI PCG	Part I and II
23	Grummit C Dr	Head of HealthCare	Kingston Prison	Part I Only
24	Gurney N Mr	Chief Executive	Portsmouth City Council	Part I Only
25	Harris S Dr	GP Board Member	PI PCG	Part I and II
26	Hogan J Dr	Vice Chair	PI PCG	Part I and II
27	Hooper J Professor	Non Exec	PI PCG	Part I and II
28	Hudson P Mr	Chair, Buckland	Portsmouth Neighbourhood Forum	Ag & Mins Only
29	Hughes J Dr	Chair	East Hants PCG	Part I Only
30	Hutchinson R Mr	Social Services	Portsmouth City	Part I and II
31	Jackson M Cdr	Chair, Old Portsmouth	Portsmouth Neighbourhood Forum	Ag & Mins Only
32	Jones C Mrs	Chair, Stamshaw & Tipner	Portsmouth Neighbourhood Forum	Ag & Mins Only
33	Godden Janet	Non Exec Director	Oxfordshire Mental Healthcare Trust	Ag & Mins Only
34	Kirtley J Mr	Chief Executive	Fareham & Gosport PCG	Part I Only
35	Knight H Mr	PCG Link	Age Concern	Part 1 Only
36	Lewis C Dr	Chair	PI PCG	Part I and II
37	Lovell M Mrs	Chief Executive	Community Health Council	Part I Only
38	McKenning S Dr	Chairman	Portsmouth LMC	Part I Only
39	Millett M Mr	Chief Executive	Portsmouth HealthCare NHS Trust	Part I Only
40	Moor R Mr	Secretary	Local Pharmaceutical Committee	Part 1 Only
41	Murray P Mr	Chair, South Somerstown	Portsmouth Neighbourhood Forum	Ag & Mins Only
42	Newcombe S Ms	Chief Executive	Portsmouth City Community Service	Part I Only
43	Olford C Dr	Vice Chair	PI PCG	Part I and II
44	Painter T Mr	Chair, Landport	Portsmouth Neighbourhood Forum	Ag & Mins Only
45	Potter M Mrs	Lay Member	PI PCG	Part I and II
46	Robinson P Mrs	Nurse Representative	PI PCG	Part I and II
47	Robson S Mrs	Chief Executive	East Hants PCG	Part I Only
48	Rose E Mr	Carers Association	Portsmouth & SE Hampshire Branch	Ag & Mins Only
49	Samuel R Mr	Policy & Performance	Portsmouth Health Authority	Part I Only
50	Shepherd T Mr	Chief Executive	Age Concern	Part 1 Only
51	Smith J Ms	Chair, Baffins	Portsmouth Neighbourhood Forum	Ag & Mins Only
52	Smithson M J Mr	Chair, North Somerstown	Portsmouth Neighbourhood Forum	Ag & Mins Only
53	Sommerville G Dr	Chair	Fareham PCG	Part I Only
54	Swinney A Mr	Service Dev Manager	PI PCG	Part I and II
55	Steger-Lewis B Mr	Chair, East Southsea	Portsmouth Neighbourhood Forum	Ag & Mins 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	Tarrant D Mrs	Service Dev Manager	PI PCG	Part I and II
59	Thornton J Dr	GP Board Member	PI PCG	Part I and II
60	Wellman J Mr	Chair, Eastney	Portsmouth Neighbourhood Forum	Ag & Mins Only
61	Widdecome Teresa	NHS Business Manager	Janssen-Cilag Ltd	Ag & Mins Only
62	Wilkinson T Dr	GP Board Member	PI PCG	Part I and II
63	Wright Joan	Practice Manager	Lake Road Surgery	Part I Only

DRAFT

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PORTSEA ISLAND PRIMARY CARE GROUP

NOTES OF THE PUBLIC BOARD MEETING
Held on Wednesday, 16 January 2000 at Portsmouth College, Tangier Road, Portsmouth

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Present:

Dr Charles Lewis (Chair)
Dr Jim Hogan
Dr Colin Olford
Dr Tim Wilkinson
Dr John Thornton
Dr Simon Harris
Dr Elizabeth Fellows
Rob Hutchinson
Pauline Robinson
Professor Jean Hooper
Marie Potter
Sheila Clark
Tracy Green (in attendance)

No	Discussion	Action

1. Apologies for Absence

Apologies were received from Julie Cullen.

2. Chairman's Report

Dr Charles Lewis welcomed everyone to the meeting and introduced the members of the Board to the public. Dr Charles Lewis reminded members of the public that they were welcome to submit written questions to the Board, and that these should be received at least 7 days prior to the Board meeting. Members of the public were also welcome to meet and talk to members of the Board over coffee, following the Board meetings.

Dr Charles Lewis had no further items to report which were not covered elsewhere on the agenda.

3. Minutes of the last meeting

The Board considered the minutes of the previous meeting held on 15 December 1999.

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

4. Matters Arising

4. 1 Questions from the Public

No questions had been received from the public.

No	Discussion	Action

4.2 Future of St Mary's Hospital Site

Dr Charles Lewis reported that following the practice visits to discuss the future of the site a meeting had been arranged for 23 February 2000 where representatives from each practice had been invited to discuss and reflect upon the report and to discuss the way forward.

4.3 Patient Conference Action Plan

Sheila Clark reported that since the patient's conference the PCG had been looking at the recommendations made, assessing what work was already ongoing, and to identify any gaps. Sheila Clark then went through the recommendations set out within the paper.

Rob Hutchinson drew the Board's attention to the City Council older persons strategy group that was currently looking at service deficits and felt that the work of the older peoples planning board should link with the work of this group. Rob Hutchinson also reminded the Board of the leisure card scheme operated by the City Council that offered discounted leisure pursuits.

Dr Simon Harris asked if recommendation one could be extended to cover the promotion of the prevention of stress. This was agreed.

Rob Hutchinson, in response to a question from Professor Jean Hooper, explained that there were ambitious plans for the integration of Social and Health services for older people which would aim to ensure that 'at risk' persons are offered adequate support. In addition Social Services were planning to place Social Workers within GP practices where appropriate to try to make the service more seamless.

Pauline Robinson asked if recommendation 1.1 – managing stress could include school children and young families. This was agreed.

Dr Colin Olford raised the difficulties of balancing the unpredictable demand in primary care with appropriate appointment booking systems. Marie Potter acknowledged these difficulties but felt that people's expectation and experiences had to be recognised and responded to. Dr Tim Wilkinson noted that he felt that there was a need to better educate the public about how to use the services available to them appropriately. Dr Simon Harris noted that the DoH had been looking for practices to operate as pilot sites to consider patient access to primary care and that the PCG should ensure it obtains feedback from these pilots.

Dr Colin Olford asked that any training offered to practices under recommendation 3.2 should be from people with direct primary care experience, and that the demands being placed on practice staff be recognised.

No	Discussion	Action

The Board noted the progress and actions underway and planned and agreed the three priorities set out as areas for developmental work in 2000/01.

5. PCG Development

5.1 OD Plan

Sheila Clark explained that the PCG was committed to producing an OD plan. The plan presented to the Board built upon the first six months of the PCG and had looked at other relevant documentation and reviews undertaken during the year. The plan proposed was a rolling programme and the recommendations would form part of the PCG Business Plan for 2000/01.

The Board noted the tasks to be included in the next Business Plan and approved the Organisational Development proposals in section 3 of the report.

5.2 Terms of Reference

Dr Charles Lewis explained that the PCG had undertaken to review its terms of reference during the course of the year. Dr Charles Lewis also explained that the PCG had devised its original terms of reference before the national model had been released.

Dr Charles Lewis set out each of the proposed amendments. He noted that the amendment at point 8 regarding deputies had been previously agreed at an earlier Board meeting.

The proposal under section 5 to extend the length of election of Board members to three years rather than two years had the support of the LMC and it was felt that this offered greater Board stability and continuity. Dr Charles Lewis noted that if agreed this amendment would need to be discussed with the Steering Group.

Sheila Clark reported that eight organisations had expressed an interest to be co-opted onto the Board. At this time it was proposed not to extend the Board membership but to work hard to be inclusive and open in other ways with each organisation. Sheila Clark noted that the CHC had responded after the paper had been written and that the PCG would like to have an extra-ordinary meeting with the CHC to discuss their comments and concerns. Dr Simon Harris, although supportive of the proposal, felt uneasy that the PCG might not be liasing adequately with the professional bodies. Dr Charles Lewis responded that substantial progress had been made in liaison with professional committees but that this needed to continue.

The Board approved the proposed revisions to the terms of reference.

No	Discussion	Action

6 Health Improvement

6.1 Associated Health Action Zone (HAZ) Update

Sheila Clark updated Board members regarding progress as a HAZ. The City Council and the PCG had appointed a jointly funded HAZ project manager, Jackie Charlesworth to take forward this agenda for a period of 18 months. The first project being undertaken was a bid for Health Improvement funding for the secondary prevention of coronary heart disease. The PCG has been shortlisted and would hear in the next few months whether it had been successful.

7 Commissioning Issues

7.1 Performance Report

Dr Charles Lewis thanked Jeremy Douglas for producing the attached performance report. Tracy Green presented the key messages from the report.

Dr Colin Olford noted that the total patient waiting time from GP referral to surgery in some instances in Orthopaedics was exceeding 3 years and this was unreasonable.

Professor Jean Hooper asked how the concerns previously raised regarding quality of services during Portsmouth Hospitals 'red alert' over the winter had been raised with the Trust. Dr Charles Lewis reported that he had written to Mr. Dick Bishop, Chief Executive of Portsmouth Hospitals Trust as had the City Council and the HealthCare Trust raising their concerns. The Hospitals Trust were collating all views before deciding how to respond. Professor Jean Hooper felt that the results of the national bed enquiry and the local circumstances gave the PCG an opportunity to improve services for older people.

Rob Hutchinson noted that the PCG needed to ensure it developed action plans to take forward issues raised from the information presented. It was felt that the commissioning and performance sub group would be tasked to ensure that appropriate actions are taken.

Dr Colin Olford raised concerns regarding admissions and readmission rates and ICU bed capacity leading to cancellations and patients being transferred to alternative providers. It was agreed that these points would be considered in the next performance report.

Dr John Thornton noted how important the quality agenda was and it was agreed that the performance report would provide further information on this including quality visits.

Dr Simon Harris asked how practices should raise concerns about services with the PCG. Sheila Clark proposed to introduce a scheme

No	Discussion	Action

along the lines of the earlier GP Prompt card scheme. This was agreed.

The Board noted the performance report.

7.2 Out of Area Treatments (OATs)

Dr Charles Lewis introduced this item and explained how the OATs process now worked and the risks this process gave to the PCG. Tracy Green presented the key points from the report. It was noted that the information on individual enquiries included both Out of Area Treatments and procedures not usually purchased.

Dr Colin Olford asked whether GPs should provide information of emergency and urgent admissions made outside of service agreements. Tracy Green responded that providers were required to inform PCGs of this activity on a monthly basis. GPs were not required to provide this information, however should GPs be aware of a high cost case it would help the PCG in its financial planning and risk assessment to know as early as possible.

The Board noted the report

7.3 Commissioning and Performance Sub Group Minutes

Dr Charles Lewis outlined the work of this sub group.

The Board approved the minutes of the sub group.

8 Primary Care Development

8.1 IT Reimbursement

Dr Charles Lewis introduced the paper that set out the reimbursement policy of the PCG including the criteria for investment in IT. Dr Charles Lewis thanked Dr Colin Olford and the IM&T sub group for their work in producing the policy.

The Board approved the policy.

8.2 IM&T Sub Group Minutes

Dr Colin Olford reported on the work of the IM&T sub group and noted in particular the work being undertaken as part of the LIS.

The Board approved the minutes of the sub group.

No	Discussion	Action

9. Finance Issues

9.1 Finance Report

Tracy Green presented the finance report for the period April to December 1999 and advised the Board of a £106,000 overspend. Prescribing remained the main area of concern – however the recently received October information suggested that the prescribing overspend might be stabilising.

The Board was asked to pay particular attention to the 2 extraordinary funding decisions made during the period, and which required ratification by the Board.

The Board noted the report and ratified the extraordinary funding decisions.

9.2 Prescribing Additional Allocation

Dr Charles Lewis explained to the Board that the PCG had received £272,000 additional allocation for prescribing in recognition of the increased cost of generics, this being part of £90m awarded nationally. Generic drugs had in some instances increased in price by as much as 600% and this was the main cause of the overspend being experienced by the PCG. The PCG Board had to decide how to allocate this funding within the prescribing budget. The Prescribing sub group had considered the four options presented.

Professor Jean Hooper asked how confident the PCG was that the budget setting methodology was accurate. Dr Colin Olford responded that there was confidence in the methodology in setting budgets at a PCG level, but that no-one had yet found a methodology that worked entirely satisfactorily to set practice level budgets but that better ways for budget setting were being considered.

The Board approved option b) to increase individual practice budgets calculated on the basis of the number of prescriptions written by its GPs generically.

9.3 Year End Financial Forecast and Management

Tracy Green presented a report setting out the projected year end position of the PCG. She explained that this report had been produced as part of the financial management and mid year review with the Health Authority. The paper set out two scenarios, as it did not prejudge the decision taken regarding the application of the additional prescribing funding. Now that this decision had been taken, Tracy Green informed the Board that using scenario 2 (Option (b) in item 9.2 above) the PCG had a projected year end underspend of £76,000 across the entire unified budget.

The Board noted the report.

No	Discussion	Action

10. Quality and Clinical Governance

10.1 Q&CG Sub Group Minutes

Dr Jim Hogan introduced the minutes of the last meeting and reported on the work being undertaken. Clinical Governance leads for each practices had now been identified, the baseline assessment had been undertaken and an event involving all practices was being held on 2 March 2000. This would look at the baseline assessment, to set priorities for the future and to agree a development plan for the next year.

The Board approved the minutes of the sub group and noted the work being undertaken.

10.2 Communications and Public Involvement Sub Group Minutes

Professor Jean Hooper outlined the work of this group and noted that the Board had approved the action plan for the patient conference earlier in the meeting.

Marie Potter outlined the work she had been undertaking to engage 'hard to reach' groups which she considered was the entire population of Portsea Island.

The Board noted the work of the sub group and approved the minutes.

11. Prescribing

11.1 Prescribing Sub Group Minutes

Dr Colin Olford introduced the minutes from the last meeting of the sub group and outlined the work being undertaken by the sub group. Dr Colin Olford noted in particular the intention to develop prescribing interface packs and developing alert cards for GPs.

The Board approved the minutes of the sub group.

11.2 New Drugs Development Fund

Dr Charles Lewis presented the paper which proposed the development of a fund to allow new drugs to be used in a limited way prior to funding being made available through the Service and Financial Framework (SAFF) process.

Dr Colin Olford noted that the contribution requested from PCGs was intended to be for year one only, and it was hoped that savings would be made in the future to fund this proposal.

No	Discussion	Action

Dr Elizabeth Fellows supported the proposal but questioned how realistic it was to expect savings to be obtained.

The Board approved the proposal to establish a development fund for new drugs to be managed by the D&TC subject to a contribution being made by the three other local PCGs.

12. Date and Venue of Next Meeting

The next Board meeting will be held on Wednesday 12 April 2000 at 7.15pm.

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.

Signed:_____ **Date:** _____

Chair – Portsea Island Primary Care Group

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Agenda Item No:

2.1

1999/2000 Business Plan Review

Background & Summary

As the PCG's first year of operation draws to an end it is timely to review progress against its first Business Plan. Of the original 96 targets and tasks in the Business Plan 61 have been fully completed, a further 30 have been completed in planning or initial phases terms and become part of longer term or ongoing tasks, 4 have had start times carried forward and 1 has become unnecessary. 10 new tasks have been incorporated into the PCGs work plan in year and 4 of these completed.

There has been significant progress in the way the PCG involves its partners in consultation and planning including

- Public and patient involvement and communications
- Practice Steering Group
- Task groups with Portsmouth HealthCare NHS Trust
- Nursing network
- Collaborative commissioning with other PCGs
- Information sharing across practices
- Practice managers consultation and task groups
- Mental Health services review
- Integrated care forum for older people's services
- Children's services (notably mental health and early years)
- Local representative committees
- Voluntary organisations

Whilst this list is not exhaustive it demonstrates real achievement against the declared aspirations of inclusivity, transparency and sharing best practices.

There has also been positive progress in patient centred care developments including

- Equity and quality reviews of primary care based physiotherapy and counselling
- Community based rehabilitation services, diabetes services and glaucoma screening
- Integration of services with Social services for OT and some aspects of child mental health and services for older people
- Piloting of integrated nursing teams

There have also been a number of achievements in the areas of organisational development, clinical governance and prescribing – the full summary is attached.

Recommendations:

The PCG Board is asked to note progress to date and the necessity for its second operational year to concentrate on delivering improved health and healthcare services for its residents.

Date: 21/03/2000

Paper Prepared by: Sheila Clark

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BUSINESS PLAN END OF YEAR REVIEW

	DEVELOPMENT AREA	RESP	TIMESCALE	PROGRESS
1.	**Area 1. Improving Health**			
1.1	Establish Strategic Planning and Partnerships subgroup to develop agreed priorities in health and social welfare services (initially services for older people, adult mental health and child and adolescent mental health)	SC/CL	Completed – extend next year to cover services for children.	Established at high level. Group now to meet on ad hoc basis as work overtaken by care group and whole system arrangements.
1.2	Contribute to City wide strategic agendas relevant to improving the lifestyles and environment of local people – City Council Health Plan, Crime and Disorder Strategy, Anti-poverty plans and Social Regeneration Initiatives.	SC/CL	Completed. Repeat next year.	Working well but demanding of time – inclusion of PCG on Heart of Portsmouth Board very helpful. Need to find ways of rationalising planning in city next year.
1.3	Develop PCG wide approach to "Health Needs Assessment" to be used to inform all aspects of service planning – including HimP, interagency plans and primary care developments	JH	Carry forward to next year	Original timescale revised to allow for development time. DPP reports very useful but practice based and non health information needs incorporating. Project based work successful – e.g. for patient conference and aHAZ bid for coronary heart disease.
1.4	Develop action plans, local targets and monitoring arrangements for local HImP priorities			
	• Coronary heart disease and stroke	TW/JC	Ongoing	TW working with District on NSF. JC working on HAZ bid
	• Cancers	CL	Ongoing	CL working with District group. 2 week waits rolled out.
	• Suicides	SC/TG	Ongoing	Plans in new city M Health strategy/NSF.
	• Perinatal mortality	DT	Start next year	Plan to be devised next year
	• Accidents	SC/DT/JC	Start next year	Plan to be devised next year
	• Asthma	JT	Ongoing	Focus groups held. Service models to be reviewed in 00/01.
	• Diabetes	JH/SC	Ongoing	Focus group held. Nurse led service model in primary care in development. Shared records and standards developed.
1.5	Review HImP priorities and contribute to plans for 2000/2001	CL	Completed	Completed
1.6	Contribute to District wide discussions on resourcing health inequalities	CL/ J Hooper	Ongoing	Need for movement in 2000/01 to address inequity and inequality agendas : pace of change being negotiated

DEVELOPMENT AREA	RESP	TIMESCALE	PROGRESS
Area 2. Service Commissioning 2.1 Establish mechanisms for monitoring existing service level agreements and agree new approach to SaFF development for 2000/20001. Agree framework for moving to longer terms SLAS.	TG	Completed	Service monitoring improved due to recent availability of information. TG and AS working with District groups. JD providing quarterly reports for Board.
2.2 Agree policy for Out of Area treatment referrals and funding and establish effective monitoring mechanisms	TG	Completed	Completed. Appears to be working well: GPs supportive.
2.3 Undertake regular waiting list monitoring exercises and ensure no patients are waiting excessively for in patient services.	AS	Completed Repeat next year.	Successful so far – information now timely and responsibilities clear.
2.4 Work with HA, Trusts and Social Services to develop and monitor whole systems projects which prevent unnecessary hospital admissions and delay discharge	SC/ AS	Completed/ Ongoing	PCG taking lead with PCC on new whole systems project based on older people. Community rehab team established and other winter pressures schemes (e.g. CAPS) extended.
2.5 Agree projects/ pilot initiatives to develop better social and healthcare service integration (see 1.1 and 1.4) and link to HA work on disinvestments. Use commissioning pilot and GPFH savings to pump prime initiatives as agreed.	CL/AS/TG	Completed. Review next year.	Programme agreed at October Board meeting. Project work areas also benefiting from national finances for waiting times (eg CAMHS and ophthalmology)
Area 3. Primary Care and Community Services Development 3.1 Develop arrangement to implement "A first class service" in primary Care:			
• Conduct baseline quality assessment in all practices	JH	Completed	Completed following development half day
• Hold half day CG session for practice lead personnel	JH	Completed x 2.	One held – another being planned
• Agree CG programme of work for 99/2000	JH	Completed	Priorities for PCG agreed. Detailed programme worked up by CG practice leads and Q&CG subgroup .
• Support practices in GMC revalidation through development of personal learning portfolios	JH/ Anne White	Ongoing	Awaiting further national guidance but now linked into CG development plan.
• Agree programme and participate in collaborative and interface audits	JH	Completed. Repeat next year.	Majority of practices involved in LEAP. Audit of shared standards for diabetes planned for 2000.
• Use Performance Assessment Framework as opportunities arise	SC	Completed	SC working with SP – will test use of PAF headings in PCG HA reports and use for next year's accountability agreement.

DEVELOPMENT AREA	RESP	TIMESCALE	PROGRESS
• Update Beacon Practices register • Hold two educational events to disseminate best practice	SC SC/JH/CL	Completed. Repeat next year	Events held on Community Hospital aspirations and Clinical Governance development plan. Locality based events piloted but not popular.
3.2 Citizen involvement Agree and deliver patient involvement programme of work including			
• Patient conference	JC/MP	Completed. Continue action plan. Repeat event	Event held 27/9/99. Reported to PCG Board and participants. Action plan agreed based on patient recommendations..
• Citizen's jury recommendations action plan	MP	14/15 completed. Continue 2000.	Plan agreed. 14/15 recommendations implemented.(Code of conduct for Board members to be drawn up next year)
• Public Education campaign aligned to HimP	M Stratford	Ongoing	National programme (antibiotics, flu etc) not HimP.
• Conduct annual patient survey if funds permit	M Stratford	Completed	Survey completed near year end – action plan to be devised in spring 2000.
• Development of website	JD/MP	Completed/ Ongoing	Went "live" in October. Updated monthly. Need to decide about Practice pages.
• Communications initiatives based on Healthcheck, Flagship, PCCS Community News, Rant and other partner publications as appropriate	JC	Ongoing	Communications subgroup agreed and implemented programme of work.
• A programme of presentations and discussions with neighbourhood fora	CL/SC	Completed	Initial programme of completed. Continue to respond to requests.
• A plan for involving traditionally "hard to reach" groups (e.g. ethnic minority groups, lone parents, housebound etc)	JC/MP	Carry forward to 2000	Presentation at Social Inclusion conference for E.M.. groups. Visits made by MP. Develop plans next year in aHAZ work.
• Participation in HA and Quality Partnerships programme of work for promoting independence and using patient experiences to improve services	M Stratford/ SC	Completed/ Ongoing	Work undertaken in asthma, diabetes, arthritis, and services for older people. More planned through QP and MS. Lifestyle survey very useful too.

	DEVELOPMENT AREA	RESP	TIMESCALE	PROGRESS
	• Development of practice based leaflets explaining PCG and how public can be involved	MS	Completed	Leaflets in surgeries; updated twice a year
	• Review effectiveness of public involvement in Board meetings	CL/MP	Completed. Carry forward.	Reviewed after every Board meeting. Survey of attendees underway
3.3	Develop use of information sharing across practices in order to support the dissemination of best practices in ways which do not compromise the need for confidentiality.	JH/JD	Ongoing	Using SIMPLE data initially Agreements now reached with practices to share prescribing and referral data.
3.4	Develop three year Primary Care Investment Plan (PCIP) in accordance with national requirements	JH/AS	Completed	Completed.
3.5	Review processes and procedures for prioritising and allocating funding for General Medical Services (including practice staffing, relief budgets, staff training ,premises, and IT)	DT/AS Practice Managers	Ongoing	Completed for prioritising and funding allocations. Further process reviews underway to enable devolution of relief budgets and more efficient reimbursement practices. Post Evaluation project underway with view to promoting best HR and employment practices in PCG.
3.6	Develop nursing network to ensure effective involvement of nurses in PCG	JC/PR	Ongoing	Multi disciplinary locality based network established.
3.7	Implement national nurse prescribing initiative	CO	Ongoing	Being rolled out in District wide programme.
3.8	Pilot integrated community nursing teams	PR/JC/SC	Ongoing	Pilots running and being evaluated.
3.9	Roll out revised District Nurse as Care Manager initiative across city	PT	Ongoing	Progress only impeded by training and recruitment difficulties.
3.10	Implement local "Information for Health" strategy priorities			
	• Ensure all IT equipment is year 2000 compliant	JD	Completed	Completed. No problems
	• Link all practices to NHS net	JD/J-JC	Ongoing.	Programme experiencing delays – HA IT staff in charge
	• Agree and implement a clinical coding strategy	CO	Completed Implement next year	Difficulties experienced in getting District wide approach overcome by taking strong PCG lead. Survey underway to establish practice based support needs.
	• Provide practice based training to ensure minimum skill bases in all practices	JD/DT	Ongoing	IT training plan needs to be further developed and programme rolled out.

	DEVELOPMENT AREA	RESP	TIMESCALE	PROGRESS
3.11	Evaluate current arrangements for Training and Education in primary care and propose revised approach which maximises the advantages of intra and inter practice lifelong learning.	JH/ Anne White	Ongoing	Agenda subsumed into National and District initiatives to review training and Education. Priorities from CG baseline to form local plan.
3.12	Ensure prescribing budgets are contained within cash limits and monitor incentive scheme.	CO/KA	Ongoing	PACT data delays continues to cause problems –
3.13	Review budget setting and incentive scheme procedures for next financial year.	CO/KA	Completed. Ongoing.	Need to continue to examining use of cdm /GIS and other data sources to make budgets more sensitive to local needs.
3.14	Provide practice based pharmaceutical support where requested and promote best practice prescribing in individual practices in key areas and across PCG (including antibiotics)	KA	Ongoing	Pharmaceutical adviser roles very effective.
3.15	Manage the introduction of new drugs in accordance with D&TC guidance.	CO	Ongoing	Being progressed as required.
3.16	Develop a PCG core formulary in line with District one.	CO/KA	Completed/ Ongoing	Using District one - working with PHT/PHCT on interface issues.
3.17	Agree a range of services to be provided in primary care in line with aspirations expressed in the baseline questionnaire (where these can be delivered to agreed quality and efficiency standards). Work with NHS Direct to promote best use of GP time/skills.	JH/CL	Ongoing – further phase of implementation next year	Proposals developed in PCG for diabetes, counselling, physiotherapy, integrated nursing, back pain, nurse triage and minor surgery. Other work to continue in line with District opportunities.
3.18	Collaborative work with PHCT / Social Services not already included – children			
	• Produce Joint Investment Plan (JIP) in line with Joint Children's Services Plan (JCSP)	DT	Completed	Completed – linked to modernisation funding for CAMHs and Sure Start..
	• Develop a joint strategy for children with disabilities	DT	Ongoing	Task group reconvened to develop this.
	• Review management arrangements for JENI	DT	Completed	Now locally managed – partnerships in Action flexibilities being sought to authorise integration of funding/ services..
	• Produce and implement action plan for better integration of child and adolescent mental health services	DT	Plan completed. Continue next year	Plan developed. Further opportunities being explored.
	• Implement agreed actions for Quality Protects , Sure Start and Crime and Disorder strategy	DT/SC	Implementing /Ongoing	All going according to plans.

DEVELOPMENT AREA	RESP	TIMESCALE	PROGRESS
3.19 Collaborative work with Social Services – Homeless People Provide and monitor outreach primary care services	SC /Dr V Randall	Completed/ ongoing	Original tasks completed. Now working with Housing and SSD to produce new strategy for the City.
3.20 Collaborative work with PHCT/Social Services – physical disability services • Further develop schemes for supporting people in the community using rehabilitation teams (notably younger physically disabled people)	JC	Ongoing	New pilot project underway with voluntary sector and SSD.
3.21 Collaborative work with Social Services – general			
• Produce version 3 of directory	MS	Completed	Completed.
• Evaluate link social worker scheme	DT	Completed.	Review complete – development plan underway.
• Examine feasibility of integrating OT services	JC	Completed. Develop next year	Integrated service established for older people – needs extending to all groups.
• Hold information workshop for staff groups in October	SC	N/A	Postponed to next year due to patient conference.
• Review posts as vacancies arise for opportunities for shared posts	SC	Ongoing	HAZ project manager in post. Looking at mental health potential.
• Examine feasibility of shared office accommodation	SC/MS	Ongoing	Original space too small – continuing to look.
3.22 Collaborative work with other primary care providers • optical services • pharmaceutical services • dental services	TG/SC/CL	Ongoing	Proposals being implemented for projects with optical and dental services.
Area 4. Organisational Development			
4.1 Develop performance monitoring arrangements with HA using this Business Plan, HA/PCG Accountability Agreement and Performance Assessment Framework as appropriate	SC/TG	Completed Ongoing	Monitoring agreed and implemented in line with plans.
4.2 Develop robust financial plans and financial monitoring /reporting mechanisms	TG	Completed/ ongoing	Monthly reports in place.
4.3 Draw up both internal and external PCG communications strategies and implement supporting plans following communications Board "Time out" recommendations in May (see also 3.2)	JC	Completed	Completed.

	DEVELOPMENT AREA	RESP	TIMESCALE	PROGRESS
4.4	Produce a prioritised OD plan, incorporating those areas already noted from the HQS assessment: Priorities include • team building • clarity of roles/contributions to business plan objectives • developing inter agency approaches to patient centred commissioning/service provision • capitalising on prescribing progress • IT • Clinical governance arrangements and supporting culture • develop collaborative work in primary care (e.g. comparative evaluation of staffing needs, information sharing, bulk purchasing etc) • building relationships with all departments of the city council and local voluntary organisations • boundary review	SC	Completed Completed Completed Completed Completed Completed Completed Completed Completed May 2000	See OD plan
4.5	Ensure that the PCG adheres to national HR guidance (e.g. E.U. Working Times directive) and is able to demonstrate its preparedness to sign up to the requirements of "Working Together" in terms of best practices in employment, recruitment and retention of staff.	SC/DT/SA	Ongoing	Practice Managers group undertaking post evaluation and development project through peer visits. More formal work needed on Working Together implications for practices
4.6	Develop communications arrangements with professional bodies (LMC, LPC, LOC & LDC)	CL	Completed	Arrangements in place.
4.7	Agree and implement confidential information sharing protocol across all Portsea Island practices	CL	Completed	In place.
4.8	Continue to monitor the effects of lack of co-terminosity of PCG boundaries	SC	Ongoing	PCG "log" operational but little information from other partners. Boundary review to be conducted in 2000
4.9	Review and revise constitution of PCG	CL/SC	Completed	Logging issues as they arise (e.g. membership, deputies etc)

DEVELOPMENT AREA	RESP	TIMESCALE	PROGRESS
Additional Future of St Mary's : Consultation with GPs/Proposals/Funding and links to scenario plans for District	SC/CL	Ongoing	Visits conducted with every practice to discuss GP aspirations. Summary paper produced and consultation event held to inform wider debate.
Take up aHAZ status and associated planning requirements including funding bids			
Adult Mental Health LPG set up etc	TG	Ongoing	Implementation plans following Sainsbury Review now developed and being actioned.
SFF/SLA Negotiations	TG/AS/DT	Ongoing	Further devolution of responsibilities to PCG in hand. Need to reconsider collaborative links with other PCGs.
"Public speaking" training event for Board members	MS	Completed	Evaluations show that this was a useful event
"Working with the Media" training event for Board members	MS	Completed	"
Millennium arrangements for primary care and PCG	SC/CL/TG	Completed	No problems
Further Finance Training for Board Members	TG	Completed	Evaluations show that this was a useful event
DDA section 21 implementation	SC/DT	Ongoing	Audit completed. Further plans required to ensure compliance before 2004.
Asylum seekers services	DT/SH	Ongoing	Time consuming but urgent work in hand on multi disciplinary basis for initial assessment services.
Violence to staff initiative in accordance with HSC	SC/DT/AS	Ongoing	Conference and monitoring in 2000 to inform plans.

Agenda Item No: 5.1

Portsea Island PCG Business Plan 2000/01

Background and Summary:

The proposed business plan for the second year of Portsea Island Primary Care Group (PCG) is attached. It sets our intentions for 2000/01 in a longer-term context. The Business Plan draws from a number sources and is intended to be a comprehensive framework guiding the work of the PCG. It is a natural development of previous collaborative activity across the PCG, which arose from the work of the PCG in its first year, practice visits, an active multi agency steering group, and several educational and organisational development initiatives held during the year.

The PCG hopes to continue to involve all partners effectively in its work – by further developing the programme of patient and public involvement as well as creating additional opportunities to work with other agencies. The PCG will continue to seek to streamline health and social care services wherever this will deliver improved patient centred services and to contribute to the city wide priorities of its partner organisations.

We will conduct work under the same four priority headings this year as we did in 1999/00.

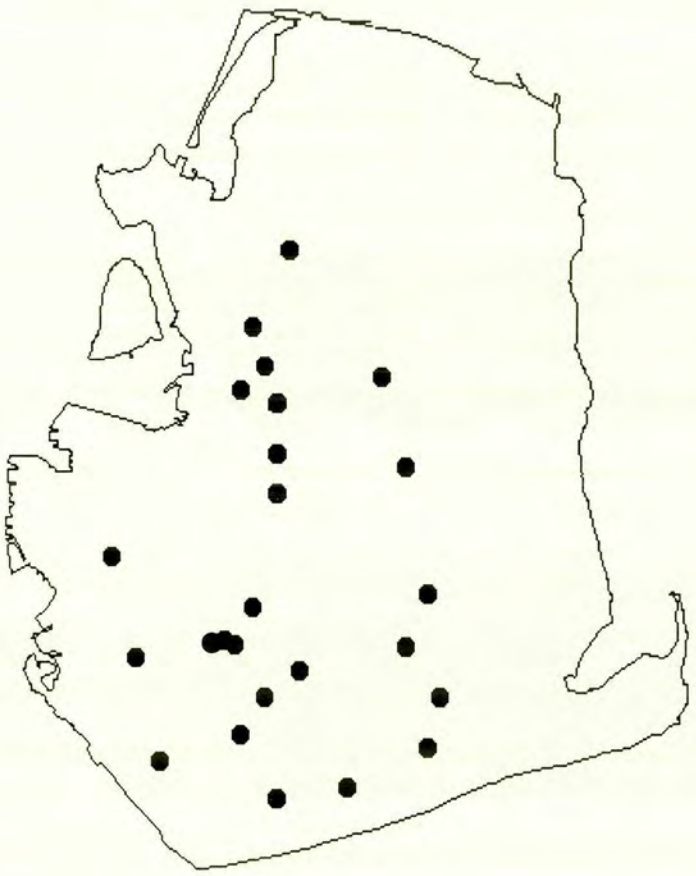
- Improving health and reducing inequalities – more detailed actions under this heading are given in the Health Improvement Programme (HImP). Coronary heart disease, stroke, cancer, accident, mental health, perinatal mortality, asthma and diabetes are all conditions for priority action this year.
- Commissioning services – in addition to monitoring the current Service and Financial Framework (SFF) agreements the PCG wishes to develop services outlined in the HImP and find further ways of integrating services for older people, those with mental health problems and for children. This year will see increasing attention on monitoring the quality of services that we commission.
- Developing primary and community services – the PCG will implement its Primary Care Investment Plan (PCIP) to maximise service development opportunities. This three-year programme has an annual schedule of work with priorities for 2000 including plans for meeting the Disability Discrimination Act and Clinical Governance. The PCG will continue collaborative work with community nursing, older people, mental health and children.
- Organisational Development – the PCG recognises a need to develop its communications infrastructure. Priority will also be given to enhancing our current arrangements for sound financial performance, service quality and clinical governance, human resources issues and performance monitoring.

Recommendations: The PCG Board is asked to approve the Business Plan.

Date 30 March 2000

Paper prepared by: Tracy Green

PORTSEA ISLAND PRIMARY CARE GROUP



BUSINESS PLAN 2000/2001

Draft
27 March 2000

INDEX

1. Introduction and Executive Summary

This is the second business plan for the Portsea Island Primary Care Group (PCG). It builds on progress in 1999/2000 and sets out our intentions for 2000/2001. The Business Plan draws from a number of important national and local sources and is intended to be a comprehensive framework guiding the work of the PCG from April 1st 2000. It is a development of previous collaborative activity across the PCG which has arisen from the achievements of the PCG in its first year, the earlier GP commissioning pilot, practice visits, discussions with community based groups, an active multi agency steering group, supporting professional networks, and several educational and organisational development initiatives over the last two years.

The PCG wishes to involve all of its partners in its work - developing a programme of patient and public involvement as well as creating additional opportunities to work with other agencies. This includes more obvious partners like service users and their representatives, NHS Trusts, the city council, voluntary organisations and the CHC, but also some groups less obviously involved in the past like carers and the independent sector providers. Our aspirations are extended in this year's plan. We will continue to streamline health and social care services wherever this will deliver improved patient centred services and remain actively involved in citywide priorities of partner organisations – particularly the Departments of the City Council.

The first year was a challenging one financially with little in the way of "un-earmarked" new monies available to develop services, great costs pressures in prescribing and unavoidable investments to be made making practices Year 2000 compliant. Many of the service developments envisaged will come on stream in this year and the following one although progress has been made using local commissioning pilot savings to pump prime initiatives and also by working with the Health Authority and other local PCGs to invest in waiting lists and winter pressures initiatives which meet local health needs.

We will conduct work under the same four priority headings this year as we did in 1999/00. The difference being in concentrating on implementation of plans and adding new topics:

- Improving health and reducing inequalities – more detailed actions under this heading are given in the Health Improvement Programme (HImP). Coronary heart disease, stroke, cancer, accident, mental health, perinatal mortality, asthma and diabetes are all conditions for priority action this year.

- Commissioning services – in addition to monitoring the current Service and Financial Framework (SFF) agreements the PCG wishes to develop services outlined in the HImP and find further ways of integrating services for older people, those with mental health problems and for children. This year will see increasing attention on monitoring the quality of services that we commission.

- Developing primary and community services – the PCG will implement its Primary Care Investment Plan (PCIP) to maximise service development opportunities. This three-year programme has an annual schedule of work with priorities for 2000 including plans for meeting the Disability Discrimination Act and Clinical Governance. The PCG will continue collaborative work with community nursing, older people, mental health and children.

- Organisational Development – the PCG recognises a need to develop its communications infrastructure. Priority will also be given to enhancing our current arrangements for sound financial performance, service quality and clinical governance, human resources issues and performance monitoring.

Charles Lewis (Chairman) ***Sheila Clark (Chief Executive)***

2. CONTEXT

2.1 Development of Primary Care Groups

Primary Care Groups (PCGs) were established nationally on April 1st 1999. They comprise natural communities of General Practices (and their attached staff) and encourage collaboration between practices. The Portsea Island PCG builds upon recent experiences of the majority of local practices working together in a GP commissioning pilot scheme. The reorganisation of the Health Authority enabled a dedicated management team to be put in place to support the PCG. This second business plan covers the year April 2000 – March 2001 but encompasses many longer-term aims.

2.2 PCG Composition

Portsea Island is one of four Primary Care Groups (PCGs) in the Portsmouth and South East Hampshire Health Authority District. It comprises twenty-five general practices and includes eighty-eight general practitioners. The practices range from two single-handed ones to three six-partner partnerships. Geographically the PCG covers Portsea Island south of the M27. Whilst all current PCG practices have their surgeries situated on Portsmouth Island and lie within the boundary of Portsmouth City Council, co-terminosity with Portsmouth City Council is not mutual as a small number of Portsmouth mainland practices lie within the neighbouring East Hants PCG boundary. This boundary will be independently reviewed during 2000 in accordance with an earlier agreement.

2.3 Patients

The PCG covers a population of just over 150,000. The city is largely urban and densely populated. There are significant numbers of unemployed people and single parent families living here and pockets of the city are sufficiently deprived to warrant eligibility for Social Regeneration Budget funding. The city has a particularly high incidence of certain health problems – low birth weight babies, breast and lung cancers, long term limiting illnesses (especially in over 65s), coronary heart disease and accidents.

2.4 Partners

This business plan concentrates on the healthcare priorities of the PCG. It is clear that the majority of the aspirations in this document will only be realised in collaboration with partners – not least patients, their carers and the general public. Other significant partners include the city council, voluntary organisations and colleagues from local healthcare service providers.

Partnership is seen as a reciprocal relationship with the PCG contributing to the aspirations and achievements of other key stakeholders agendas.

3. Principles and Aspirations:

The group envisages great benefits to patients arising from the closer collaboration of participating practices. It has extended its original underlying principles and aspirations to its work as follows:

- to improve health and healthcare in response to identified needs of our population
- to reduce inequalities of access to health care for all our residents
- to encourage closer collaboration between member practices and other agencies
- to negotiate service requirements directly with hospital and community based clinicians
- to continue to improve the quality of primary care services by developing and sharing best practice
- to be centrally involved in discussions over the planning of future local NHS and other relevant services
- to provide a vehicle for supporting innovation and improving morale within primary health care teams and other health care providers
- to improve the quality and range of health care which can be provided within participating practices by working together as a commissioning group
- to engage the public in all aspects of our work and to encourage them to become informed and responsible partners
- to be transparent, fair and open in all decision making processes
- to remain independent of commercial, party political and other sectional interests in pursuit of a fair, accountable and needs-based National Health Service

4. Improving Health and reducing inequalities

4.1 Inequality and deprivation

PCGs are tasked to improve the health and address the health inequalities of their population.

Just over 150,000 people live within the boundaries of the Portsea Island Primary Care Group and this population is anticipated to increase by approximately 2,200 by the year 2004. Of these 6.2% of the PCG's population is aged under five and 14.9% aged 65 years and over. About 35.5% of Portsea Island's elderly population live alone, whilst single parents' head 4.1% of households. 6.9% of the PCG's households are headed by someone belonging to an ethnic minority group. These figures all exceed the averages for Portsmouth and South East Hampshire.

Portsmouth City has a dense population and is one of the most deprived local authorities in the South East. It has pockets of deprivation, including two wards, which are among the most under privileged in the country (Charles Dickens and St Thomas) and three others Nelson, St Jude, and Fratton suffer significant deprivation.

Against this deprived background the city has higher than average levels of unemployment (4.6% compared with 3.2% for the district), higher rates of smoking (35% of the population

over 16 years smoke compared with 29% of residents in Portsmouth and South East Hampshire), higher levels of alcohol abuse (42% drink above sensible limits in Portsea Island compared with 30% in the district as a whole) by both sexes and poorer diets (54% of the PCG's population eat fruit, vegetables or salad at least once a day compared with 61% for the district).

Deprivation and poor lifestyle leads to higher morbidity and mortality from cancers, coronary heart disease, strokes and accidents. In 1999 there were 1,610 deaths to Portsea Island residents - 16% of these deaths were to people aged under 65 and many of these deaths were from preventable causes. Cancers (24%), coronary heart disease (21%), strokes (10%), other cardiovascular disease (9%) and accidents (1%) were the principal causes of deaths to Portsea Island residents. In 1999, Portsea Island death rates for cancers (260 per 100,000) and coronary heart disease (230 per 100,000) were higher than those for Portsmouth and South East Hampshire residents (252 per 100,000 and 215,000 per 100,000 respectively).

4.2 Improving Health

The Health Improvement Programme (HImP) is the vehicle with which the PCG will begin to make a concerted effort to tackle these issues in partnership with healthcare providers and the local authority. It is hoped that this can be achieved through joint planning and resultant joint strategies/action plans. The HImP formally expresses our aspirations to improve prevention and care for local people in the following areas

- coronary heart disease
- stroke
- cancers
- accidents
- mental health
- perinatal mortality
- asthma
- diabetes

4.3 Financing health improvements

In order to reduce health inequalities it is important that there is awareness of the difficult challenges that face the NHS and the PCG financially as well as in involving patients and the public in taking some responsibility for their health and well being. The Health Authority has devolved much of its healthcare commissioning role to Portsea Island and the other PCGs at a time when there is little new un-earmarked money to invest in services and Portsea Island finds itself 5% below equity for 2000/01 in its unified historic budget. With minimal growth monies and a national pledge not to lower service levels, our pace of change towards equity is likely to be slow. This will mean that any developments will have to be made through reviews of existing services and possible resource shifts in conjunction with the Health Authority, Trusts and other PCGs. This will be achieved by robustly reviewing all current spending and service effectiveness and through bidding against national funding for specific projects. The PCG has been successful in accessing Health Improvement funding from the

NHS Executive for Coronary Heart Disease. We will pursue other opportunities to access funding to improve the inequalities of health within the PCG

It is hoped that, as well as targeting earlier diagnosis and improving the appropriate management of established illness, disease prevention will feature highly on health education and promotion agendas of our partners. The principal risk factors to overcome for most preventable deaths are smoking, poor diets, alcohol consumption and lack of exercise – all of these are included in the HImP and the city health plan.

5. Commissioning services

5.1 Service and Financial Framework (SaFF)

The PCG has been involved in the district wide production and development of the SaFF for the local health economy for 2000/01. This has formed the basis for the negotiation of Service Level Agreements with providers. It has also been the vehicle for agreeing across the local health economy the utilisation of modernisation and growth funding, the identification of district wide service development priorities and the pace of change model for moving PCGs towards equity.

5.2 Service Level Agreements (SLA)

From 1 April 2000 the PCG will undertake additional service commissioning for its population as further devolution of commissioning from the Health Authority to PCGs will be occurring. This means that the PCG will now commission all Hospital and Community Services (HCHS) for its population with the exception of learning disability services (pending the outcome of the current strategic review), specialist services (as defined by national guidance) and services which are nationally prescribed to remain the Health Authority's responsibility such as screening services and AIDs/HIV.

As well as agreeing SLAs with our two local health providers, Portsmouth Hospitals NHS Trust and Portsmouth HealthCare NHS Trust, SLAs have also been negotiated with other NHS providers to cover services provided to the whole district. Portsea Island is party to all these agreements.

During the year the PCG will work with the other local PCGs and the Health Authority to monitor and manage these SLAs. For external agreements, a PCG (or Health Authority) manager has been nominated to co-ordinate and lead on behalf of all Portsmouth and South East Hampshire commissioners. Portsea Island PCG has agreed to co-ordinate 5 external agreements on behalf of the other PCGs and the Health Authority and has also agreed to act as the nominal lead for the local Portsmouth Hospitals NHS Trust agreement. The other two PCG management teams will also act as nominal lead for other local agreements: East Hampshire for Portsmouth HealthCare NHS Trust and Fareham and Gosport PCGs for Hampshire Ambulance Service NHS Trust.
In addition the PCG will manage voluntary organisation grant agreements and non-NHS agreements relating to the PCG area and contribute to the remaining district wide agreements.

5.3 Out of Area Treatments (OAT)

The PCG, at is inception, agreed to adopt the existing Health Authority protocols. There is little in-year, short term financial risk to the PCG from the OATs process. However, the PCG needs to put in place adequate measures to limit and control the long term financial risk of OAT referrals and activity increasing in order that there is not a financial burden in future years.

During 1999/00 the PCG established monitoring mechanisms, worked with PCGs on developing the policy and protocols and set in place a mechanism for primary care to notify the PCG of out of area referrals prior to treatment taking place.

For 2000/01 the Service Level Agreement and Out of Area Treatments guidance will be updated and reissued to primary and secondary care. This will notify clinicians of the new range of service level agreements in place for 2000/01 and also the approved extensions to the policy on procedures and treatments not normally purchased. Work is also ongoing with the local Trusts to establish 'gatekeeping' responsibilities with local NHS consultants to reduce the number of OATs referrals and in particular reducing the levels of tertiary referrals to non-contracted providers, including piloting devolved budgets to the cardiologists.

5.4 Priorities

In its second year the PCG intends to look at the following areas:

- to progress the PCG's vision for a community hospital by engaging in the debate over the future of St Mary's Hospital and the Portsmouth Hospitals NHS Trust's Private Finance Initiative (PFI)
- to develop services in the primary care setting where appropriate to improve access to services for patients
- to work in partnership with all agencies to re-engineer services for elderly people
- to work in conjunction with other PCGs and other commissioning sub-groups to jointly review services
- to develop further opportunities for collaborative commissioning with neighbouring PCGs and the Health Authority
- to investigate the feasibility of moving to longer term service agreements focused around care pathways, looking initially at asthma
- to develop effective services for asylum seekers, in recognition of the significant numbers now placed within Portsea Island
- to develop and implement plans in line with the National Service Frameworks within Mental Health, Coronary Heart Disease and older people

In reviewing the commissioning of services the PCG will look to ensure that quality, effectiveness and value for money from current service configurations are being provided. Services will be re-configured where appropriate in conjunction with our local healthcare partners. Patients and/or carers will be involved in all such discussions.
In order to improve some services, additional funding may be required and the PCG will look to access new funding where opportunities become available. The PCG will also look to re-

configure and disinvest in services, where appropriate, to allow development of priority areas.

5.5 Waiting Lists and Emergency Service Issues

The PCG will continue to seek more effective and innovative ways of managing demand for both elective and emergency services. It will continue to play a role in the district wide groups such as the waiting list taskforce, demand management group and the winter pressures group. It will work with local constituency members and local partners to develop local solutions to improve access to services, preventing admissions and delayed discharges by taking a whole system approach to the provision of care.

6. Developing primary and community services

6.1 Introduction

One of the PCG's major responsibilities is the development of primary care and the PCGs detailed plans for the next three years are set out within it's Primary Care Investment Plan which was completed in Autumn 1999.

6.2 Primary Care Available Funding for Portsea Island

The PCG receives general medical services funding from the Health Authority in respect of:

- cost rent scheme
- practice and health centre staff
- computer maintenance and purchases
- investment in premise/improvement grants
- staff relief and training

In addition the PCG receives primary care modernisation funding which has been used, in part, to fund inflation uplifts to GMS (General Medical Services) and to provide growth funding for new reimbursements.

In 1999/00 the PCG received recurrent funding of £2,653,000 for cash limited GMS, (which included primary care modernisation funding of £245,000). For 2000/01 the Health Authority has confirmed that this recurrent funding will be rolled forward and a further addition will be made from primary care modernisation sources. An uplift of 2.76% for inflation (£73,000) and £105,000 for growth has been agreed from primary care modernisation funds. The planned application of the available funds during 2000/01 could be summarised as follows:

Programmes	Budget
Cost Rents	£143,872
Practice and HC Staff	£2,224,825
Training and Relief	£103,418
Computer Maintenance	£75,000
Investment in IT	£0
DDRB Funding reserve	£14,067
Available reserves	£269,818
Total	**£2,831,000**

Commitments against the available reserve funding include: increased cost rents, additional computer maintenance costs, to manage in year financial risks and to be considered against bids received from practices for primary care developments.

6.3 Staffing, Relief and Training

The PCG intends to continue the tasks set out in its 1999/00 Business Plan. These include a number of significant tasks which need to be undertaken to gain more detailed understanding of current staffing levels, grading, employment contracts, baseline staffing needs, equity between practices, future workforce needs and responsibility and accountability for the GMS cash limited staff budget and growth. The PCG will support the dissemination of best practices in recruitment and retention of staff and assist in a comparative post evaluation initiative.

The PCG will continue to work with practices through the practice managers group to identify the best way of managing the relief and training budgets. If supported by the practices, consideration will be given to find ways to devolve responsibility for this budget to practices.

6.4 Premises

For 2000/01 the main focus of the PCG will be to address the needs of DDA, health and safety and achieving minimum standards in practice premise within Portsea Island PCG. The PCG will work with those practices seeking to relocate premise, including incorporation of practices within Health Living Centres. The PCG will continue to seek to improve the facilities in Somertown Health Centre in order to offer better access and standards of accommodation for practices and their populations.

6.5 I.T.

Investment in IT was a major priority for the PCG in 1999/2000 to ensure all practices were Year 2000 compliant. Therefore investment in IT will not be a major priority for the PCG in 2000/01. However the PCG will support those developments felt necessary to ensure functionality and RFA compliance.

The work as set out and agreed in the district Local Implementation Strategy (LIS) will continue, with the PCG IM&T sub group overseeing the PCGs contributions to this programme. The roll out of the NHSnet to practices will continue during 2000/01, as well as the implementation of the clinical coding strategy within the PCG.

Practice based training will be developed to ensure that each practice has a minimum skills base.

6.6 Prescribing

The PCG has two main aims for its approach to prescribing. Firstly, it will promote high quality cost effective prescribing amongst all practice members of the Portsea Island PCG and secondly it will promote work with secondary care to develop and ensure coherent prescribing. In light of the financial pressures facing primary care prescribing costs much of the PCGs work during 2000/01 will be to try to minimise the impact of the increased costs for practices.

In 2000/01 the PCG will:

- develop and manage the prescribing budget for Portsea Island PCG. This will include the setting of individual practice prescribing budgets for 2000/01 and monitoring individual practice performance against agreed budgets
- maintain and improve the quality of prescribing by promoting " best practice prescribing" in key areas
- develop and implement a practice incentive scheme for 2000/01, learning from the 1999/2000 scheme
- ensure practices have opportunity to access pharmaceutical advice as necessary
- assist Community Pharmacists working in practices and those involved in the HImP development
- manage the introduction of new drugs, in accordance with D&TC recommendations
- assist in the development of nurse prescribing
- liaise with the Health Authority in other projects e.g. clinical audit

6.7 Secondary Care Services provided in Primary Care

The PCG reviewed the provision of primary care physiotherapy and counselling services during 1999/2000 for equity and quality of service. These reviews supported the continuation of these services.

The PCG will consider further projects to increase, where appropriate, the secondary care services provided in primary care in order to make services more accessible to patients. This will include services provided by pharmacists, optometrists and dentists if appropriate. Attention will be given to moving chronic disease management, outpatient and minor surgery clinics into primary care if feasible and appropriate.

6.8 Community Nursing

The PCG intends to progress the following projects:

- roll out of the District Nurses as Care Managers initiative across the City to all practices
- implement of the national nurse prescribing initiative
- develop a of specialist diabetic service within the practice setting
- give consideration to the development of respiratory nurses within the practice setting
- develop nurse triage within practices
- move towards further integration of community nursing teams with practice nurses

6.9 Collaborative Projects with Social Services

A series of general and client group priorities have been agreed with Portsmouth City Council social services department for 2000/01.

General:

- production of version four of the joint Health and Social Services Directory
- seek further opportunities for joint appointment working across both Health and Social care

Children:

- development of a Strategy for Children with Disabilities
- agree future management arrangements for the Portsmouth Joint Exceptional Needs Initiative
- take forward the work of the Portsmouth Child and Adolescent Mental Health Sub Group established to explore joint working opportunities
- achievement of Quality Protects focusing on meeting the requirements for health assessments for looked after children
- develop the Sure Start initiative centred around the Somerstown area

Homeless:

- health input into the Rough Sleeping Initiative through provision of outreach primary care services
- collaboration with the Housing department regarding agreement of, and implementation of its strategy for Homeless People

Asylum Seekers:

- in conjunction with both Social Services and the local NHS Trusts, to provide support for GP practices by establishing nurse led triage centre for initial health status assessments of asylum seekers

Older People:

- implementation of action points arising from the Joint Investment Plan for Services for Older People
- development of integrated services for older people through the Older Peoples Partnership Board
- to identify winter pressures and demand management initiatives

Mental Health:

- appointment of a joint commissioning manager for adult mental health services
- further development of integrated Health and Social care service provision within the City

Physical Disability:

- continue discussion and development of community rehabilitation teams to support physical disability (particularly ABI and other neurological problems) in under 65s and contribute to the development of the Joint Investment Plan (JIP)

7. Financial framework

7.1 2000/01 Budget

PCG budgets will be based upon the rolled over recurrent budgets from 1999/00, transfer of budgets from the Health Authority central control, and inflation/growth uplifts as agreed in the SAFF process. The Health Authority is not yet able to propose initial Primary Care Group budgets for 2000/01 in full, however initial budgets have been produced encompassing those elements available.

Programme Heading	**£000s**
Prescribing (inc. 8.8% uplift and after agreed topslices)	13,678
GMS/Primary Care modernisation (inc 2.76% inflation uplift and £105k growth)	2,831
HCHS (current private provider and ECR elements only)	150
Management Costs	415
Total	**17,074**

* Excludes FH/Commissioning Pilot savings carried forward

In addition to these notified budgets the PCG is anticipating budgets in respect of:

- allocation of the PCG element of service agreements for 2000/01
- allocation of funding in respect of pace of change
- increased allocations for HCHS and management budgets in respect of the further devolution of commissioning agreed with the Health Authority
- Other modernisation funds e.g. waiting list and winter pressures

The Health Authority will provide updates of the PCG budget when further information is available, although it is anticipated that the analysis of service agreements will take several months due to the time taken to undertake the process of agreeing the PCG splits of the service agreements with the providers, and the extended range of services now devolved to PCGs.

7.2 Baseline and Distance from Target

The PCG remains, on current calculations, some distance below equity, with updated population figures actually moving the PCG further from target.

Initial calculations by the Health Authority illustrated that the PCG is 5% below its equity (or "fair shares") target. However this does not take into account the pace of change funding anticipated from the Health Authority, nor does it reflect the revised usage of service agreements within the PCG. Once these two factors are included within the calculation the PCG should move closer to equity, although by how much is not known.

7.3 New Funding

The PCG will have the opportunity to bid against small pockets of additional modernisation funding currently being retained centrally by the Health Authority. In addition the PCG needs to ensure that it considers all opportunities to access additional funding for service developments during the year and for future years.

It is not yet known what impact the recent Chancellors budget announcements for the Health Service will have on the Health Authority and the PCG. However the funding may be significant. The PCG will work with the Health Authority and other PCGs to develop plans for the utilisation of any additional funding received.

7.4 Risks and Risk Management

The PCG will be required to manage its over and under spends in year, with any overspends being required to be covered from future years funding, whereas in 1999/00 the Health Authority managed this risk for NHS service agreements.

The main areas of risk are within prescribing, GMS, and referrals to Trusts (including private providers) with whom the PCG does not have a service agreement (initiated either from primary care or tertiary referrals from our local Trusts).

A contingency will be kept within the prescribing budget to provide for the potential in year risks of overspends and the impact of the incentive scheme. Primary care funds will not, initially, be fully committed and will be held as a contingency to in year risks.

The majority of HCHS expenditure will be on a block basis, and consequently will limit the risk to the PCG. However, there is an in-year risk against the volume related service agreements and the non-contracted provider budget. The non-contracted provider budget will

increase to reflect the increased level of services commissioned by the PCG. There are no specific additional funds to act as a contingency for this element and therefore activity charged against this sum needs to be controlled and managed carefully.

8. Quality and clinical Governance

8.1 "A First Class Service"

This publication forms the foundation for the PCG's approach to quality and clinical governance (CG). It underlines the need for an inclusive, collaborative approach to improving the quality of healthcare based on commitment to high standards, reflective practice, risk management and personal and team development. The PCG will support the development of an open, blameless and learning culture among its constituent practices and key partners. The patient experience is given new emphasis by including information from national and local surveys and complaints investigations. Last year's successful patient's conference will be repeated this year and recommendations from last year's event can be found in the action plan appended to this document. Clinical governance (CG) brings with it a statutory duty of quality and lifelong learning.

8.2 Quality in Primary Care

In 1999 Clinical governance leads were nominated from every practice and they will continue to meet as a multi disciplinary group to devise the PCG approach to CG and support individual and groups of practices. The baseline assessment that was conducted in individual practices last year has been co-ordinated into a single summary document and a development plan formulated based on expressed practice priorities of:

- Improving the quality and usefulness of data in primary care (starting with diabetes, asthma, mental health and coronary heart disease)
- Diabetes standards, guidelines and education
- Practice nursing developments and accredited education
- Creating time for multi disciplinary reflection/education and audit

We will also continue to pursue work commenced last year including:

- Agreeing an approach to support practices with GMC revalidation through audit and the development of personal learning portfolios
- Links with District CG group
- Agreement over local/ district information sharing and reporting for CG
- Commitment to continuing professional development on a practice and PCG basis.
- Greater patient involvement

8.3 Quality in Service Commissioning

The PCG intends to continue to participate in the interagency forum "Quality Partnerships" in order to enhance the partnership approach to monitoring quality based on total patient experiences. The programme of work associated with this group is likely to be based on current quality requirements in the SaFF and new NHS Charter and will include

- Mental health services
- Hospital Nursing
- Communications between primary and secondary care – especially regarding admissions to and discharge from hospital
- Patient involvement
- Care pathways in asthma
- Other HImP priorities

The PCG intends to take greater interest in the quality of services it commissions and will set up a number of new initiatives to ensure that quality is improved wherever it falls short of agreed standards and requirements and that providers are informed when a service appears to be surpassing agreed standards. These initiatives will include a "Prompt" scheme for individual practice members to alert us to areas where services appear to be a cause for celebration or concern based on real general practice and patient experiences.

8.4 Clinical Quality "Interface" Issues

In addition to the intentions outlined above, the PCG wishes to encourage opportunities for multi disciplinary education and learning based initially on HImP priorities.

The PCG also hopes to increase the number of collaborative audits undertaken and thus provide additional opportunities to learn from best practice (e.g. diabetes, thrombolysis, anti-biotic prescribing and infection control). The use of clinical indicators will also assist in such collaborative ventures.

9. Organisational Development

9.1 Board Development and Communications in PCG

Building on previous time out sessions for board and management team, the PCG will continue to develop effective communications in three areas

- to engage all members of the Board in planning and decision making
- to ensure all practices are actively involved and supported
- to involve patients and public in the work of the PCG

To progress in the first two areas the PCG will continue to set up regular time out sessions for the Board and will agree individual objectives and development/support plans for all its members. We will continue to develop the newsletter and enhance the role of the constituency nurses, practice managers and GPs in communications, and complement this work with further practice visits by the Chairman and Chief Executive. We also hope to

establish better IT links using electronic communications more effectively, ensuring that people have the necessary support and training to do this.

The detailed action plan in the appendix highlights the main milestones in a programme of work for involving public and patients alike and incorporates agreed recommendations from our lay member, the CHC, members of the public attending Board meetings, and the report from the Patients Conference and national and local surveys.

9.2 Human Resources

The PCG believes that its greatest assets are the diversity and experience of the partners it engages in pursuit of its aims and objectives. Every opportunity will be taken to ensure that practice based staff along with the PCG Board and management team are supported and developed in ways that will assist the PCG in attaining its goals. Opportunities will also be sought to work with colleagues in the two local NHS Trusts, the city council and voluntary sector on Human Resource issues – for example sharing training programmes based on HImP priorities.

The "Working Together" national strategy asks the PCG to demonstrate its preparedness and commitment to sign up to the requirements set out within it which reflect best practices in employment terms and conditions and the empowerment of staff. The PCG will work with the HA and the other PCGs to ensure that this document is complied with once additional guidance on the specific requirements becomes available.

9.3 Health Quality Standards and PCT guidance

The PCG has worked with "HQS" (a Kings Fund Organisation) during the pilot phase of the PCG OD standards development and has used the tool to identify its organisational development needs as it establishes itself and examines its fitness for operating at level 2 and beyond. Further development sessions will be held to ascertain the benefits of moving to PCT status and all subsequent development needs to meet national requirements.

Priorities for organisational development (OD) are set out in the OD plan approved by the Board in February 1999 and include

- team building
- clarity of roles/contributions to business plan objectives
- developing inter agency approaches to patient centred commissioning/service provision
- capitalising on prescribing progress
- clinical governance arrangements and supporting culture
- use of PCIP to develop collaborative work in primary care (e.g. comparative evaluation of staffing needs, information sharing, bulk purchasing etc)
- arrangements for sound financial performance, service quality and clinical governance, human resources issues and performance monitoring.

10. Monitoring and Review

There is a Health Authority/PCG accountability agreement that will be used to monitor performance and progress along with the action plan appended to this report in a similar way to that used last year.

At a minimum a mid-year and end of year review of the action plans will be reported to the PCG Board and the Health Authority. As new requirements become known from the NHS Executive and other sources these will be incorporated.

The steering group that has representatives of all General Practices involved in the PCG will continue to be the main forum for involving GP partners in the debate about the performance and direction of the PCG. The sub groups and task groups established by the PCG will be the main vehicle by which the PCG achieves its business and involves partners both within and outside the NHS. Subgroups and task groups will report to the main PCG Board.

The PCG will also continue to seek feedback on its performance and aspirations from local people and patients.

Action Plans

DEVELOPMENT AREA		Link to HA Plan	TIMESCALE
1.	**Area 1. Improving Health**		
1.1	Continue the Strategic Planning and Partnerships subgroup to develop agreed priorities in health and social welfare services and extend to include services for children		Ongoing
1.2	Continue to contribute to City-wide strategic agendas relevant to improving the lifestyles and environment of local people – City Council Health Plan, Crime and Disorder Strategy, Anti-poverty plans and Social Regeneration Initiatives.	3.18	Ongoing
1.3	Develop PCG wide approach to "Health Needs Assessment" to be used to inform all aspects of service planning – including HImP, interagency plans and primary care developments	1.10	By midyear review
1.4	Develop action plans, local targets and monitoring arrangements for local HImP priorities: • Coronary heart disease and stroke • Cancers • Accidents • Asthma • Diabetes • Mental health • Screening programmes • Children's services focusing on : teenage pregnancies, CAMHs, and children with disabilities • Stress • And contribute to other care groups and service plans	1.10 1.1, 1.5 1.4 1.8 1.6 1.12 1.3, 1.6, 3.18 1.12	Ongoing
1.5	Contribute to District wide discussions on resourcing health inequalities and accelerating pace of change for the PCG		Ongoing
1.6	Develop the PCG as an associated Health Action Zone, including developing bids to attract additional funding into the PCG to improve the health of the population	1.5,1.14,1.7	Ongoing
1.7	Develop a prison HimP in conjunction with Kingston prison and work with them to deliver health improvements for the prison population	1.9	Ongoing
Area 2. Service Commissioning			
2.1	To contribute to the Health Authority wide Service and Financial Framework development for 2000/01, maximising benefits to the PCG	3.15,5.8	April 2000
2.2	To negotiate and monitor service agreements with providers to ensure adequate access to services for patients in 2000/01	3.3	May 2000
2.3	Undertake regular waiting list monitoring exercises and ensure no patients are waiting excessively for in patient services	3.1	Ongoing

DEVELOPMENT AREA		Link to HA Plan	TIMESCALE
2.4	Continue to work with HA, Trusts and Social Services to develop and monitor whole systems projects which prevent unnecessary hospital admissions, delayed discharges and improve access and configuration of services (e.g. rehabilitation and diagnostic services reviews)	3.4,3.6,3.11	Ongoing
2.5	Future of St Mary's : progress the development of a community hospital model within Portsea Island, in line with the outcome of the consultation with GPs and the Health Authority scenario plans		Ongoing
2.6	Identify and develop opportunities to establish longer term service agreements based around a care pathway	3.12	Ongoing
2.7	Respond to, and develop and implement plans, in line with National Service Frameworks and look towards opportunities for service integration with Social Care within : • Adult Mental Health (including the further development of the Locality Implementation Team) • Elderly People (through the Older People Partnership Board) • Services for people with Coronary Heart Disease (including implementation of the aHAZ initiatives)	2.3 1.6 1.7, 3.8 1.5	 Ongoing Ongoing Ongoing
2.8	Movement of Secondary Care services to Primary Care : • Develop secondary services within the primary care setting where this is appropriate and in line with aspirations expressed in the baseline questionnaire (where these can be delivered to agreed quality and efficiency standards). • Monitor those schemes already implemented		Ongoing
2.9	Consider opportunities for the development of HCHS practice based incentive schemes for 2001/02		Ongoing
2.10	Quality in Service Commissioning : Participate in the interagency Quality Partnership and its agreed programme of work which will include : • Mental Health services • Hospital Nursing • Communication between primary and secondary care • Patient involvement • Care pathways for asthma The PCG will also undertake to introduce the 'Prompt' scheme for practices to allow compliments and criticism of services to be provided to the PCG	4.5, 3.7	Ongoing June 2000

DEVELOPMENT AREA	Link to HA Plan	TIMESCALE
Area 3. Primary Care and Community Services Development		
3.1 Further develop arrangements to implement "A first class service" in primary care	4.3,4.4,4.10,6.2,	
• Agree Clinical Governance programme of work for 2000/01 and beyond		June 2000
• Support practices in GMC revalidation through development of personal learning portfolios		Ongoing
• Agree programme and participate in collaborative and interface audits		Ongoing
• Hold two educational events to disseminate best practice		March 2001
• Improve the quality and usefulness of data in primary care (commencing with asthma, diabetes, mental health and coronary heart disease)		Ongoing
• Establish and implement diabetes standards, guidelines and education for primary care	4.7	Ongoing
• Create time for multi-disciplinary reflection and education and audit		Ongoing
3.2 Public Involvement		
Agree and deliver public, patient and carer involvement programme of work including	2.13	
• Run a patient conference in conjunction with the City Council and promote the work of the associated Health Action Zone		October 2000
• Public Education campaign aligned to HImP		Ongoing
• Develop action plan from patient survey	4.2	Ongoing
• Develop practice based patient involvement schemes		Ongoing
• Continue to respond to requests for presentations and discussions with neighbourhood fora		Ongoing
• A plan for involving traditionally "hard to reach" groups (e.g. ethnic minority groups, lone parents, housebound etc)		By October 2000
• Participation in HA and Quality partnerships programme of work for promoting independence and using patient experiences to improve services		Ongoing
• Update practice based leaflets explaining PCG and how public can be involved		By June 2000
• Review effectiveness of public involvement in Board meetings		Ongoing
• Develop and implement a plan and build capacity within the population for the prevention and management of stress in the population		By Feb 2000
• Develop plans to support the carers of older people	3.8, 4.9	By Jan 2001
• Continue the development of the PCG local health charter	4.1	Ongoing

DEVELOPMENT AREA	Link to HA Plan	TIMESCALE
3.3 General Medical Services :		
• Evaluate flexibilities available to the PCG such as aHAZ premise flexibilities and PMS pilots and take forward those which are perceived to advantage the PCG		By Jan 2001
• Develop action plans in conjunction with practices to ensure compliance with the DDA section 21 requirements by 2004. Develop investment plans to support the implementation of these plans.	2.2	Ongoing
• Continue post evaluation project with a view to promoting best HR and employment practices within the PCG		Ongoing
• Continue to develop the primary care investment plan, achieving targets for improvement of premise, staffing and IM&T for practices	6.1, 6.3	Ongoing
3.3 Nursing		
• Develop nursing network to ensure effective involvement of nurses in PCG		Ongoing
• Roll out revised District Nurse as Care Manager initiative across city		Ongoing
• Work with Health Authority and Trusts to develop and implement an action plan relating to the nursing strategy 'Making a Difference'	2.21	Ongoing
• Identify opportunities for improved nursing services through changes in practice or greater collaboration		Ongoing
• Establish specialist diabetic services in practices		Ongoing
• Consider the options for establishing respiratory nursing in practices		Ongoing
• Pilot and develop nurse triage in practices		Ongoing
• Develop a programme of practice nurse development (CPD)		Ongoing
3.5 Prescribing	6.4	
Set practice based budgets for 2000/01		By May 2000
• Ensure prescribing budgets are contained within cash limits and monitor incentive scheme		Ongoing
• Review budget setting and incentive scheme procedures for next financial year		By Dec 2000
• Provide practice based pharmaceutical support where requested and promote best practice prescribing in individual practices in key areas and across PCG (including antibiotics)		Ongoing
• Manage the introduction of new drugs in accordance with D&TC guidance.		Ongoing
• Hold a half day prescribing workshop for practices within the PCG		By Nov 2000
• Implementation and further development of the national nurse prescribing initiatives		Ongoing
• Provide support to practices to realise disinvestments proposed by the D&TC		Ongoing
3.6 Undertake a review of access to GP surgeries including a review of appointment systems in place, in order to identify and promote best practice.		By Dec 2000

DEVELOPMENT AREA		Link to HA Plan	TIMESCALE
3.7	Work with practices, co-operatives, deputising services, NHS Direct, the Health Authority and other services to explore and develop further integrated access to primary care	2.1	Ongoing
3.8	Implement local PCG information strategy including "Information for Health" priorities including : • Link all practices to NHS net • Implement and support practices in the development of the agreed clinical coding strategy • Provide practice based training to ensure minimum skill bases in all practices • Develop sharing of information between practices further • Develop IT investment plans, setting out priorities for the next three years • Contribute to the development plans to meet the requirements of the Data Protection Act, Caldicott Guardians and national records management guidance	2.10	 By Sept 200 Ongoing Ongoing Ongoing By Dec 2000 Ongoing
3.9	Collaborative work with PHCT / Social Services – Children • Develop a joint strategy for children with disabilities • Agree the future management of JENI • Produce and implement action plan for better integration of child and adolescent mental health services • Implement agreed actions for Quality Protects , Sure Start and Crime and Disorder strategy	 2.3 	 By Oct 2000 Ongoing Ongoing Ongoing
3.10	Collaborative work with Social Services – Homeless People • Provide and monitor outreach primary care services • Work with the City Council to agree a homeless strategy and its implementation		Ongoing
3.11	Collaborative work with PHT/PHCT/Social Services – Asylum Seekers • Establish a nurse led triage centre for initial health status assessment		 April 2000
3.12	Collaborative work with PHCT/Social Services – physical disability services • Participate in the development of the Joint Partnership Board • Further develop schemes for supporting people in the community using rehabilitation teams (notably younger physically disabled people)	 3.10	Ongoing
3.13	Collaborative work with Social Services – Other/General • Develop integrated OT services • Participate in the development of Joint Investment Plans for Older People and Mental Health • Hold information workshop for staff groups in October • Review posts as vacancies arise for opportunities for shared posts • Produce version four of the joint Health and Social Services directory • Examine feasibility of shared office accommodation	 2.3 3.9	 Ongoing Ongoing October 2000 Ongoing Dec 2000 Ongoing

DEVELOPMENT AREA		Link to HA Plan	TIMESCALE
3.14	Collaborative work with other primary care providers • optical services • pharmaceutical services • dental services		Ongoing
Area 4. Organisational Development			
4.1	Develop Business Plan, Primary Care Investment Plan and accountability agreements	7.2,7.3	Ongoing
4.2	Develop robust financial plans and financial monitoring /reporting mechanisms including assessment of financial risks	5.1,5.2,5.3,5.4	Ongoing
4.3	Participate in the Health Authority led review of the PCG boundaries within Portsea Island and East Hampshire	2.18	May 2000
4.4	Ensure that the PCG adheres to national HR guidance (e.g. E.U. Working Times directive) and is able to demonstrate its preparedness to sign up to the requirements of "Working Together" in terms of best practices in employment, recruitment and retention of staff and workforce planning	2.4,2.11	Ongoing
4.5	Continue to monitor the effects of lack of co-terminosity of PCG boundaries	2.18	Ongoing
4.6	Discuss the potential development of the PCG to PCT status	2.17,2.19	Ongoing
4.7	Hold programmed 'time out' sessions for the PCG Board to allow its development		Ongoing
4.8	Contribute to the Health Authority work programme of risk assessment and controls assurance		Ongoing
4.9	Devise plans to enhance the inputs from Health Authority managed functions including : • Finance • Human Resources • IT and information • Public Health and Quality	2.8 2.12	Ongoing
4.10	Review and revise PCG Board roles and management resources to meet the new agenda of the PCG	2.8,3.13	Ongoing
4.11	Reassess personal and team development needs and develop plans to address identified shortfalls	2.8	Ongoing

Agenda Item No:
No: 6.1

2001/2002 HOUSING STRATEGY UPDATE

Background & Summary

A copy of a presentation on the 2001/2 Housing Strategy Update is attached outlining:

- Why we have a strategy
- Feedback from GOSE on 2000/1 Strategy
- What is proposed for 2001/2 Strategy
- Portsmouth Housing Service

Recommendations:

The Board is asked to comment on the presentation

Date: 29 March 2000

Paper Prepared by: Helen Keates, Housing Initiatives Manager, Portsmouth City Council

2001/2 Housing Strategy Update

Portsmouth
CITY COUNCIL

/2 Housing Strategy Update

Portsmouth
CITY COUNCIL

1 Why we have a strategy

2 Feedback from GOSE on our 2000/1 strategy

3 What we propose for 2001/2

4 Your involvement

5 Questions/discussion

Why we have a strategy

Portsmouth CITY COUNCIL

- We have over 200,000 customers, a budget of £100m and over 500 staff - we need a strategy to run our business
- It is a government requirement
- It helps other organisations and our customers see where they fit in

Portsmouth
CITY COUNCIL

dback from GOSE on 2000/1 Strate

- Rated best authority in South-East Region so we got more money (£500,000 per year)
- Liked both Minority Eth and main Housing strategies
- Excellent performance programme delivery
- Extensive resident involvement
- Good links with housing associations, both in new build programme and Empty Property Campaign
- Effective joined-up and interagency approach
- Tackling private sector problems well

Portsmouth
CITY COUNCIL

What We Propose for the 2001/2 Strategy

- An **update** of the 2000/1 strategy
- Shorter, focusing on which programmes and initiatives we will do in 2001/2
- Retain same 4 aims and 12 objectives listed in 2000/1 strategy
- Include all items suggested by GOSE:
  - business planning
  - single homeless strategy + ME strategy topics
  - Supporting People
  - Portsea benefits initiative
  - planning gain

Portsmouth Housing Service

Portsmouth
CITY COUNCIL

- Who knows the issues best:
  - us in the council?
  - People who deal with it every day?
  - We think it's you!
- Can you or your organisation suggest **three things** you would like Housing to do that we are not already doing and which would assist you
- Put them on the form supplied and return either at the end of the session, or post to the address on the bottom

PORTSMOUTH HOUSING SERVICE

2001/2 HOUSING STRATEGY UPDATE

Name: _____

Organisation: _____

Housing could do the following things to improve the way my organisation delivers its service:

1. _____

2. _____

3. _____

Please return form within 1 week to: Helen Keats (Housing Initiatives Manager), Housing Service, Portsmouth City Council, Civic Offices, Guildhall Square, Portsmouth, PO1 2AX

Agenda Item No:

6.2

CHD Bid against HImP Performance Fund

Background & Summary

As an associated Health Action Zone, Portsea Island PCG was invited to submit a national bid against the HImP Performance Fund to develop coronary heart disease projects to tackle some of the health inequalities that exist on Portsea Island.

The attached bid was submitted to South East Regional Offices, and was one of three bids from the Region to be put forward to the national bidding round. A letter was received from Regional Office on 16th March 2000 with notification that the bid had been successful, and the sum of £439,000 per annum for 3 years would be allocated to Portsea Island PCG to put the projects into place.

The PCG has been asked to treat this information as confidential until a Ministerial announcement in early April.

The HAZ Projects Manager is currently working with partner agencies to fully develop the projects outlined in the bid, and a Steering Group has been set up to provide support for the work.

Recommendations:

The Board are asked to note the content of the bid.

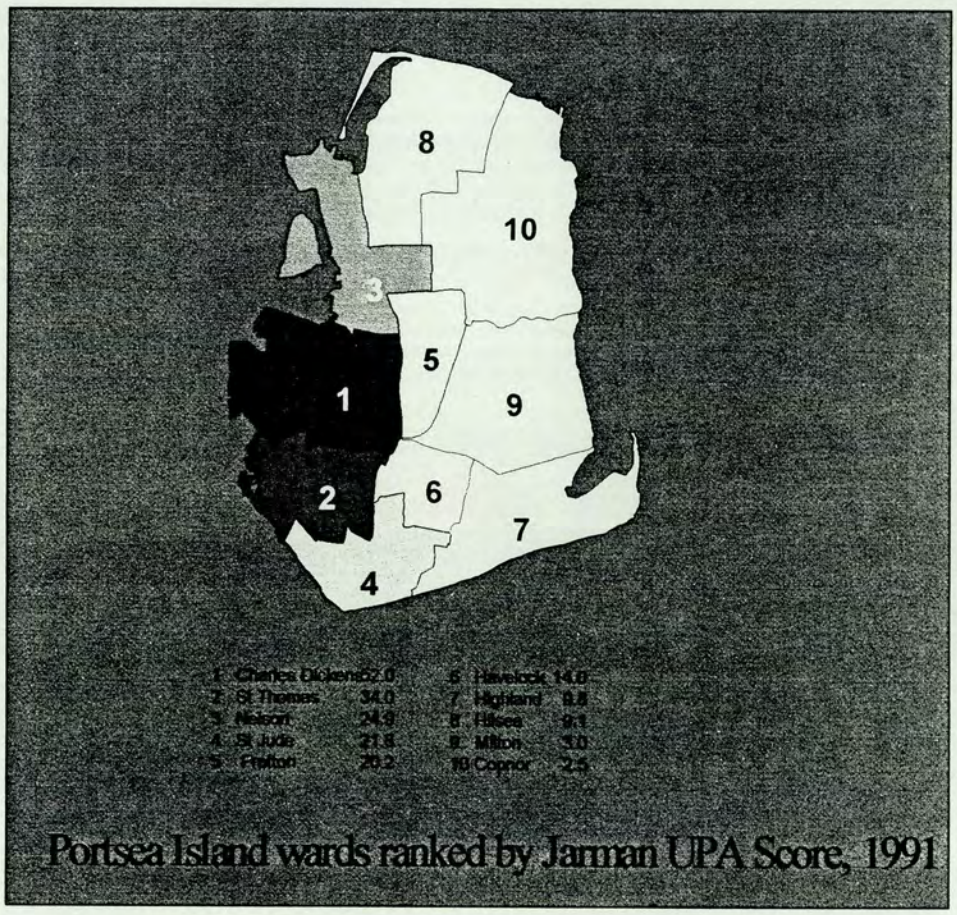
Date: **31 March 2000**

Paper Prepared by: **Jackie Charlesworth**
HAZ Projects Manager

PORTSMOUTH & SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PORTSEA ISLAND PRIMARY CARE GROUP

Bid for Funding for Coronary Heart Disease Prevention Schemes



16th March, 2000
Portsea Island Primary Care Group

ENDORSEMENT OF THE CORONARY HEART DISEASE BID

This paper is a bid for HImP Performance Reward Scheme funding to support coronary heart disease prevention schemes in community and primary care settings within the Portsea Island PCG area. It has been co-ordinated by Portsea Island PCG in partnership with Portsmouth & South East Hampshire Health Authority and Portsmouth City Council.

Endorsed and signed by

Sheila Clark
Chief Executive
Portsea Island Primary Care Group

Penny Humphris
Chief Executive
Portsmouth & South East
Hampshire Health Authority

Nick Gurney
Chief Executive
Portsmouth City Council

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PORTSEA ISLAND PRIMARY CARE GROUP

Bid For Funding For Coronary Heart Disease (CHD) Prevention Schemes

Introduction

This paper is a bid for HImP Performance Reward Scheme funding to support coronary heart disease prevention schemes in community and primary care settings within the Portsea Island PCG area. It has been co-ordinated by Portsea Island PCG in partnership with the Health Authority and Portsmouth City Council. It has also taken into account results of recent public consultation events, such as the Lifestyle Survey, a public conference entitled "Working Together to Build a Healthier City" which took place in September 1999 and a Citizens' Jury which took place in March 1999. Local users, carers and residents of Portsea Island will be fully involved in further development of these projects through fora such as the Citizens' Panel and SRB Community Groups.

Portsea Island PCG Perspective

Tackling coronary heart disease has been identified as a HImP and Portsea Island PCG priority and this is motivated by factors such as the increase in frequency of cardiovascular disease in England as a whole. In 1998 20% of deaths to people in Portsea Island constituency alone were as a result of CHD[1]. Contributing factors to CHD have been identified as including smoking, poor diet and lack of exercise. The 1999 Lifestyle Survey reported that 35% of Portsea Island residents smoke, and that Portsea Island PCG residents were the most likely in the Portsmouth and South East Hampshire District to take no exercise. Portsmouth is also recognised as having a high percentage of deprived wards, with a high percentage of the population coming from low socio-economic groups. This deprivation inevitably leads to health care inequalities and is something that needs to be addressed as part of the campaign against CHD and for better health as a whole. Portsea Island PCG has recently become an associated Health Action Zone and has identified the secondary prevention of CHD as one of the priority areas for action.

The people

149,768 people live within Portsea Island Primary Care Group and this population will increase by approximately 2,200 by 2004.

6.2% of the PCG's population is aged under five, and 14.9% aged 65 years and over.

About 35.5% of Portsea Island's elderly population live alone. 4.1% of households on Portsea Island are headed by single parents. 6.9% of the PCG's households are headed by someone belonging to an ethnic minority group **(Fig 1)**.

[1] Portsmouth & South East Hampshire Health Authority Public Health Annual Report 1999

Socioeconomic factors

4.6% of Portsea Island's working population was unemployed at 30 September 1999 - compared with 4.3% of the total working population of Portsmouth City and 3.2% in Portsmouth and South East Hampshire. (**Fig 1**)

23% of the PCG's residents belong to social classes IV and V compared with 20% of Portsmouth and South East Hampshire's residents.

30% of the PCG's residents belong to social classes I and II compared with 34% of Portsmouth and South East Hampshire's residents.

Portsmouth City as a whole is one of the most deprived local authorities in south east England with a Jarman Under Privileged Area (UPA) score of 23.25.

Two wards in Portsea Island are among the most deprived in the country (Charles Dickens (52.0) and St Thomas (34.0)) and three others (Nelson (24.9), St Jude (21.8) and Fratton (20.2)) suffer significant deprivation.

Fig 2 highlights the five most deprived wards in Portsea Island. **Fig 3** shows the Jarman UPA scores of each ward.

Lifestyles

The principal risk factors for coronary heart disease are cigarette smoking, a diet high in fat, lack of exercise and alcohol consumption.

The principal cause of strokes is high blood pressure - with smoking, alcohol consumption, lack of exercise and high fat diet being major contributory factors.

Thirty-five percent of Portsea Island's residents aged over 16 years smoke compared with 29% of residents in Portsmouth and South East Hampshire. (**Fig 4**) Forty-three percent of young people aged 16-24 in Portsea Island smoke compared with 40% of young people in the health district as a whole.

Forty-two per cent drink alcohol above sensible limits compared with 30% in the health district as a whole. (**Fig 4**) Fifty-two percent of men in Portsea Island drink above sensible limits compared with 39% of men in the health district as a whole. Thirty percent of women in Portsea Island drink above sensible limits compared with 20% of women in the health district as a whole.

Fifty-one per cent of Portsea Island's residents eat chips and other fried food at least once a week compared with 46% in Portsmouth and South East Hampshire. (**Fig 4**) Fifty-four per cent of Portsea Island residents eat fruit, vegetables or salad at least once a day compared with 61% in Portsmouth and South East Hampshire.

Thirteen per cent of Portsea Island residents never take any exercise compared with 12% in Portsmouth and South East Hampshire. (**Fig 4**) Fourteen per cent of Portsea Island residents aged 50-64 take no exercise compared with 11% elsewhere in the

district. Thirty-four per cent of Portsea Island residents aged over 65 take no exercise compared with 27% elsewhere in the district.

Major causes of death

In 1999, there were 1,610 deaths to Portsea Island residents – 16% of which were to people aged under 65. Most of these latter deaths were preventable. (**Fig 5**)

Cancers (389 deaths), coronary heart disease (344), strokes (157), other cardiovascular diseases (145) and accidents (19) were the principal causes of deaths to Portsea Island residents (**Fig 5**).

In 1999, Portsea Island resident death rates for cancers (260 per 100,000) and coronary heart disease (230 per 100,000 were higher than those for Portsmouth and South East Hampshire residents (252 per 100,000 and 215 per 100,000) (**Fig 6**).

Coronary Heart Disease

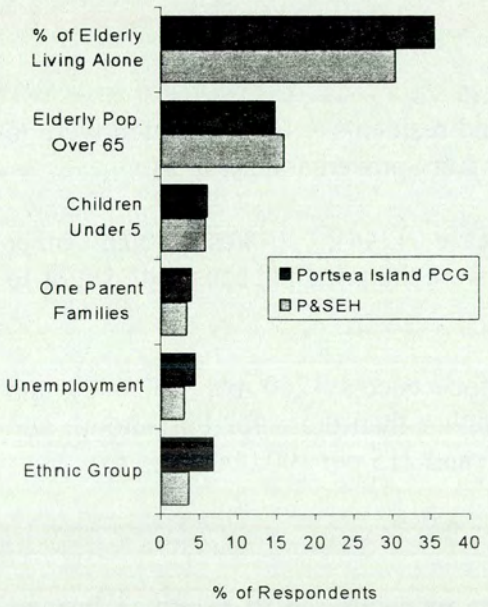
Coronary heart disease is the major single cause of death and ill health to Portsea Island residents.

In 1998/99, coronary heart disease was responsible for 1,053 Portsea Island residents being admitted to hospital. **(Table 1)**.

Of those living in the community, an estimated 5,200 suffer from angina, 9,700 are survivors from myocardial infarction and 21,600 are taking cardiovascular drugs.

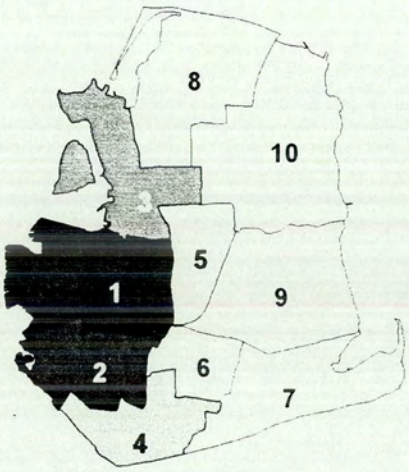
There are about 27,500 people with high blood pressure in Portsea Island, and 41% of these are not receiving treatment.

Fig 1 Selected Socioeconomic Indicators, Portsea Island 1999



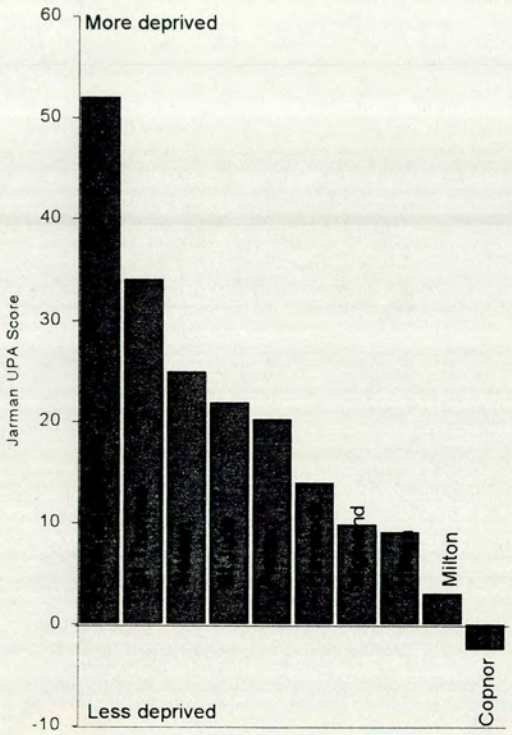
Source: Health and Lifestyle Survey, 1999

Fig 2 Most deprived wards in Portsea Island,1991



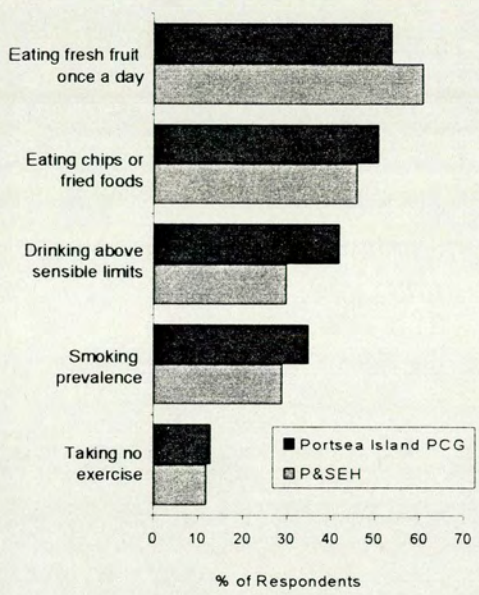
1	Charles Dickens	52.0	6	Havelock	14.0
2	St Thomas	34.0	7	Highland	9.8
3	Nelson	24.9	8	Hilsea	9.1
4	St Jude	21.8	9	Milton	3.0
5	Fratton	20.2	10	Copnor	-2.5

Fig 3 Portsea Island wards ranked by Jarman UPA Score, 1991



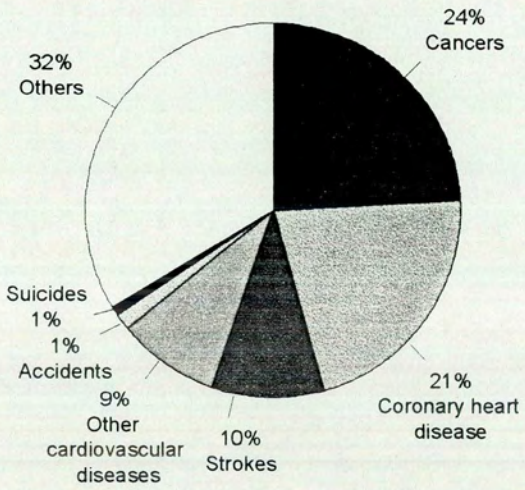
Source: Portsmouth and SE Hampshire Community Health Atlas, 2000

Fig 4 Lifestyle Preferences, Portsea Island PCG & P & SEH, 1999



Source: Health and Lifestyle Survey, 1999

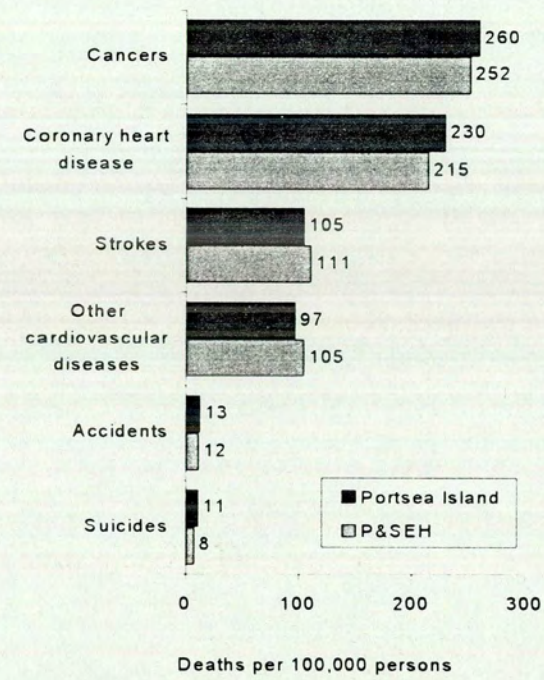
Fig 5 Major Causes of Death, Portsea Island PCG residents, 1999



n = 1610

Source: Public Health Mortality File, 2000

Fig 6 Mortality Rates per 100,000 persons, Portsea Island PCG residents, 1999



Source: Public Health Mortality File, 2000
HCC 1997-based population projections for 1999

Table 1 Burden of CHD

The Burden of Coronary Heart Disease in Portsea Island, 1998/99

	Males	Females	Persons
Coronary Heart Disease			
No. with Angina	3006	2210	5216
No. with Myocardial Infarction	6013	3683	9696
No. Consultations with GPs	3983	2431	6414
No. taking Cardiovascular Drugs	10522	11049	21571
No. Admitted to Hospital*	681	372	1053
Other Cardiovascular Disease			
No with High Blood Pressure	14005	13579	27584
No with Hypertension untreated	7563	8555	11309
No. Admitted to Hospital*	859	770	1629
No. Consultations with GPs	12055	18672	21571

Source: GP Morbidity Survey, HCC 1997-based Population Projections for 1998, HPS February 2000

Local progress made through the Health Improvement Programme

In Portsea Island PCG area there has been substantial progress made through the Health Improvement Programme (1999 – 2002). Namely:

- Smoking policy in place for all NHS premises, all Local Authority headquarters and Cascade Shopping Centre (Portsmouth).
- Healthy Schools Award Scheme in operation to promote non-smoking, sensible diet in all schools. Currently 39 schools received the award and 11 are working towards it.
- Healthy Workplace Award Scheme underway through the Health Workplace Alliance aimed at promoting the health and well being of working adults.
- Healthy University Initiative is a joint venture to address the health promotion needs of university students, who form a large population group within the City.
- Lifestyle survey of Portsmouth & South East Hampshire Health Authority carried out in 1999 to ascertain CHD risk factors in the community. Larger samples taken of areas of higher deprivation to support the process. Detailed maps of risk factor prevalence developed for each PCG and Local Authority.
- Schools survey carried out in Jan 2000 to identify prevalence of CHD risk factors in school children.
- Teacher adviser employed to support the Healthy Schools Initiative.
- PCC banned the advertising of tobacco in its hoardings.
- Plans for smoking cessation service developed and awaiting Department of Health announcement of the HA allocation of funds.
- Regular articles to practice staff on evidence based smoking cessation advice.

- Smoking cessation support programme for pregnant women in place at St Mary's Hospital
- Three breakfast clubs developed in most deprived wards of Portsmouth and one in the most deprived ward in Havant.
- Low cost recipe cookbook developed by Portsmouth City Council.
- An exercise strategy is currently being developed which will include projects already underway such as Prescription for Exercise, Trim-in Project and The Fitness Trial.
- Extensive network of cycle paths developed by Portsmouth City Council and strategy for cycle ways developed by Havant Borough Council and East Hampshire Borough Council.
- All leisure centres (5) provide prescription for exercise
- Project worker to develop Health Living Centre bid, appointed by Portsmouth City Council.
- LEAP Project encourages GPs to identify people at high risk of CHD and advise on risk factor management. 99% of all practices are participating in this project. Two study days for practice nurses, attended by 30 nurses, covered guidelines for prevention and management of CHD in primary care.
- Lipid lowering policy developed and disseminated to all GPs and Hospital Doctors.
- Audit of use effective medication for myocardial infarction patients admitted to hospital undertaken
- Comprehensive coronary rehabilitation service in place for patients who had a myocardial infarction or who had cardiac surgery.
- Cardiopulmonary resuscitation for the public continues and has been enhanced through PCG monies.
- Protocols for investigating / treating people with angina and heart failure developed.
- Pilot stroke service for people 70-74 started in Jan 2000. This is an extension to the highly successful stroke service for 75+.
- Stroke rehabilitation service for 75+ in place. Pilot service for 70-74s started in Jan 2000.
- Public consultation day run by Portsea Island PCG focused on CHD
- Hampshire Ambulance Service is auditing the care patients with suspected myocardial infarction receives using the standards set in the National Service Framework for CHD.
- Smoking cessation advice from 6 community Pharmacists in Portsea Island to promote Nicotine Replacement Therapy.
- Portsmouth Aspirin Project involved community pharmacists in identifying high risk patients eligible for aspirin.

Portsea Island Primary Care Group, Portsmouth Hospitals NHS Trust, Portsmouth HealthCare NHS Trust, Portsmouth City Council and Portsmouth Health Authority are addressing the issue of coronary heart disease through a variety of health improvement projects. The initiatives outlined in this bid aim to complement current prevention/treatment services, support the HImP; Portsmouth City Council Health Plan; CHD National Service Framework and implement new initiatives in the fight against coronary heart disease.

Portsea Island PCG Bid

The table on pages 10-12 displays an outline of the proposed primary and/or secondary prevention initiatives aimed at reducing residents of Portsea Island risk of CHD. These initiatives are not designed to target only those people thought to be most at risk from CHD, but at all residents. They aim to combat CHD by improving health generally, as well as educating residents about lifestyle issues and the disease itself.

These have been compiled in consultation and collaboration between Portsea Island PCG, Portsmouth & South East Hampshire Health Authority, Portsmouth HealthCare NHS Trust, Portsmouth City Council Environmental Health Department and the Urban Regeneration Team who are co-ordinating the SRB process. Emphasis has been placed on initiatives that create 'joined-up' plans with other agencies which will help deliver the HImP objectives for coronary heart disease.

The initiatives have been ranked in order of priority for funding, and the formula used to determine the ranking has been:

- Benefits to local community
- Feasibility of mainstreaming, post initial funding
- Links to HImP Agenda
- Links to wider policy agenda
- Population target group
- Joint working
- Innovation
- Evidence based

The initiatives are described in greater detail from page 13 - 18, and Appendix 1 is an extract from Portsmouth & South East Hampshire Health Improvement Programme 2000 – 2003 detailing the Coronary Heart Disease agenda.

Portsea Island PCG Bid against HImP Performance Reward Scheme - Outline of CHD Initiatives

Rank	Initiative	Benefits	HImP Link	Other Links	Agencies Involved	Est Cost	Monitoring
1	'Can't Cook – Won't Cook' health promotion based on fun cooking education and subsidised sales of ingredients with Tesco Stores PLC *(target group – All)*	Promote healthy eating, leading to improved general health and reduced risk factors of CHD	Objective A2 – to increase the number of people who have a healthy diet *(Specifically A2.1/A2.4/A2.5)*	SRB 5 – Community Café within Portsea Healthy Living Centre City Health Plan (dietary education & advice) SRB proposal – Food & Health Project Worker	PCG/ PCC/ HA/ Commun -ity groups/ Tesco/ local media	£60,000	Lifestyle survey baseline and follow up
2	Secondary prevention of heart disease, including: - Care/exercise programmes & clubs - Lifestyle advice - CHD checkups post MI - LEAP Project - Aspirin Project - Thrombolytic Therapy *(target group – all)*	Secondary prevention clinics have been shown to improve patient's health and reduce hospital admission. Secondary prevention is an important factor in the reduction of CHD mortality.	Objective A4 – to provide accessible and effective services to prevent, treat, rehabilitate and care for people with CHD and stroke *(specifically A4.2/A4.3/ A4.5/A4.6 A41.12/A4.13/ A4.14/A4.15*	City Health Plan (increase physical activity programmes) SRB proposal – Improving access to sporting facilities in Somerstown	PCG/HA/ PHT	£215,000	-Death rates from strokes and CHD to under 75s. -% practice participation in Leap Project. -Statins/ other drug prescriptions in primar care.

Rank	Initiative	Benefits	HImP Link	Other Links	Agencies Involved	Est Cost	Monitoring
				SRB proposal – extension of the 'prescription for exercise' scheme SRB proposal – multicultural centre Prison HImP			- Endarte-rectomy rates
3	'Armchair Aerobics' exercise for the over 60s *(target group – older people)*	General improved physical fitness, and a raising of awareness of exercise options available leading to a reduction of risk factors for CHD.	Objective A3 – to increase the proportion of the local population taking regular physical exercise *(specifically A3.1/A3.5*	City Health Plan (develop health promotion activities for people aged over 50) Prison HImP	PCG/HA	£15,000	-Number of participants who sustain physical activity after completing the scheme.
4	Sponsor exercise and relaxation sessions in the workplace *(target group – adults)*	General improved physical fitness, and a raising of awareness of exercise options available leading to a reduction of risk factors for CHD.	Objective A3 – *(specifically A3.1/A3.3)*	City Health Plan (on-site exercise classes) Prison HImP	PCG/HA/ PCC/ local business commun-ity	£25,000	-Number of participants who sustain physical activity after completing the scheme
5	Walking Bus! and after school clubs for the family *(target group – school*	General improved physical fitness, and a raising of awareness of exercise options available	Objective A3 – *(specifically A3.1/A3.2)*	City Health Plan (implement Safe Routes to	PCG/ PHCT/ HA/PCC	£30,000	- Number of schools taking part in scheme

Rank	Initiative	Benefits	HImP Link	Other Links	Agencies Involved	Est Cost	Monitoring
	children and adults)	leading to a reduction of risk factors for CHD. Also leads to a building of community feeling and a reduction in congestion around the school area.		Schools initiatives)			
6	Community Conservation Projects *(target group – all)*	General improved physical fitness, and a raising of awareness of exercise options available leading to a reduction of risk factors for CHD.	Objective A3 *(specifically A3.1/A3.2)*	City Health Plan 'Green Gym' programme 'Healthy Walks' programme SRB proposal – Somerstown Adventure Playground	PCC/ local communities	£25,000	
7	Improved access to existing leisure centres *(target group – all)*	General improved physical fitness, and a raising of awareness of exercise options available leading to a reduction of risk factors for CHD.	Objective A3	City Health Plan (obesity programme)	PCG/ PCC	£20,000	
8	Healthy Heart Bus tour	Education process leading to improved general knowledge about CHD and a possible reduction of risk factors for CHD	Objectives A1, A2 , A3 *(specifically A1.2/A2.5/A3.1*		PCG/ PCC/ Trusts/ British Heart Foundation	£50,000	- Number of campaigns

Initiatives described in full

1. Healthy Living Café – 'Can't Cook, Won't Cook' – health promotion with Tesco Stores PLC

Aim: To reach the widest target audience possible and improve health within the community as a whole by influencing the development of a community café whose menu is based entirely on 'healthy' diet options.

Background: Tenders are currently being invited by Portsmouth City Council to manage a community 'healthy living café' in Portsea Healthy Living Centre based around the John Pounds Centre in Portsmouth. As part of the franchise the new owners will be required to provide a 'healthy' menu, and to work in partnership with local health professionals and health care organisations. As part of the health promotion that could take place at the café an idea has been suggested involving a 'Can't Cook-Won't Cook' type programme. Discussions are currently taking place with the local television station, local newspapers and local radio stations in order to explore the potential for involving them in these events. Tesco Stores PLC have already indicated that they would be interested in supporting these events, and discussions are underway to define their level of involvement. A format being discussed is to invite celebrity chefs to come and cook 'healthy' and easy meals that would be filmed and broadcast on Meridian TV, and promoted through other media forms. To enter a 'competition' component to the programme these meals will be rated on taste and 'health value' by a dietician and local people. This could also be linked to local schools whose cafeterias could run the same 'healthy' diet and be part of the Home Economics classes. Part of the education process will be to clear up some of the common misconceptions around a 'healthy' diet. A final idea to tie the promotion together is to link this to the cookery book already produced by Portsmouth City Council with details of the menus, and costing of the meals illustrating that eating healthily doesn't necessarily mean eating expensively.

Objectives: To use the Portsea Community Café as a base for opening the Healthy Community Café, by working in close partnership with PCC and the franchise owner. This would, in turn, promote healthy eating leading to improved general health and reduced risk factors of CHD.

2. Secondary prevention of heart disease

Aim: Secondary prevention of heart disease has been shown to improve patient's health, reduce hospital admission, further cardiovascular events and deaths. This initiative will link together a comprehensive secondary prevention strategy across primary and secondary care as well as proposals contained within the Portsmouth City Health Plan , SRB proposals and the Prison HImP that is currently being developed.

Background: : Most health professionals already accept that one of the most effective ways of reducing coronary mortality in Britain is effective secondary prevention. One study showed improved level of general health reduced number of subsequent cardiovascular events, significant reductions in hospital admissions in the

first year post MI and improvements in levels of pain, anxiety and depression.[2] Plans are being developed to address secondary prevention across the spectrum of care as follows:

- **Practice Nurse led 'Heart Clinics'**

Carrick Primary Care Group based in Truro, Cornwall have set up nurse run secondary prevention clinics jointly funded by the PCG and the British Heart Foundation. For a period of two years the BHF will fund a nurse who will 'ease' the discharge of patients from hospital and back into the community. There will also be training available for a lead nurse from each GP practice. The PCG has provided money for each of their 13 practices for a scheme that will involve creating a register of coronary patients, starting a call and recall system and developing improved links with acute care.[3] This proposal would aim to develop the Carrick approach in Portsea Island PCG and incorporate within it all aspects of effective secondary prevention, eg. Lifestyle advice, drug treatment and rehabilitation.

- **Continuation of LEAP project**

LEAP is an audit of the guidelines for cholesterol testing and secondary prevention interventions. The project also organises teaching classes for practice nurses covering the rehabilitation and future care of CHD sufferers. The results of the LEAP project would be targeted to the more deprived wards within Portsea Island. Using the outcomes of the audit, GP's within the PCG would be able to ensure that secondary prevention measures were targeted to people at greatest need.

- **Continuation of Aspirin pilot**

The Aspirin Pilot involved community pharmacies and 10 practices across the Health Authority area in an audit of patients who would potentially benefit from taking low dose aspirin as part of a CHD prevention/treatment scheme. It is proposed to carry out a Portsea Island PCG lead audit assessing the use of prescribing low-dose aspirin to known individuals who would benefit from such treatment. The results of this audit would then be used to inform and develop an approach within the PCG to encourage the use of aspirin as a secondary prevention measure against CHD.

- **Thrombolytic therapy for patients presenting with acute myocardial infarction (AMI)**

The acceptance of thrombolytic therapy as an important treatment for AMI is recognised as one of the major therapeutic advances of the past two decades. It's mortality benefits have been clearly demonstrated in a number of randomised trials, and evidence consistently suggests a clear link between time to treatment and subsequent mortality. This project aims streamline the process from assessment of AMI to receiving thrombolytics across the two acute trust sites within Portsmouth.

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[2] Campbell N " Secondary Prevention Clinics for Coronary Heart Disease: randomised trial of effect on health" British Medical Journal Vol. 316 1999

[3] Details of this project are from a letter from Dr. Hugh Bethell (Secondary Prevention and Rehabilitation Committee, Coronary Prevention Group) & Dr HM Delal GP to the Editor, BMJ.

This project would aim to set up a dedicated cardiac triage bay within the A & E Department at Queen Alexandra Hospital which would be manned by a cardiac nurse specialist, who would provide assessment and initiate thrombolysis for all AMI patients as appropriate. This service will be district wide.

Links with other agendas

The Portsmouth City Council City Health Plan has a number of physical activity programmes which will complement the proposals put forward for a secondary prevention programme for those suffering from CHD. The Urban Regeneration Team is working with local communities to develop three separate proposals looking at issues around access to sporting facilities, prescription for exercise, and a multicultural centre. The PCG already has strong links with both of these agendas, and will be actively encouraging a two-way flow of information/support linking all the proposals. Discussions are also underway with the multi-agency team who are developing the Prison HImP in order to incorporate these initiatives into their proposals.

Objectives: To develop a comprehensive secondary prevention CHD service for the people of Portsea Island which links together services provided by primary care, secondary care and Portsmouth City Council Health Plan. This will provide accessible and effective services to prevent, treat, rehabilitate and care for people with CHD.

3. 'Armchair aerobics' exercise for the over 60s

Aim: This initiative will aim to provide information and access to exercise geared to the over 60 age range, including help to stroke victims and people with reduced mobility.

Background: This is part of the EXTEND scheme which provides trained staff to deliver an exercise programme to older people. It is a fun, gentle exercise regime that can be undertaken either standing, sitting or laying down which will increase mobility and thereby promote independence. The scheme will be piloted in a GP surgery in Portsmouth with the aim of introducing it across the City if audit shows this be a viable proposition. It is proposed to train a member of the practice staff to become an accredited EXTEND instructor.

It is also proposed to offer this scheme to groups of older people who live in sheltered accommodation, older people in nursing and residential care homes, the new multi-cultural centre, leisure centres, community centres, day centres etc. Discussions will also take place with Age Concern Hampshire who are developing a similar scheme which will complement this proposal.

Objectives: To provide access to exercise for older people with reduced mobility, thereby promoting independence. General improved physical fitness and a raising of awareness of exercise options available will lead to a reduction of risk factors for CHD.

4. Sponsored exercise and relaxation sessions at work

Aim: To encourage people in non-manual 'desk bound jobs' to participate in some form of exercise or relaxation during their working day.

Background: Working in collaboration with local employers and through groups such as the Commercial Road Traders Association, we would encourage people to spend their lunch hour doing pre-arranged cardiovascular workouts and/or relaxation sessions. This could take the form of aerobics or swimming for example, and employees would also be encouraged to walk to and from work etc. The PCG would pay for qualified instructors to facilitate the sessions, and suitable venues would be found close to the workplace.

Objectives: To set up regular and suitable exercise and relaxation sessions at local business' or convenient locations in order to encourage healthier lifestyles and promote the benefits of exercise and relaxation in relation to lowering the risk of CHD.

5. **Walking bus! and after school clubs for the family**

Aim:

- **The Walking Bus!**

The idea behind the 'walking bus' is that adults (preferably parents of the children at the school) walk along a set route to school picking up children along the way. The children all walk to school in a formal and safe crocodile formation.

- **After school clubs for the family**

Working with local schools to encourage them to sponsor after school clubs for the whole family in, for example, swimming or team sports.

Background:

The 'walking bus' would require sponsorship and advertising from the PCG and partner organisations, who would also be responsible for developing the project. This initiative will not only limit congestion on the roads around schools which is a particular problem in Portsea Island, but improve the health and fitness of the children. The scheme would be introduced as a pilot at one school in the City, which, if successful, could be rolled out to other schools in the area. Funding for the project would need to include provision of safety equipment and reflective equipment for the children and parents who would be using the 'walking bus'. In addition a co-ordinator would be needed who would work across agencies to develop the project.

The after school clubs initiative is one that is wide reaching in its target audience. This would encourage the entire family to 'get fit' and would have lasting implications in improving fitness.

Objectives: To set up a pilot scheme for the 'walking bus' to test the viability of the scheme before applying it to other schools in the area. To work with partner agencies to set up after school clubs at local schools that will involve whole families in a 'get fit' campaign.

6. Community conservation projects

Aim: To encourage families and groups of people within communities to work together with local and national conservation organisations to improve and maintain the local environment.

Background: The PCG will work together with established local and national conservation charities to encourage families and groups of people within local communities to become involved in local conservation projects such as maintaining the local shoreline, or other 'green' areas within the City. This will not only encourage people to partake in physical activity but will also hopefully build a sense of community and pride in local areas.

Objectives: To set up a pilot scheme in Portsea Island which will focus on engaging local residents in improving their environment whilst at the same time encouraging physical activity and fostering a sense of community and pride in local areas.

7. Improved access to local leisure centres

Aim: To improve access to local leisure centres through a variety of routes, namely improved cycle-ways and pathways, as well as possibly subsidising car parks and working with local transport agencies to make bus routes as accessible as possible for the people of Portsea Island. Consideration would also be given to providing subsidised crèche facilities at leisure centres

Background: Discussions will take place with colleagues in Portsmouth City Council and community groups about improving access for local people to leisure facilities within Portsea Island. This will encompass travelling to the centre, and assisting with the provision of creche facilities where appropriate. This proposal will link with other initiatives outlined in this bid including secondary prevention of heart disease (*initiative 2),* exercise and relaxation classes in or near workplaces *(initiative 4),* after school clubs for the family *(initiative 5).*

Objectives: To improve access to leisure centres for local people.

8. Healthy Heart bus tour

Aim: A nurse led 'bus' touring the local area offering risk assessment and lifestyle advice.

Background: Discussions will take place with partner organisations, the Health Authority, Portsmouth Hospitals NHS Trust, local employers and the British Heart Foundation about participation in roadshow type presentations at various locations around the City. The target audience will be those considered to be at greater risk of developing CHD, such as middle-aged 'professional' men for example. The purpose

would be to offer risk assessments and tailored lifestyle advice to members of the public.

Objectives: A bus focusing on workplaces and the relevant Occupational Health departments to target those people who are thought to be most at risk from CHD. It would also be used as a mechanism for reinforcing messages from all of the initiatives outlined in this bid.

Summary of Portsea Island PCG Bid

Portsea Island Primary Care Group believe that developing strong links with partner agencies, voluntary organisation, users, carers and members of the public will enable a joint approach to be taken towards addressing the health needs of the Island.

The above initiatives will provide innovative new approaches to tackle smoking, lack of exercise and unhealthy eating which are major contributing factors of coronary heart disease in Portsea Island.

The initiatives link not only with each other, but also with the wider health agenda that we and our partner agencies are currently in the process of delivering. They will assist in delivering the HImP agenda, the Portsmouth City Council City Health Plan and link with the Urban Regeneration Team and Community Groups to deliver the SRB agenda.

Together with our partners we propose to deliver a comprehensive package of measures for tackling health inequalities in relation to coronary heart disease across the whole health economy within Portsea Island. These are:

Primary Prevention

Smoking will be targeted through:

- Healthy Heart bus tour

Exercise will be targeted through:

- Exercise sessions at work
- Walking bus! and after school clubs
- Community conservation projects
- Improved access to leisure centres
- Healthy Heart bus tour

Healthy Eating will be targeted through:

- 'Can't Cook – Won't Cook' promotion
- Healthy Heart bus tour

Primary Care and Secondary Prevention

Smoking will be targeted through:

- Secondary prevention and lifestyle advice
- Healthy Heart bus tour

Exercise will be targeted through:

- Secondary prevention and lifestyle advice
- Armchair aerobics exercise group
- Walking bus! and after school clubs
- Healthy Heart bus tour

Healthy Eating will be targeted through:

- Secondary prevention and lifestyle advice
- Healthy Heart bus tour

Secondary Care

- Secondary prevention and lifestyle advice
- Thrombolytic therapy

These initiatives, together with work already planned by all agencies, will help tackle the inequalities of CHD that are prevalent on Portsea Island.

References:

Campbell N " Secondary Prevention Clinics for Coronary Heart Disease: randomised trial of effect on health" **British Medical Journal Vol. 316 1999**

Dr. Hugh Bethell (Secondary Prevention and Rehabilitation Committee, Coronary Prevention Group) & Dr HM Delal (GP) Letter to British Medical Journal

Godlee Eds. " **Clinical Evidence – A compendium of the best available evidence for effective health care**" BMJ Publishing Group 1999 pg. 87

P&SEHHA Public Health Annual Report 1999

DRAFT

Health Improvement Programme 2000-2003

Portsmouth and South East Hampshire

December 1999

Health Improvement Programme: Heart Disease and Stroke

Heart Disease: This is due to the build up of fatty deposits in the walls of the arteries supplying the heart. This leads to the narrowing of these arteries and reduced blood supply to the heart muscle. This may lead to chest pain during exercise or rest (angina), heart attacks, rhythm disorder and heart failure.

Stroke: This is a condition in which part of the brain is suddenly damaged or destroyed by a vascular event (blocking of a blood vessel by a clot or the bursting of an artery).

Heart disease and strokes were responsible for 32% of all deaths to Portsmouth and South East Hampshire residents in 1997. They are also responsible for prolonged ill health, impaired quality of life, inability to work, early retirement and premature death.

Causes: The causes of heart disease and strokes are similar. The main preventable risk factors include:

- Smoking
- High blood pressure and diabetes
- Diet high in saturated fats and low in vegetables, fruit and fish
- Obesity
- Lack of exercise
- Alcohol intake
- Non-rheumatic atrial fibrillation
- Transient ischaemic attacks

National Target: To reduce the death rate from heart disease and stroke and related illnesses amongst people aged under 75 years by at least 40% by the year 2010 compared with the average for the years 1995 to 1997

Current Rates : There were an average of 782 deaths per year to Portsmouth and South East Hampshire residents under the age of 75 from heart disease between 1995 and 1997

Target: By the year 2010 there should be no more than 469 deaths per year to Portsmouth and South East Hampshire residents under the age of 75 due to heart disease, stroke and related illnesses

Inequality Targets: To reduce smoking prevalence in Portsmouth City from —% in 1999 to —% by 2010

To increase the number of Portsmouth City practices participating in secondary prevention of CHD/Stroke (Leap Project) from __% in 1999 to __% in 2002

To increase the prescription rate of statins in Portsmouth City by 20% by 2005 from – per 1,000 in 1999 to __ per 1,000 in 2005

PROGRAMME: HEART DISEASE AND STROKE

Target **To reduce death rate from heart disease, strokes and related illness amongst people under the age of 75 by at least 40% by the year 2010.**
By the year 2010, there should be no more than 469 deaths per year to Portsmouth and South East Hampshire residents under the age of 75 due to heart disease, stroke and related illnesses.

Baseline 782 Portsmouth and South East Hampshire residents under the age of 75 died each year from heart disease, stroke and related illnesses between 1995-97.

		Participating Organisations												Timescale			
		HA	PCGs	PCC	HCC	GBC	FBC	HBC	EHDC	PHCT	PHT	RHH	Other	2000/2001	2001/2002	2002/2003	Performance Measure
A1	**Objective: To reduce the prevalence of smoking in Portsmouth and South East Hampshire**																
A1.1	Encourage effective smoking policies in all NHS, Local Authority, University, Shopping Centres and local businesses premises	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	UP	✓	✓	✓	No. of no smoking premises
A1.2	Deliver regular public education campaigns to encourage young people not to start smoking, current smokers to give up and to raise awareness of the dangers of passive smoking	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	UP	✓	✓	✓	No. of campaigns
A1.3	Schools to include structured approach to non-smoking education as part of the Healthy Schools initiative and revised Personal, Social and Health Education curriculum			✓	✓					✓				✓	✓	✓	No. of schools with non-smoking policies
A1.4	Extend Heartbeat, Healthy Workplaces and Healthy Schools Award Schemes	✓		✓	✓	✓	✓		✓	✓			Priv	✓	✓	✓	Smoking prevalence in children reduced from 19% to 9% by 2010
A1.5	Enforce legislation prohibiting sale of cigarettes to people under the age of 16			✓	✓					✓				✓	✓	✓	No. of awards given
A1.6	Ban tobacco advertising in local authority hoardings			✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	
A1.7	Develop smoking cessation service to target low income smokers and localities with high smoking prevalence	✓	✓											✓	✓	✓	
A1.8	Support the development of a 'Proof of Age' scheme to reduce underage sales of cigarettes and alcohol	✓	✓	✓	✓	✓			✓	✓	✓	✓			✓		
A1.9	Encourage Licensing Authorities to include smoke-free areas in the condition of licenses locally	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓		
A1.10	Provide update training for primary, secondary and community healthcare staff on evidence-based smoking cessation support	✓	✓							✓	✓	✓		✓			
A1.11	Provide comprehensive smoking cessation support to pregnant women wishing to give up	✓	✓							✓	✓	✓		✓	✓	✓	Reduce smoking prevalence from 29% to 4% by 2010
A2	**Objective: To increase the number of people who have a healthy diet**																
A2.1	Encourage employers to provide healthier food choices in workplace canteens and restaurants	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	Priv UP	✓	✓	✓	No. of Heartbeat awards given
A2.2	Set catering standards for healthy eating in all nurseries, schools, colleges and universities, tuckshops and for lunchboxes			✓	✓					✓			UP		✓	✓	
A2.3	Implement Breakfast Club schemes as part of the Healthy School initiative and ensure promotion of healthy eating			✓	✓									✓			

		Participating Organisations												Timescale			
		HA	PCGs	PCC	HCC	GBC	FBC	HBC	EHDC	PHCT	PHT	RHH	Other	2000/2001	2001/2002	2002/2003	Performance Measure
A2.4	Set catering standards for healthy eating for organisations providing meals for vulnerable groups, eg. elderly, mentally ill, disabled etc	✓		✓	✓					✓			PCCS		✓	✓	
A2.5	Raise awareness of healthy eating amongst people on low income and amongst parents			✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	
A3	**Objective: To increase the proportion of the local population taking regular physical exercise**																
A3.1	Raise public awareness about the benefits of regular exercise	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	
A3.2	Develop and extend safe walking routes, cycleways, leisure and sports facilities and encourage and support more non-sport exercise			✓		✓	✓	✓	✓	✓				✓	✓	✓	No. of cycle routes developed No. of leisure and sports facilities
A3.3	Promote physical exercise in schools, college and workplaces and implement Safe Routes to Schools initiative			✓	✓	✓	✓	✓	✓	✓			Priv UP	✓	✓	✓	
A3.4	Extend the "Prescription for Exercise Scheme"		✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	No. of participants who sustain physical activity after completing the scheme
A3.5	Develop health promotion activities for people over 50, with particular emphasis on non-smoking, diet and exercise.	✓	✓	✓		✓	✓	✓	✓	✓					✓	✓	
A3.6	Promote the development of Healthy Living Centres in the most deprived areas of PSEH	✓	✓	✓	✓	✓		✓						✓	✓	✓	
A4	**Objective: To provide accessible and effective services to prevent, treat, rehabilitate, and care for people with Coronary Heart Disease and Strokes**																
A4.1	Encourage and support clients to stop smoking (including advice on nicotine replacement therapy), eat a healthier diet, exercise and reduce alcohol intake.		✓							✓	✓	✓		✓	✓	✓	
A4.2	GP practices to identify and treat earlier and more intensively people with/at high risk of cardiovascular disease, particularly those with high blood pressure and diabetes.		✓												✓	✓	**Death rates from strokes and coronary heart disease to under 75s**
A4.3	GPs and hospital clinicians to ensure all patients with a previous medical history of myocardial infarction or angina are offered cardiac rehabilitation, help to stop smoking, aspirin, beta blockers, ACE inhibitors and lipid lowering drugs		✓							✓	✓	✓		✓	✓	✓	% participation in Leap Project Statins/other drugs prescriptions in primary care
A4.4	All pregnant women who smoke to receive advice and support on how to stop so as to reduce % of women who smoke during pregnancy from 27% in 1998 to 18% by 2005		✓							✓	✓	✓		✓			% of women smoking at booking
A4.5	Develop and disseminate a district lipid lowering policy	✓	✓								✓			✓			
A4.6	Establish and audit integrated care pathway for the management of coronary heart disease at PHT, RHH and Primary Care.		✓								✓	✓		✓			
A4.7	Centralise Cardiology Services at a hospital site with an A&E Department										✓				✓		
A4.8	Raise public awareness of the signs of a heart attack.	✓	✓							✓				✓	✓		
A4.9	Continue to provide cardiopulmonary resuscitation training to the public.	✓								✓				✓	✓	✓	No. of people trained/yr

		Participating Organisations												Timescale			
		HA	PCGs	PCC	HCC	GBC	FBC	HBC	EHDC	PHCT	PHT	RHH	Other	2000/2001	2001/2002	2002/2003	Performance Measure
A4.10	Ambulance services to review protocols for managing suspected heart attacks and ensure response time for heart attacks to be 90% within 8 minutes	✓											HAS	✓			Ambulance response time
A4.11	Heart attack patients should be assessed professionally and, if indicated, receive aspirin. Thrombolysis to be given within 60 minutes of calling for medical help or by dialing 999 by establishing & auditing an A&E thrombolysis service									✓	✓	✓		✓	✓	✓	% AMI patients given thrombolysis within 60 minutes of call for help Case fatality rate for MI, **30 day mortality rate after MI**
A4.12	Increase coronary artery revascularisation rate from 1,052 per million population in 1998/99 to 1,150 per million in 2001/02 and ensure equitable access across the district	✓	✓								✓			✓	✓	✓	**Coronary revascularisation rate** Waiting times for surgery
A4.13	Develop primary care based cardiac rehabilitation schemes and introduce shared care patient held record card		✓								✓	✓			✓		
A4.14	Develop hospital/primary care protocols for investigation/treatment of people with angina or heart failure. Carry out audits to demonstrate that ACE inhibitors offered to at least 75% of heart failure patients	✓	✓							✓	✓	✓			✓		ECG/ECHO rates % of heart failure patients receiving ACE inhibitors **Heart Failure admission rate**
A4.15	GPs/hospital clinicians to ensure all patients who have had a previous stroke or TIA are prescribed low dose aspirin. Appropriate patients with TIA and carotid artery obstruction over 70% to be offered carotid endarterectomy. For those with non-rheumatic atrial fibrilation anti-coagulation to be prescribed		✓							✓	✓	✓		✓			TIA operation rates
A4.16	Develop integrated care pathways for strokes and remodel stroke services to ensure extension of stroke service to people under 75									✓	✓	✓		✓			No. patients treated in stroke unit
A4.17	All stroke patients admitted to hospital, and who survive, to receive appropriate rehabilitation at hospital, residential care or at home.	✓	✓	✓	✓					✓	✓	✓		✓	✓	✓	**% of stroke patients discharged to usual place of residence within 56 days of emergency admission**
A4.18	Improve stroke patients access to CT and MRI scanning	✓								✓	✓	✓		✓			No. of CT/MRI scans for strokes
A4.19	Develop a community stroke team to support patients recovering from stroke in the community.	✓	✓							✓					✓		
A4.20	Ensure prompt social services assessment of patients who have suffered a stroke and develop appropriate care packages to meet their needs both at home and in residential care.			✓	✓										✓	✓	
A4.21	Develop delivery plan by April 2000 in the light of the publication of the coronary heart disease National Service Framework.	✓	✓											✓			

Agenda Item No:

Part I No: 7.1

St Mary's Hospital – Options for Healthcare

Background & Summary

This paper summarises the discussion arising from the "Options for Healthcare – GP aspirations for services on SMH site" event on held 23 February 2000. It develops further ideas which appeared in the paper 'Future of St Mary's site as a Community Hospital' which was presented to the Board on 15 December 1999.

The four areas covered in the paper are:

- Outreach Outpatient clinics
- Inpatient Services
- Minor Injuries clinic
- Information, Advice and Health Promotion Service

Each area was considered within constituency discussion groups and the results are grouped into three sections; positive comments, negative comments and considerations/queries.

Recommendations:

- The Board is asked to note the paper and to approve the recommendations outlined at Page 2.

Date: 29 March 2000

Paper Prepared by: Andrew Swinney, Service Development Manager

PORTSEA ISLAND PRIMARY CARE GROUP

Options for Healthcare - GP aspirations for services on SMH site

CONTENTS

RECOMMENDATIONS

Outreach Outpatient clinics

- Develop wide-range of (nurse led, "drop-in") outreach out patient clinics at St Mary's site
- Types and numbers of clinics will be dependent on those that can be technically supported and which offer advantages over centralised clinics at QA Hospital. Access to diagnostics was given high importance.
- Engage with Portsmouth City Council to ensure that the infrastructure (e.g. public transport) develops at pace with the St Mary's site

Inpatient Services

- Inpatient beds should be included in the new hospital.
- The use of these beds should be flexible and include "step-down" beds for the elderly/CAPs, but not Maternity.
- Clinical responsibility around discharge/admission needs to be clearly defined and the implications for GP time carefully managed

Minor Injuries Clinic

- Develop (nurse lead) minor injuries clinic and possible out-of-hours centre.
- Public education campaign on what to do/where to go in an emergency. Also, clear protocols to prevent A&E's being shunted between clinics.
- Ensure links to manpower strategy to ensure appropriately skilled staff
- Minimise impact on GPs

Information, Advice and Health Promotion Centre

- St Mary's should be considered as a site for a multi-agency Information, Advice and Health promotion satellite centre
- Possibly "shop-front" style offering care pathways and "sign posting"
- Important that the centre does not create work for GPs

OUTREACH OUTPATIENT CLINICS

POSITIVE;

NORTH

- Definitely required, and helps to provide a sense of local identity
- Opportunities for nurse led activities using technology and 'step down' facilities

SOUTH WEST

- There is not enough room at QA Hospital for everything
- Gives SMH an identity/importance
- Would like as many outpatient services (with drop-in philosophy) that can be technically supported

CENTRAL

- Car travel to QAH not a problem but parking is
- Would like following clinics: elderly, young families, GUM/Family Planning, "Simple" services

SOUTH EAST

- Diagnostics and GP access important.

NEGATIVE;

NORTH

- Local clinics reduce patient travelling, although scoping and high tech may not be appropriate locally

CENTRAL

- Concerned about traffic congestion on 3 roads off island to QAH and also on Milton junction

SOUTH EAST

- Not best use of clinician time travelling from base to clinic. Also results in clinics not running to time. Having all clinics in the same place makes the most sense, and is more convenient to patients.

Considerations/queries;

NORTH

- Look through clinics to include as many as possible locally within technical constraints
- Consult with consultant colleagues
  (Not a problem linking with other parts of the service)

CENTRAL

- Need an improved bus service

SOUTHEAST

- What do we need? What would most benefit patients v. what are the disadvantages of moving clinics from QAH?
- Depends on how many clinics already at SMH and how much of the site will remain. Should we be splitting services between sites?
- Need to review/improve efficiency of OPD to avoid frequent cancellations

INPATIENT SERVICES

POSITIVE;

NORTH

- Two types required:

1) Cottage Hospital (like pro rata Petersfield GP beds) – staffed by PHCT and ensure best utilisation (only half used at Gosport WMH = risk of staff being used for other duties).

2) 'Step Down beds' at SMH e.g. for Elderly Care – staffed by consultant, or nurse led with OT and Physio – INTERACTIVE services. (Consultant responsibility with protocols).

Exclusion: Maternity

SOUTH WEST

- Would support although beds should encompass all care groups
- Takes pressure off QAH and makes services more accessible

CENTRAL

- Should relieve pressure on acute beds
- Links to Elderly medicine beds on SMH for Portsea patients. Nurse led planned development
- Should meet unmet demand, reduce admissions/length of stay for acute admissions and cater for existing CAPs patients
- Need strong physiotherapy, OT rehab and investigations to support this

SOUTH EAST

- ? CAPs beds
- Need for clear criteria regarding responsibility for discharge/admission

NEGATIVE

SOUTHEAST

- Time consuming if you do not know the patient
- GPs do not want clinical responsibility for inpatient beds

Considerations/ Queries;

SOUTH WEST

- Need to clarify patient responsibility and remuneration, issue of GP time

CENTRAL

- CAPs – nursing home care deteriorates when complex patients placed. Use beds for CAPS concept but improve quality /control over care by GPs and extend to whole year. Need to consider 2-week time limit (adequate?) and the benefits of investigations on site and also the continuity of care enabled by patients being in the same place.
- Should beds be; GP led, Consultant Nurse led, or GP Clinical Assistant Beds? NB would be time-consuming for GPs therefore limited interest in pure GP beds
- Focus should be on elderly, and the unsupported young e.g. Students, and rapid turnover/response services only

MINOR INJURIES CLINIC

POSITIVE;

NORTH

- Needed:
  1) Out of Hours Centre (to include Community Mental Health services)
  2) Primary Care Centre
- Would help to reduce QA workload/parking

SOUTH WEST

- Agree in principle
- GP or Nurse led?

CENTRAL

- Ground rules important for operating an MIU

SOUTH EAST

- Good idea if nurse led – see Gosport model, or
- Satellite casualty – nothing to do with GPs

NEGATIVE;

SOUTH WEST

- Concern re. GP involvement/impact

CENTRAL

- Nurse led, but still knock-on concerns about e.g. Sicknotes, prescriptions
- Danger of patients being passed from A&E to many sites – better to concentrate services on one site
- A significant minority abuse current services – more opportunity to for abuse with MIU

Considerations/ Queries;

NORTH

- We should wait to test Haslar model, e.g. specialist nurses with consultant lead. Should not be 24 hours though (maybe 18).
- Would require a lot of advertising for population to understand what to do when

SOUTH EAST

- Need appropriate experience/staffing levels
- A&E should tighten access criteria – need for patient education

INFORMATION, ADVICE AND HEALTH PROMOTION CENTRE

POSITIVE;

NORTH

- Needed

SOUTH WEST

- Support in principle
- In favour of a "shop-front" style

CENTRAL

- In addition to locally based services
- CAB etc. offer care pathways

SOUTH EAST

- Is this the correct place for such a centre? Should be targeted to where most appropriate
- May divert inappropriate workload from GP practices

Considerations/ Queries;

NORTH

- Should be mix of staff. Help bring all services, not just health, together. (Centralisation of community nursing noted)
- Risk of over-centralisation to be balanced with risk of over-dispersion of service
- Need to sort out details such as who would go to Portsea and who to SMH.

SOUTH WEST

- Already Health Information Centre at QAH, need to add CAB, Social Services, Housing, Voluntary Organisations etc.

SUMMARY

Outreach Patient Clinics

- Recurring theme from all constituencies that outreach out patient clinics would provide a sense of identity for both the local community and St Mary's. It would also reduce the amount of running around that clinicians have to do, save money and time. There was also a feeling that QA Hospital cannot cope with whole demand and that St. Mary's would be able to provide better facilities – from car parking to improved use of technology. However, there were also fears that the local infrastructure may not be able to cope with the increase in traffic (especially around the Milton roundabout). The bus service locally would need improving (there still is not a bus that runs directly from Fratton station to St. Mary's) to perhaps counter this. The Southeast constituency was particularly keen on assessing existing clinics at St. Mary's, and whether the benefit to patients would outweigh the disadvantages of moving staff and clinics from QA.

In patient Services

- There were quite diverse suggestions from the constituencies concerning Inpatient Services. The North think that there are two types of inpatient service required, a cottage hospital staffed by PHCT staff and 'step down' beds for elderly care – they think maternity should be excluded. The South West would support In-patient services but would like to see ALL care groups encompassed, and feel that this would take the pressure off of QA. Central agree with South West and say that in patient services will reduce pressure and demand on existing beds, and may also reduce lengths of stay, as well as cater for existing CAPs patients. Southeast say that they agree in theory, but do not want the clinical responsibility for inpatient beds. They also say we need clear-cut criteria regarding responsibility for discharge and admissions etc. However, they feel that GP Beds can be very time consuming if you do not personally know the patient. There were general requests of clarification as to the issue of GP time, (Central & Southwest) and the integration of CAPs beds (Central & Southeast).

Minor Injuries Clinic

- There was generally quite a positive response to this suggestion from all four constituencies. There was a general consensus that this service was needed, and

also that it should be either nurse or GP led. However some concerns were expressed about the impact on GPs: Should they be involved (Southwest)? And the danger of A&E patients being shunted from one site to another (Central). Some concerns that were highlighted included the level of advertising required to make the population understand what to do when (North) and also erring on the side of caution and waiting to see how the consultant led/specialist nurse model works out at Haslar (North).

Information, Advice and Health Promotion Centre

- Again there was a quite positive response to this suggestion. All areas agreed to the idea in principle, say that there was a need, but that this should be set up where it was most appropriate and run in addition to locally based services. Also, that the Centre may divert work from the GPs. There were quite a few consideration and queries suggested and these included the notion that staff should be mixed, to bring all services (and not just health) together. Closely linked to this was the point that there is already an information centre at QA, and that CAB, Social Services Housing, Voluntary organisations. etc need to be added

Agenda Item No:

No: 7.2

COMMISSIONING AND PERFORMANCE MANAGEMENT

Background & Summary

The committee for the Commissioning And Performance Management Sub Group met on Wednesday 1 March 2000. A copy of the meeting notes are attached.

Recommendations:

The Board are asked to approve these minutes.

Date: **29 March 2000**

Paper Prepared by: **Charles Lewis**

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PORTSEA ISLAND PRIMARY CARE GROUP

Commissioning and Performance Management Sub Group

Notes of the Meeting held: 1 March 2000

Present: Dr C Lewis, Dr T Wilkinson, Debbie Tarrant, Jeremy Douglas, Vicky Turner, Andrew Swinney

No	Discussion	Action
1.	**Apologies for Absence** Tracy Green.	
2.	**Commissioning Update** • **Back Pain** – AS updated the Group: Best fit for Dr Tanner into future district triage model would be for him to see and treat direct GP referrals via agreed protocol. Details were expected of the type of patient Dr Tanner could best treat and how his service was different to that provided locally. • **Dermatology** – AS to produce a proposal for the development of community clinics treating 'C' grade non-malignant lesions which links into the proposed District-wide scheme. • **Glaucoma** – Meeting with the Trust and interested Optometrists rearranged for 22/3/00. Scheme likely to commence 1/5/00. • **LVAs** – no progress to report. • **OATs** - no PCG update available, although District over-spend is forecast. OATs Co-ordinating Group would be producing a year-end report to identify high referrers. TG to update at next group. • **Waiting List Summary** - numbers continue to rise and PHT unlikely to achieve April 2000 target until at least June. No +18 month waiters reported for PIPCG to date although numbers of +15 months continue to rise.	**CL/AS/DT** **AS** **AS** **TG**
3.	**Commissioning Performance Report** Suggestions for future reports included: • Include information on readmissions and ITU • Information on the total waiting experience (from receipt of referral letter to a procedure). JD to trawl for available data and possibly to research total waits for hips/knees/cataracts. • Long clinic lags (outpatient clinics) and what action is being taken to address problems • Conversion rates: referral to procedure • Changed/cancelled appointments & DNA rates • Exceptions to 2 week cancer waits AS/DT outlined the Review process with both local Trusts which were essentially regular meetings with Trust operational Managers which	**JD**

tied-in individual directorates on a rolling basis.
It was agreed that these were the correct forum for raising specific operational issues but that it may also be useful to invite Trust representatives to Board meetings to discus areas of concern in a more open setting. This could act to develop relations between the Trust/PCG/Public. CL agreed to discuss this with Sheila Clark. **CL**

JD agreed to look into reviving the "Prompt Card" scheme, possibly with an electronic version. **JD**

4. Future Development Priorities

- Agreed that the projects under 2 should continue to be progressed **ALL**
- AS tabled ideas that had been generated for the Demand management Group to take forward.
- Other suggestions included
  - Improving clinician to clinician communications e.g. feedback on inappropriate referrals (starting in specialities with waiting time difficulties – Orthopaedics, Ophthalmology, ENT, Dermatology, Cardiology, Rheumatology, Urology and also Diabetes)
  - Alternative access criteria for e.g. Hips/Cataracts
    NB Nigel Sylvester criteria for orthopaedics
  - Improving Elderly Care – Rehab/Stroke, Community geriatrician (NB Part of SMH provision discussion)
  - Quality issues – improving Outpatient waiting times e.g. more flexible clinic times

Suggestions to be considered for action. **ALL**

5. Any Other Business

None.

6. Dates of Future Meetings

Wednesday 3 May 2000 **ALL**
Wednesday 5 July 2000
Wednesday 4 October 2000
Wednesday 6 December 2000

all at 12 noon in F1 Meeting room

Distribution:

All present and Apologies
PIPCG Board Meeting Agenda

G \Comm & Perf Sub Group\minutes 1 march 2000 doc

Agenda Item No: 8.1

ASYLUM SEEKERS

Background and Summary: There has been a recent increase in the numbers of asylum seekers coming into this area. The vast majority are being accommodated in Southsea and until now this has mainly impacted on six practices in the area. Following negotiation with Social Services it has been agreed that in future all new arrivals will be allocated to practices via Coitbury House in an attempt to spread the workload more equitably. This will mean that potentially 50% of practices within the PCG will be affected. We have been told by Social Services that there are currently around 500 asylum seekers in the City. A further 220 persons are expected to be placed here by the Home Office by or during April, and for planning purposes we have been advised to anticipate approximately 1000 by the summer. Although practices have coped well until now the PCG has recognised the need to provide them with some additional support in view of the further numbers expected.

The PCG invited representatives from Social Services, general practice, the two local Trusts and the Health Authority to a series of meeting to discuss how the health needs of the asylum seekers might best be met. It was agreed that managing the initial health input is the priority and that this could be achieved by establishing a nurse triage centre through which all refugees arriving in the City will be routed, once they have been registered with a GP. The purpose of the service will be to obtain from each client basic health information. Immediate problems will be identified and dealt with, and relevant information will be passed to the appropriate GP.

The screening clinics will initially be staffed by Health Visitors, District Nurses and School Nurses supported by translators and administrative staff. Input by other services will be considered once demand has been established. The screening will cover physical health, mental health, immunisation and vaccination status, sexual health, and developmental assessment for children. The clinics will provide some services direct (e.g. immunisation and vaccination), follow up clients where necessary until they are established with a GP, and refer as appropriate to services such as mental health, dental, family planning, podiatry and community paediatric services. Staff will ensure that the results of this input are shared with the allocated GP practice. The attached information has been circulated to practices across the PCG and an information sharing session for all practice staff was held on 5 April.

Initial costings for a five day a week service suggest a recurring commitment of £8,000 per month plus initial set up costs of £5,000. It is anticipated that the clinics will run for four months in the first instance with a review and evaluation at the end of that time. The PCG will meet the costs of the service initially but will be working with the Health Authority to identify other possible funding sources.

Recommendations: The Board is asked to note:

- the arrangements put in place for asylum seekers,
- the need to identify a funding source for the service.

Date: 29 March 2000

Paper prepared by: Debbie Tarrant, Service Development Manager

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PORTSMOUTH
HealthCare
NHS
TRUST

Our ref

PT/JC
Your ref

Date

21 March 2000
DDI. Tel

Dear Colleague

Re: Asylum Seekers

As you will be aware the PCG has been working with us to develop a screening clinic for asylum seekers. The aim of the clinic is to provide you with some basic health information about the patients as soon as they are registered with your practice.

In process terms, the Health Authority will be providing us with details of these patients as they enter your list. We will then offer them an appointment provide a basic health assessment and share it directly with you after the event.

We also intend to offer a follow up which will provide immediate, practical help in the form of advice: prescribing to nurse prescribing formulary: referrals where appropriate: supply of condoms etc.

The service commences of April 3rd and in the first instance will operate 3 afternoons a week.

This letter seeks to assure you that any patient registered to your practice will be seen.

However, should you wish to undertake this yourself or have any information that you would like to share with us in advance the contact details are as follows:

Mrs. Veirka Douch
Kingsway House, 130 Elm Grove, Southsea, Portsmouth PO5 1LR
Tel no: Code A Fax no: Code A

Please do not ask the patient to contact us directly.

Yours sincerely

Code A

Paula Turvey
Divisional General Manager

DIVISIONAL HEADQUARTERS

Kingsway House, 4th Floor
130 Elm Grove, Southsea, Portsmouth, Hampshire PO5 1LR
Tel: Code A Fax: Code A

Agenda Item No:
9.1

Finance Report for the Period ended 29 February 2000

Background and Summary:

The attached report sets out the financial position of the Primary Care Group against its devolved budgets for the first eleven months of the financial year (1999/2000).

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

Further prescribing information has now been received reflecting the period April to November 1999. Unfortunately this has shown a further deterioration in the projection of £105,000.

Consequently the PCG is now projecting a small overspend against its financial allocation for the year and will need to be watchful of the impact of future reports from the prescription pricing agency.

Recommendations:

The Board are asked to note the report.

Date

29 March 2000

Paper Prepared by :
Tracy Green, General and Finance Manager

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PORTSEA ISLAND PRIMARY CARE GROUP

FINANCE REPORT FOR THE PERIOD ENDED 29 FEBRUARY 2000

1 Overview

This report presents the performance of the PCG against its financial programmes for the first eleven months of the financial year, covering the period April 1999 – February 2000.

As at the 29 February 2000, the overall budgetary position is an overspend of £60,000 (0.1%) against the PCGs devolved budget. This is an increase of £30,000 from the position reported for January, but with the percentage overspent remaining at 0.1%. The projected year-end position for the PCG is, currently, a £28,000 (0.0%) overspend against available funds. This deterioration is due to the receipt of November prescribing information that has shown a further overspend. The reported position can be broken down across the main programme headings as follows:

Programme £000s	Annual Budget	Forecast Outturn	Year to Date			
			Budget	Expenditure	Variance	Variance %
Prescribing	12,846	(337)	11,776	11,883	(107)	(0.9)
GMS	2,741	178	2,297	2,292	5	0.2
HCHS	46,554	(2)	42,673	42,679	(6)	0.0
Management	475	26	407	359	48	11.8
Sub-Total	**62,616**	**(135)**	**57,153**	**57,213**	**(60)**	**(0.1)**
FH savings	107	107	0	0	0	0
TOTAL	**62,723**	**(28)**	**57,153**	**57,213**	**(60)**	**(0.1)**

Note: () Brackets indicate an overspend

Further analysis within programme heading is provided at appendix 1.

2 HCHS Budget

A £6,000 (0.0%) over-spend is reported against the Hospital and Community Services budget, with a forecast year-end over-spend anticipated of £2,000. A detailed analysis of this is provided within appendix 1.

This estimate reflects an assessment of year-end commitments and the funding of non-recurring schemes from HCHS rather than from other sources of funds.

3 Prescribing Budget

Updated figures have been received from the prescription pricing agency (PPA) for the period April – November 1999. Disappointingly these project a further deterioration of the forecast outturn position for the primary care prescribing expenditure of some £105,000 after a stable position had been maintained between September and October.

The forecasts included within this finance report have been updated to reflect these revised figures and a £223,000 overspend is now projected. However the estimated provision required for the prescribing incentive scheme has reduced by £25,000 to £114,000.

4 GMS (Cash Limited) Budget

The reported position at the end of month 11 is a slight underspend (£5,000 0.2%). This relates to the training budget.

The year-end projection against the GMS allocation is an underspend of £178,000 based on the latest assessment of likely year end commitments and those schemes which will be completed by 31 March 2000.

The increase to the A&C pay award has been allocated to practices during February.

5 Management Budget

The PCG is continuing to manage within budget and the current position is an underspend of £48,000 (11.8%). It is anticipated that the PCG will underspend against this budget at the year-end and will not exceed its management cost target as set by the Health Authority.

6 Conclusion

Unfortunately, due to the worsening prescribing position, the overall PCG financial position has swung from a forecast small underspend to a small overspend of £28,000. However this is only 0.04% of the total unified budget.

The PCG will need to await the further prescribing forecasts from the PPA to establish whether this position will deteriorate further.

Tracy Green
General and Finance Manager
29 March 2000

Financial Report for Portsea Island PCG for 1999/2000, to the end of February 2000

		Year to date				Forecast Outturn	Current Month			
	Annual Budget £000's	Budget £000's	Expenditure £000's	Variance £000's	Variance %	Variance £000's	Budget £000's	Expenditure £000's	Variance £000's	Variance %
Prescribing										
Prescribing	12846	11776	11883	(107)	(0.9)	(223)	1215	1274	(59)	(4.9)
Incentive Scheme	0	0	0	0	0.0	(114)	0	0	0	0.0
Total Prescribing	**12846**	**11776**	**11883**	**(107)**	**(0.9)**	**(337)**	**1215**	**1274**	**(59)**	**(4.9)**
GMS Programme										
Reimbursement - Practice Staff	2109	1929	1933	(4)	(0.2)	0	181	185	(4)	(2.2)
Training - Practice Staff	44	40	31	9	22.5	10	4	3	1	25.0
Relief - Practice Staff	57	52	52	0	0.0	0	5	5	0	0.0
Health Centre Staff	7	6	6	0	0.0	0	1	1	0	0.0
Premises - Cost rents	144	132	132	0	0.0	0	12	12	0	0.0
Premises - Improvements	142	0	0	0	0.0	135	0	0	0	0.0
Computing - Purchases	108	75	75	0	0.0	(7)	7	7	0	0.0
Computing - Maintenance	70	63	63	0	0.0	(2)	2	2	0	0.0
DDRB Reserve	14	0	0	0	0.0	14	0	0	0	0.0
Reserves	46	0	0	0	0.0	28	0	0	0	0.0
Total GMS	**2741**	**2297**	**2292**	**5**	**0.2**	**178**	**212**	**215**	**(3)**	**(1.4)**
Hospital and Community Services										
Service Level Agreements										
Portsmouth Hospitals NHS Trust	30555	28008	28008	0	0.0	0	2547	2547	0	0.0
Portsmouth HealthCare NHS Trust	13489	12365	12365	0	0.0	0	1124	1124	0	0.0
Southampton University Hospitals NHS Trust	1220	1118	1118	0	0.0	0	102	102	0	0.0
Southampton Community NHS Trust	1	1	1	0	0.0	0	0	0	0	0.0
Salisbury Healthcare NHS Trust	209	191	191	0	0.0	0	17	17	0	0.0
Royal West Sussex, St Richards, NHS Trust	83	76	76	0	0.0	0	7	7	0	0.0
Royal Surrey County Hospital NHS Trust	12	11	11	0	0.0	0	1	1	0	0.0
Winchester & Eastleigh HealthCare NHS Trust	29	27	27	0	0.0	0	2	2	0	0.0
Guy's & St Thomas' Hospitals NHS Trust	64	58	58	0	0.0	0	5	5	0	0.0
North Hampshire NHS Trust	42	39	39	0	0.0	0	4	4	0	0.0
UCLH NHS Trust	13	12	12	0	0.0	0	1	1	0	0.0
Gt. Ormond Street NHS Trust	27	25	25	0	0.0	0	2	2	0	0.0
Royal National Orthopaedic NHS Trust	71	65	65	0	0.0	0	6	6	0	0.0
St George's Healthcare NHS Trust	1	1	1	0	0.0	0	0	0	0	0.0
Poole Hospitals NHS Trust	21	20	20	0	0.0	0	2	2	0	0.0
Royal Free Hampstead NHS Trust	11	10	10	0	0.0	0	1	1	0	0.0
Hammersmith Hospitals NHS Trust	29	27	27	0	0.0	0	2	2	0	0.0
Frimley Park NHS Trust	27	24	24	0	0.0	0	2	2	0	0.0
Moorfields Eye Hospital NHS Trust	15	14	14	0	0.0	0	1	1	0	0.0
Royal Brompton NHS Trust	289	265	265	0	0.0	0	24	24	0	0.0
Worthing & Southlands NHS Trust	7	7	7	0	0.0	0	1	1	0	0.0
Total	**46215**	**42364**	**42364**	**0**	**0.0**	**0**	**3851**	**3850**	**0**	**0.0**
Other										
Commissioning Pilot Savings	26	26	26	0	0.0	0	26	26	0	0.0
Grants to Voluntary Organisations	194	178	179	(1)	(0.6)	0	16	12	4	25.0
Ex FH Services - Private Providers	65	58	58	0	0.0	2	6	6	0	0.0
Other Private/ECRs	54	47	52	(5)	(10.6)	(4)	4	29	(25)	(625.0)
Total	**339**	**309**	**315**	**(6)**	**(1.9)**	**(2)**	**52**	**73**	**(21)**	**(40.4)**
Total HCHS	**46554**	**42673**	**42679**	**(6)**	**(0.0)**	**(2)**	**3903**	**3923**	**(21)**	**(0.5)**
Management Costs										
Staff Costs	333	302	298	4	1.3	2	31	30	1	0.0
Non staff costs	142	105	61	44	41.9	24	9	7	2	0.0
Total Management Budget	**475**	**407**	**359**	**48**	**11.8**	**26**	**40**	**37**	**3**	**0.0**
Total Portsea Island PCG	**62616**	**57153**	**57213**	**(60)**	**(0.1)**	**(135)**	**5370**	**5449**	**(80)**	**(1.5)**
Unplanned GPFH savings returned	107	0	0	0	0.0	107	0	0	0	0.0
Total Portsea Island PCG	**62723**	**57153**	**57213**	**(60)**	**(0.1)**	**(28)**	**5370**	**5449**	**(80)**	**(1.5)**
Memorandum										
Royal Hospital Haslar	174	160	160	0	0.0	0	15	15	0	0.0
Out of Area Treatments (OATs) adj	514	471	471	0	0.0	0	43	43	0	0.0

() Brackets indicate an overspend

Prepared by Ros Grimshaw 17/3/00

Agenda Item No:
9.2

2000/01 Service and Financial Framework and PCG Budgets

Background and Summary:

This paper details the funding for the Health Authority for the financial year 2000/01 and sets out the impact on the PCG where known.

Recommendations:

The PCG Board is asked to :

- Note the Health Authority financial position
- Note the outline financial programmes for the PCG in 2000/01
- Note the additional allocations and adjustments yet to be determined

Date

27 March 2000

Paper Prepared by :
Tracy Green, General and Finance Manager

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PORTSEA ISLAND PRIMARY CARE GROUP

2000/01 Service and Financial Framework and PCG Budgets

1 Introduction

This paper details the known funding available to the Health Authority for the financial year 2000/01 and sets out those elements of budget already known as available to the PCG. Complete PCG budgets will not be known until later.

2 Health Authority Allocation

The Health Authority has received an uplift to its recurrent allocation of some £22.4m that represents an increase of 6.7% (which is the national average). The district wide SAFF group, of which the PCG has representation, has been the group that has determined how this funding should be utilised, within the remit of national guidance. The process has not yet been finalised and therefore all figures quoted are draft

The proposed allocation of this funding can be summarised as follows:

	£000s
Available additional funding	22,429
Less inflationary pressures	(14,364)
Less estimated cost of other national cost pressures	(1,000)
Less modernisation funds allocation	(4,744)
Other provisions including additional funding for non local services	(1,000)
Proposed service developments	(1,732)
Surplus/(deficit)	(411)

2.5% of the increase is deemed to be for inflation. However this sum has proved inadequate and taking into account the cost of anticipated pay awards, increased employers costs of superannuation, and the high costs of prescribing within primary care, culminate with an estimated 4.3% rate of inflation.

Other national cost pressures include high cost issues such as the European Union Working Time Directive, which need to be met by the Health Economy.

3 PCG Allocation

PCG budgets will be based upon the rolled over recurrent budgets from 1999/00, transfer of budgets from the Health Authority central control, and inflation/growth uplifts as agreed in the SAFF process.

The SAFF process has finalised the uplifts applicable for GMS, prescribing, and for HCHS. On this basis the Health Authority have produced initial budgets for elements of the PCGs budget. The position for each programme heading within the PCG can be summarised as follows:

- **GMS/Primary Care Modernisation Funds**

For 2000/01 the recurrent funding from 1999/2000 has been rolled forward and a further addition made to it from primary care modernisation funds for inflation. This inflationary increase is 2.76%. In addition growth funding will be received from modernisation funding of a minimum of £105,000. The PCG has been notified of an opening budget for 2000/01 of £2,831,000.

Recurrent Baseline from 1999/2000	£2,653,000
Inflation at 2.76% (from modernisation funds)	£73,000
Growth (from modernisation funds)	£105,000
Total Allocation	£2,831,000

- **Primary Care Prescribing**

Again the recurrent funding from 1999/2000 has been rolled forward and an addition of 8.8% made to this allocation for inflation and growth pressures for the PCG. Topslices will be made for nurse prescribing, and the Health Authority expensive drugs and list size reserve as in previous years.

Recurrent Baseline from 1999/2000	£12,731,000
Inflation and growth uplift at 8.8%	£1,120,000
Less contribution to nurse prescribing 0.75%	(£104,000)
Less contribution to exp. drugs and list size reserve 0.5%	(£69,000)
Total Allocation	£13,678,000

In addition it is anticipated that a further top slice will be made to prescribing budgets in respect of the development of a new drugs fund which will support the implementation of some new drugs approved by the D&TC in year. This is anticipated to be a deduction of approximately £26,000.

The available budget is to provide for individual practice budgets and a PCG held contingency to cover in year risks and the provision for any payments due under the 2000/01 incentive scheme.

A further addition is also anticipated for the four (new) drugs approved and funded through the D&TC and SAFF process. The value of this addition is not yet known.

- **Hospital and Community Health Services**

Initial budgets have only been drafted for the element of HCHS purchased by individual PCGs (e.g. private providers and ECRs). These have been rolled forward from 1999/00 and uplifted for inflation.

Recurrent Baseline from 1999/2000	£146,000
Inflation uplift at 2.6%	£4,000
Total Allocation	£150,000

HCHS budgets contained within pan PCG/Health Authority service agreements can not be set until the service agreements have been finalised, including agreement on unit prices and the split of activity targets across purchasers. This process is further complicated by the agreed further devolution of commissioning from the Health Authority to PCGs that may extend the time required to undertake the analysis of service agreements. It is anticipated that these budgets may not be available for several months, however the analysis and budgets should reflect agreed payments to providers.

The further devolution of commissioning will also increase the private provider and ECR budgets held by the PCG to cover the expanded portfolio of services to be commissioned by PCGs. These budgets should be adjusted within 4 – 6 weeks of the conclusion of the further devolution discussions.

The Health Authority will not be managing in year over and under performance against service agreements for 2000/01, this therefore adds an additional financial risk to the PCG.

Voluntary Organisation grant payments, relating to more than one PCG, have not yet been allocated to PCGs either.

- **Management Budget**

The recurrent budget of £415,000 has been rolled forward into 2000/01. Inflation uplifts have not yet been agreed. However it is anticipated that the full costs of Board members and management team pay increases will be funded. The setting of the management budget is also subject to change as a consequence of the further devolution of commissioning, and these adjustments will be incorporated once they have been agreed.

- **Additional Allocations**

In addition to the funds outlined above the PCG will receive £364,000 funding through the pace of change/equity agreement from the £500,000 which has been earmarked for pace of change for PCGs, from non-recurring sources.. Although funded from non-recurring sources, it is hoped that the Health Authority will put forward a proposal that this allocation is made recurrent and therefore a first call on any additional funding received in 2001/02.

In addition to pace of change, the SAFF also holds various reserves from modernisation funding which the PCG may be able to access. These include allocations for further reduction in waiting times.

Commissioning Pilot savings, fundholding savings and practice prescribing incentive scheme savings balances will also be brought forward from 1999/2000, and practice prescribing incentive savings accrued from 1999/2000 are anticipated to be available once the Health Authority accounts have been audited in August 2000.

Should the PCG over or under spend in 1999/2000 against its total unified allocation, then this will need to be carried forward as either a topslice or an addition to next years allocation. The exact value of this potential adjustment will not be known until the accounts have been closed in August 2000. However in light of recent prescribing information it is likely that the PCG will now overspend and how this is managed will need to be decided by the PCG.

4 Financial Pressures and Risks

The largest financial pressure for the PCG, in year, remains related to the increasing costs of primary care prescribing. Although additional funding has been allocated for 2000/01, significant effort will need to be continued to be taken to manage prescribing expenditure as tightly as possible.

However, the further devolution of commissioning will place greater potential risks on HCHS allocations, especially in year with regards to individual patient placements that could be of high cost and an unpredictable nature, and with the PCG having to manage over and under performance against service agreements itself.

5 PCG Equity Position

The final equity and distance from target figures for PCGs will not be able to be produced until the service agreements have been finalised and split across individual purchasers – and this may not be for some time.

However it is known that the updated population figures, including revised projections for armed forces moves the PCG further away from its equity target. However, pace of change funding and the reallocation of service agreements across purchasers based on current performance will move the PCG closer to equity. It is estimated that the PCG will move to 3.7% below equity as a consequence of these adjustments, although the actual value will not be known for some time.

6 Chancellor's Budget

None of the above take into account the Chancellor's latest budget announcements, which outlined additional funding for the Health Service recently. The full impact of the announcement on local circumstances is not yet known. However, it can be hoped that this will improve the financial position of the local health economy.

It is known that £1.4billon will be made available to the NHS in England in addition to that funding already received for 2000/01. Of this some £600million is to be allocated imminently as additional funding, and the impact for the district is some £6.4million. This funding is to address local priorities and pressures, particularly :

- Financial restructuring
- Local PCG service developments
- Implementation of winter plans, including intermediate care
- Action to improve local inpatient waiting list profiles and outpatient services
- And also help to meet any additional costs arising from the implementation of recommendations made by the National Institute of Clinical Excellence

£60million has been put aside as a performance fund to reward PCGs and Trusts for performance against agreed action plans. Action plans will be required for three areas : waiting times and lists, winter planning and achieving financial balance.

The balance of £740millon will be held to provide additional modernisation funding (including for critical care) and central budget funding (for capital and R&D). A working group will be producing a paper in July.

The longer-term targets for this funding include:

- Reducing delayed discharge
- Avoiding admissions
- Increasing flexible working e.g. PAMs and nursing
- Reducing unacceptable variations in service
- Addressing poorly performing doctors
- Implementing booked appointment systems

7 Conclusion

The PCG Board is asked to:

- Note the Health Authority financial position
- Note the outline financial programmes for the PCG in 2000/01
- Note the additional allocations and adjustments yet to be determined

The Board will be updated of further developments in concluding budget setting for 2000/01, as they are known

Tracy Green
General and Finance Manager
31 March 2000

Agenda Item No:

No: 10.1

PUBLIC INVOLVEMENT

Background & Summary

A questionnaire was sent out to members of the general public who have attended at least one Public Board Meeting.

There was a 79% response rate to the questionnaire.

A summary of the results are attached.

Recommendations:

The Board is invited to comment on the results.

Date: 29 March 2000

Paper Prepared by: Maria Smith

PUBLIC BOARD MEETING QUESTIONNAIRE

12 Copies of the attached questionnaire was sent to a variety of members of the public who have attended at least one of the Board Meetings.

Detailed below is a summary of the results. A total of 75% response.

	QUESTION	ANSWER	
1.	***Where did you hear about the meeting?***	• Board Member • CHC • Neighbourhood Forum • Salisbury Road Patients Association • Personal Contact	
		YES	**NO**
2.	***Is it advertised enough?***	3	6 1 N/A
3.	***Do you find the content of the meeting interesting? (see Other Comments)***	10	1
4.	***Were there sufficient copies of the Agenda and Papers available?***	7	3
5.	***Was the venue suitable for:***		
	• ***Location***	10	1
	• ***Access***	11	
	• ***Visibility***	11	
	• ***Hearing (see Other Comments)***	6	5
	• ***Parking (see Other Comments)***	9	2
6.	***Did you stay for refreshments after the meeting?***	10	1
7.	***Did you have an opportunity to speak to Charles Lewis or Sheila Clark?***	10	1
8.	***What else would you like to see at the public meetings?***	• opportunity for interaction • visual aids • less in house language and abbreviations • ability to ask questions at the meeting • shorter meetings • presentations in more popular form of achievements/decisions reached/goals • more time given to answering patients questions	

	QUESTION	ANSWER
9.	***What other ways can we involve the public?***	• advertise through the media that will inform the non-reading public • more directed and to accessible to non intelectuals • drop in surgeries • street surveys for feedback • radio/paper where public can ask questions • advertise short presentations on topical NHS subjects • include fliers with council/electoral forms • use doctor/health clinic notice boards • public notice boards • shop notice boards • "Watch Dog" Groups • request the public to express their views • shorter meetings
10.	***What persuaded you to attend?***	• long interest in health issues • interest in policies • member of CHC • the need to know what is being decided, how the resources and distributed and who makes the decisions • Chair of Portsmouth Pensioners Association • general desire for good of the city • out of loyalty to wife! • represented Neighbourhood Forum • support for a friend
11.	***Have you visited our Web Site?***	• Two visited but one found it difficult to find our site, the rest had not visited
12.	***Would you like to receive a copy of the results of this questionnaire?***	8 yes, 3 no
13.	***Any other comments?***	
	• when members speak towards Chairman, public cannot hear very well • insufficient parking spaces for numbers at venue • chairman often speaks too quietly • parking dark and scary especially for lone women • be more involved in the creation of the agenda • terminology hard to understand • trying to make a business meeting more "public friendly" would hinder progress • impressed with enthusiasm and energy with which you attach so many complicated issues	

Agenda Item No:

No: 10.2

PROMPT SCHEME

Background & Summary

The February Board Meeting of Portsea Island PCG requested a system through which GP practices could raise concerns about services. It was proposed that a method be introduced along the lines of the earlier GP Prompt Card Scheme.

A two-way Prompt scheme is proposed whereby primary care teams and secondary care staff can feedback information to the PCG. Trend analysis will inform discussions between the PCG and providers and set objectives for commissioning and service priorities for the future. Results will be fed back to primary care through constituency GPs. Feedback about primary care from secondary care will be forwarded to GP practices through a graphing process similar to SIMPLE (coded bar charts).

Costs will be in the region of £750 for primary care, assuming both pads and cards are offered. A major factor in the costing process is likely to be whether secondary care finance their own scheme.

Recommendations:

The Board is invited to comment on this proposal.

Date: Thursday, 30 March 2000

Paper Prepared by: Jeremy Douglas

PROMPT SCHEME PROPOSAL

Introduction

Providing feedback on a service usually takes time, particularly if there is a need to list all the details of an event. Writing a letter of praise is probably even less likely given pressures on time. An important source of concurrent quality information is therefore lost, since neither the provider nor the commissioner of services is aware of non-reported incidents as they occur.

The February Board Meeting of Portsea Island PCG received a commissioning performance report set within the context of developing quality initiatives. The Board requested a system through which GP practices could raise concerns about services. It was proposed that a method be introduced along the lines of an earlier Prompt Card Scheme.

Background

The 'Prompt Card Scheme' was introduced by Portsmouth & SE Hampshire Health Authority to encourage short comments (praise or concern) regarding any commissioned service. The resulting prompts were entered onto a database and classified by provider and specialty under a number of headings, e.g. 'communications' or 'discharge'. Comments were sent on a monthly basis to the Trust for information, and to elicit feedback for the next month's 'Practice Wise'. GPs were kept informed of responses and any action arising.

About 300 prompts from 100 GPs were received over an 18 month period in the mid 1990s, 9% of which were praise. The scheme was discontinued due mainly to providers' concern that motivation was easily affected by negative comments which failed to provide the details necessary for follow up. The wide scope of the scheme also resulted in many prompts not being repeated, although a pattern of responses was discernible for some specialties.

The Way Forward

The idea of a Prompt scheme was supported recently by the PCG Quality and Clinical Governance Sub Group, provided that it does not replace doctor to doctor communications. It should be available for any of the services we commission, but the comments should be held within the PCG rather than passed individually to providers. Constituency GPs would be an excellent way of feeding back information. The prompt comments should be two-way, i.e. from primary to secondary and from secondary to primary care, although it may be difficult for secondary care providers to find a process that only relates to Portsea Island patients. Comments from primary care should be sent via the 'FHSA' bag.

Members of the District-Wide Quality Partnerships Panel felt that if reintroduced, the Prompt Scheme should be two way, but that there were other forums for raising issues which should ideally be used. There was concern that creating yet another system for picking up issues was not the solution. PCG nurses at the Links Network meeting however welcomed the idea of the Scheme, issues likely to prompt comment include discharge and equipment.

Recommended Method

Users of Prompt

- All members of the Primary Care team should have access to Prompt.
- Each GP should have their own Prompt pack on request. Advice should be sought from practice managers and the nurses' Link Network on the best way of distributing Prompt cards for use by the whole team.
- The Quality Partnerships Panel should discuss accessibility to Prompt in secondary care, (and ways of ensuring that comments are only sent that apply to our PCG).

Prompt Card Format

- It is proposed that Prompt comments be collected as before, through use of a Prompt Pad, Prompt Cards and Prompt Fax, (for an example see Appendix One). Prompt Cards should be printed with an address so that, folded and sealed, they could be sent without requiring envelopes.
- Changes to the comment checklist may be considered, e.g. influenced by how the Prescribing Sub Group's use a prescribing 'Alert' Card.
- As NHSNet is advanced and NHSNet training takes place, the possibility of a Prompt template for use on the e-mail system should be investigated. (In future the local Extranet may provide additional methods, e.g. direct entry to a Prompt database).

Prompt Process

- All Prompts are to be sent to the Information Analyst at Portsea Island PCG.
- Prompt comments will be inputted as free text onto a database, with coded sender, (constituency), provider/practice, praise (y/n), specialty and comment type.
- No names will be entered on the database, forms may be kept 2 years for reference.
- 'Praise' Prompts will be forwarded directly to the provider's Director of Quality or the GP practice.
- Secretarial support should be available for inputting Prompt.
- Trends will be monitored on a monthly basis and linked to provider meeting dates.
- Feedback to primary care teams regarding their comments and any action resulting will be via constituency GPs.
- Feedback to the primary care team regarding the type of comments from secondary care will use a SIMPLE bar chart format with coded practices, (depending on the number of comments received).

Costs

• 50 Prompt Pads (each containing 25 duplicated sheets):	£200
• 1250 Printed C5 Envelopes:	£200
• 1000 A5 Card, printed both sides, gummed and scored:	£300
• 100 Hanging dispensers (for 10 cards)	£ 50
• Faxed prompt: A4 paper	(negligible cost)

Approximately £750.00 should cover materials for use within primary care, (dependent on the uptake of the scheme). One Prompt pad for every ward and clinic would be prohibitive however. One prompt pad per consultant would cost an additional £800 (approximately). The PCG Board may wish to state a ceiling cost that the PCG would be willing to meet for secondary care Prompt expenses, or suggest that providers fund their own system.

Agenda Item No:

No: 10.3

COMMUNICATIONS AND PUBLIC INVOLVEMENT

Background & Summary

The committee for Communications and Public Involvement Sub Group met on Monday 31 January 2000. A copy of the meeting notes are attached.

Recommendations:

The Board are asked to approve these minutes.

Date: **28 March 2000**

Paper Prepared by: **Charles Lewis**

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PORTSEA ISLAND PRIMARY CARE GROUP

Communications and Public Involvement Subgroup

Notes of the Meeting held on 31 January 2000

Present: Pauline Robinson, Sheila Clark, Maureen Beattie, Lin Kneller, Charles Lewis, Marie Potter, Jean Hooper

No.	Discussion	Action
1.	**Apologies for absence**	
	Noreen Kickham, Jackie Charlesworth	
2.	**Election of Chair**	
	It was agreed to defer this until a replacement for Jackie was in post. Charles Lewis agreed to chair this meeting.	
3.	**Minutes of the Meeting held on 10 December 1999**	
	These were agreed with the addition of "information" in item 4.4 which should now read "practice information leaflets".	
4.	**Matters Arising**	
4.1	**Neighbourhood Forum Links**	
	Mary now has the name of the link officer at the City Council and will be pursuing this.	MS
4.2	**PCG Website**	
	The website was now operational and all teething problems appear to be sorted. Lin Kneller will speak to Ann Edmeades at Hampshire County Council about the possibility of installing a counter to see how many people visited the site.	
	It was agreed that it was necessary to publicise the availability of the website, especially the facility for the public to make contact via email/ Lin Kneller will arrange for an article to go into HealthCheck and all present agreed to publicise as much as possible. Marie Potter is meeting Neil Durham of the Portsmouth news to discuss doing a possible feature and she will ask him to mention the website. Maureen Beattie will draw it to the attention of the practice managers at their next meeting and will include the website address in practice information leaflets. The website address will also be included in the Health & Social Services directory and it was agreed that laminated posters in surgeries advertising the web site would be a good idea	LK MP MB LK

4.3 Citizens Panels

The Citizens' Panel was up and running and new people were interested in joining. Mary reported that a lot of local authorities were using citizens panels as a way of gauging public opinion and the possibility of linking in with the council was briefly discussed and agreed to be a good idea. All present agreed to publicise as and when opportune to do so. All

4.4 Patients Survey

Mary is well underway with planning the next patients' survey which will be undertaken within the next few weeks by means of 20-30 street interviews per PCG. Sheila offered to fund Mary to enable her to double the size of the sample so that it would be more representative. MS/SC

Marie Potter suggested using a similar questionnaire for people to complete when we do visits to talk to public groups. This was felt to be a good idea as it could be used as a growing evidence base.

4.5 Nursing Communication Network

Pauline reported that it was going well, although it was still difficult for nurses to attend meetings.

4.6 Engaging Hard to Reach Groups

Marie reported on her encouraging meeting with the City Centre Association which was a group chaired by the Allders manager who offered us a slot whenever needed during the weekly half hour training session for staff. A meeting with the Cascades Association was scheduled for February

Mary Stratford and Marie Potter will discuss methods of communicating with ethnic minority groups. MS/MP

5. Conference Action Plan

Following on from steering group meeting Jackie Charlesworth and Sheila Clark have drawn up a list of actions which needs to be compared with initiatives already underway to see where the gaps are. A prioritised action plan will then be prepared to go to the Board meeting and then distributed as necessary with a covering letter by Jean Hooper and Charles Lewis. JH/CL

The following items were briefly discussed:

- Managing stress
- Traffic pollution and housing - Charles to speak to Alan Higgins at Portsmouth City Council about work already underway CL
- Communicating with the Elderly
- Training of practice staff - encouragement for staff to go on available courses. Working with practice managers to promote training to develop consistency and best practice. Funding for staff cover when on training will be picked up by the devolving relief budget.
- Use of leisure centres and promoting simple ideas, e.g. escorted walks
- Explanation of waiting times, appointment times, use of drop -in centres.

It was agreed that managing stress, staff training and best practice survey would be given a higher priority.

6. Charter Update

Sheila reported that we are still part of the pilot and Sue Damarell-Kewell will be taking on this work in place of Jackie Charlesworth. The NHS Exec. at Leeds has given us an extension of six months and work is proceeding smoothly.

7. Brighton & Hove Rocks

It was agreed to have another look at this document which details a lot of information to see if any ideas could be incorporated into our programme of work which we will discuss at the next meeting. All

8. Programme of Work

It was agreed that we are achieving our aims and have done well so far, especially with Marie's ongoing work with the hard to reach groups.

9. Date of Next meeting

This will be held on 22 May 2000, from 9.30 - 11.30, F1 meeting room

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Agenda Item No: 11.1

Prescribing Budget setting for 2000/2001

Background & Summary

Prescribing is one component of the unified budget. Primary Care Groups and Trusts are responsible for setting the prescribing budgets for their constituent practices. This paper outlines the following:

- Contingency reserves
- The principles of practice budget setting methodology

Guidance, from the Centre for 2000/2001, indicates that the objectives of the practice budget setting process should ensure:

- Fair and adequate prescribing budgets to meet the needs of patients;
- Improvements in the clinical and cost-effectiveness of prescribing;
- Transparent approach offering practices the opportunity to contribute to the development of the methodology.

It is recognised that there is no robust scientific formula for setting practice prescribing budgets. In the past budgets have been set using a mix of historic factors, adjustments for list size using ASTRO-PUs, numbers of patients in nursing and residential homes, estimated expensive drug expenditure, practice Jarman index, current spend and growth rates compared to the locality average and specific needs declared by practices. Last year, the NHS Executive developed a national formula to determine the prescribing element of PCGs unified equity targets. This was used as a basis for setting the 1999/2000 practice prescribing budgets. The formula provides an equity target for each practice and whilst it only accounts for 62% of the variations in prescribing costs at practice level it does provide a method for comparing practices to a target. A full explanation of the proposed methodology is indicated in the attached paper. Due to delays in receiving the final allocation for prescribing, it is anticipated that practices will receive notification of their prescribing budget by the end of April 2000. Practices will then be given one month from the date on the letter, to express any concerns about their practice budget.

For 2000/2001, it was felt that an important part of the budget setting process should include a presentation of the proposed methodology at the Steering Meeting. The aim was to provide a clear and transparent explanation of the principles and methodology involved, and allow the steering group to comment on the paper. The paper was well received and the Steering Group supported the proposals.

Recommendations:

The Board is asked to support the two main proposals outlined in this paper on contingency reserves and methodology for budget setting.

Date: 31st March 2000

Paper Prepared by: Kathryn Alder

Prescribing Budgets 2000/2001

1. Introduction

Prescribing is one component of the unified budget. Primary Care Groups and Trusts are responsible for setting the prescribing budgets for their constituent practices. This paper outlines the following:

- Contingency reserves.
- The principles of practice budget setting methodology

2. Contingency Reserves

By early March 2000, the PCG should receive notification of the total amount allocated for the prescribing budget for 2000/2001. As part of a risk management strategy, PCGs have to agree arrangements for use of contingency reserves with the Health Authority and also hold a contingency at PCG level. These amounts will be topsliced from the total amount allocated for prescribing and the remaining funds will be used for setting practice prescribing budgets.

a) Centrally held Contingency Reserve

It is proposed that the Health Authority continues to hold and administer a central prescribing contingency reserve of 0.5% of the total funds allocated to prescribing. This reserve will be used only for managing the effects of substantially increased list sizes at practice level and increases in the prescribing of a defined historical list of hospital driven specialist drugs. (**See Appendix A**). At present, there are no plans to extend this list because the focus is now on ensuring that specialist hospital drugs are not transferred inappropriately to GPs.

b) Nurse Prescribing Allocation

An indicative prescribing budget also needs to be set up for the Community Trust, whose nurses will now be prescribing from a limited formulary on behalf of practices. (Note that prescribing costs incurred by directly employed practice nurses can be charged to GP practices). Approximately 10% of all primary care prescribing costs are due to nurse prescribable items. The results of national pilot studies of nurse prescribing suggest that when there is full implementation, 1% of all prescribing costs will be attributed to nurse prescribing. Last year, the Community Trust were allocated a budget of 0.125% on the basis that only a proportion of the nurses would be trained and ready to prescribe in 1999/2000 and that prescribing would not start until later in the financial year. For 2000/2001, it is proposed that 0.75% of the total prescribing allocation is put aside for nurse prescribing. Due to delays in availability of prescribing data information, the costs of this prescribing will not be available until next financial year, therefore the size of the Community Trust Allocation will again have to be based on an estimate of the take up of nurse prescribing. By March 2001 all eligible nurse will have been trained. As the value of the transfer from the PCGs to nurse prescribing is based upon an estimate, any under or overspends against this budget will be managed by the Health Authority rather than PCGs or the Community Trust. Community Trust nurse prescribing will continue to be monitored by the Health Authority and PCGs using PACT data.

c) New Drug Development Fund

At the last PCG Board meeting, it was agreed to support and provide funding for the New Drug development fund. This is subject to approval and funding from the other three PCGs within Portsmouth and S.E Hants Health Authority, NHS Trusts and RHH. The fund would be held by the Drug and Therapeutics Committee, who would use this to fund the limited use of some of the new medicines that have been approved by Drug and Therapeutics Committee, but still awaiting funding through the SAFF process. Initially, it is proposed that funding would be sought from the Health Authority/PCGs, NHS Trusts and RHH based on current level of drug spend by the following:

- a top slice £100,000 from the Health Authority primary care drugs budget, divided per PCG on a capitation basis or a reduction in growth allocation for the year 2000 – 2001
- pro rata reduction in Trust allocations

In the longer term, it is proposed that the Drug and Therapeutics Committee could identify recurring savings for this purpose, for example through prescribing policy change and publication of guidelines. The total for the proposed fund for 2000/2001 is £116,369. Portsea Island PCG has been asked to contribute £26,305 to this fund, which will be topsliced from the 2000/2001 prescribing budget.

d. PCG held contingency reserve

As with last year, it is proposed that a local contingency reserve is held at PCG level to account for any exceptional demands in prescribing and to offset any financial risk to the PCG Prescribing budget. It is proposed that for 2000/2001 the contingency reserve should be £300,000.

3. Practice Prescribing Budget Setting Methodology

For 2000/2001, it was felt that an important part of the budget setting process should include an explanation and presentation of the methodology at the Steering Meeting. The aim is to provide a clear and transparent explanation of the principles and methodology involved.

a) Background and information

Indicative prescribing budgets were first introduced in April 1991 as part of the fundholding scheme. Initially they were set on a historic cost basis. This approach was criticised and as a result a weighted capitation process was introduced, initially using PUs (Prescribing units) and then ASTRO-PUs. These covered weightings for Age, Sex and Temporary Residents and accounted for 25% of the variations in prescribing costs. Over the years, methods have developed using historic factors, adjustments for list size using ASTRO-PUs, numbers of patients in nursing and residential homes, estimated expensive drug expenditure, practice Jarman index, current spend and growth rates compared to the locality average and specific needs declared by practices. Practice budgets were previously set by the Health Authority Pharmaceutical and/ or Medical advisors, however from the 1st April 1999, this responsibility was devolved Primary Care Groups. The Prescribing Subgroup worked closely with Katie Hovenden, the Health Authority Pharmaceutical Advisor, in setting the budgets for 1999/2000. Budgets were set using the guidance in HSC 1998/228 and the formula developed by the NHS Executive/York University with some individual practice adjustments.

b) Objectives and Aims

Overall the objectives of the practice budget setting process should ensure:

- fair and adequate prescribing budgets to meet the needs of patients;
- improvements in the clinical and cost-effectiveness of prescribing;
- transparent approach offering practices the opportunity to contribute to the development of the methodology.

The overall aim is to achieve fair budgets based on objective assessments of need. Guidance issued by the Department of Health for 2000/2001, again reiterates that it is not possible to achieve this in a mechanistic way and capitation formulae should not be solely relied upon for this purpose

This guidance states that indicative practice budgets should be set on a mix of weighted capitation methodology historic spending patterns and local judgement and recommends that the allocation method should compose the following components:

- basic uplift on allocation, adjusted to take account of PPA outturn projections
- an additional component for those whose budget share, taking account of the weighted practice population (using ASTRO97-PUs as a basis) is below the local average
- an adjustment for practices whose populations have changed significantly
- an adjustment for practices underspending significantly.

c) Funds for Practices' Prescribing budgets

The amount available for setting practice prescribing budgets for 2000/2001 is indicated in the table below:

Total allocation 2000/2001 (8.8% uplift on 99/00)	£13,851328
Topslice for shared contingency (0.5%) with Health Authority for changes in list sizes and expensive drugs	£69,259
Topslice for nurse prescribing (0.75%)	£103,885
Topslice for New Drug Development Fund	£26,305
PCG held contingency reserve	£300,000
Funds available for allocation to practices for 2000/2001	£13,651,881

d) Methodology

A proposed budget setting methodology is outlined below:

- **Baseline Budget**

The 1999/2000 practice budget excluding expensive drugs is taken as the baseline.

- **Adjusted baseline budget**

The baseline is then corrected for list size changes as measured by ASTRO-PUs to give the adjusted baseline budget.(Each Nursing home patient attracting an additional 20 ASTRO-PUs and each Residential Home patient an additional 10 ASTRO-PUs). A fall in list size results in a reduction of baseline budget.

- **Minimum Uplift**

All practices receive a minimum uplift to be decided during the budget setting process.

- **Equity adjustments**

There is no formula that has been shown to accurately reflect all the variation in prescribing costs at practice level but the NHS Executive have developed a national formula to determine the prescribing element of PCGs unified equity targets. This formula can be adapted for use at practice level. The formula provides an equity target for a practice based upon list size, relative age and sex distribution, and additional need. The age and sex profile adjustment in the formula is based on relative ASTRO-PUs. The additional Need adjustment is determined by mapping patients to wards using their postcodes, and allocating variables from the 1991 census to the patient, and then determining a needs score from the variables. The need scores of the individual patients are then used to determine the average needs score of each practice within a PCG. The census variables considered by the model are:

- The percentage of adults living in households and who are unable to work because of long term sickness or disability.
- The percentage of dependants who are in no carer households.
- The percentage of births on practice lists.
- The percentage of the working age populations who are students.

The first three variables increase the relative needs score of a practice and the last variable, looking at student populations, decreases the score. It can be argued that this formula is capable of explaining only 62% of the variation in prescribing and still does not weight adequately for deprivation and the associated excess of morbidity and mortality at practice level and expenditure at practice level. However, it does give an objective way of comparing practices current budget against a target and includes indicators of need

- **Distance from Target**

The distance from target for each practice is the difference between the adjusted baseline budget plus the minimum uplift and the equity target. The funds remaining after the minimum uplift has been applied to the baseline budgets, can then be allocated to practices that are below target. Funds are allocated according to the distance from target i.e. those practices furthest under target receive the largest equity adjustment. These adjustments will not move practices fully to "equity" but attempts to allocate additional cash to areas of demonstrated need.

Practices as a result of these adjustments can then be divided into four groups:

- Practices below target, with a predicted underspend
- Practices below target, with a predicted overspend
- Practices above target, with a predicted underspend
- Practices above target, with a predicted overspend

- **Adjustments for practices with significant overspends and underspends**

Since the model accounts for only 62% of the variations in prescribing costs, adjustments will then be made for practices with significant overspends and underspends. Huge variations in GP prescribing costs are well known and a big determinant is GP behaviour. In addition as funds are limited the approach to budget setting has to be a compromise between setting truly equitable budgets and what is seen to be "fair and achievable". For this reason adjustments will be made in the following cases:

i) Practices who are above target with underspends and who have not demonstrated a clear need for additional money.

ii) Practices who are below target but with significant underspends and have not indicated a clear need for additional money.
iii) Practices who are below target with predicted overspends, since it is recognised that equity model may not adequately account for other factors associated with need.

Adjustments will be made, as appropriate, based on: practice based Jarman scores derived from Enumeration District data, individual practice needs, historic and local knowledge of practices prescribing.

- **Prescribing budgets for 2000/2001**

After these adjustments, this will then give the proposed practice budget for 2000/2001. This is compared to current spend, growth rates, previous years budget and funding compared to the PCG average. All practices will receive a flow chart indicating exactly how the figure for their 2000/2001 practice prescribing budget has been calculated.

4. Notification of Budgets

Due to delays in receiving the final allocation for prescribing, it is anticipated that practices will receive notification of their prescribing budget by the end of April 2000. Practices will then be given one month from the date on the letter, to express any concerns about their practice budget. However, it must be remembered that the overall PCG prescribing budget is cash limited.

5. Conclusion and Summary

It is recognised that there is no robust scientific formula for setting practice prescribing budgets. The equity formula accounts for 62% of the variations in prescribing costs at practice level and provides a method for comparing practices to a target. Adjustments made to budgets are based on the recognition that other factors, which are difficult to measure and are not included in the equity formula, can affect prescribing costs. This paper was presented at the Steering Meeting on March 15th 2000 and the proposals were supported.

The Board is asked to support the two main proposals outlined in this paper on contingency reserves and methodology for budget setting.

Appendix A

Ring Fenced Hospital Driven Expensive Drugs

Where GPs **accept clinical responsibility** and agree to undertake the prescribing, adjustments will be made to prescribing budgets using a centrally held contingency reserve to allow for the financial impact of prescribing of the following drugs:

4.2.1	
Olanzapine	*Zyprexa*
Risperidone	*Risperdal*
Quetiapine	*Seroquel*
6.4.2 and 8.3.4	
Cyproterone	*Androcur, Cyprostat*
6.5.1	
Somatropin	*Genotropin, Humatrope, Norditropin, Saizen, Zomacton*
6.7.2 and 8.3.4	
Buserelin	
Goserelin	
Leuprorelin	*Suprecur*
Naferelin	*Zoladex*
Triptorelin	*Prostap SR/3*
	Synarel
	De-capeptyl

8.2.2	
Cyclosporin	*Sandimmun, Neoral*
Tacrolimus	*Prograf*
8.2.4	
Interferon alpha	*Intron-A, Roferon-A Viraferon, Wellferon*
8.3.4	
Anastrazole	
Formestane	*Arimidex*
Bicultamide	*Lentaron*
Flutamide	*Casodex*
Octreotide	*Drogenil*
	Sandostatin
9.1.3	
Erythropoietin	*Eprex, Recormon*

Agenda Item No:

No: 11.2

PRESCRIBING EXPENDITURE REPORT

Background & Summary

November figures now available from the PPA, indicate that Portsea Island PCG practices are, as a group, predicted to overspend on their 1999/2000 prescribing budget by £595,277.

Adjusting this figure to include the PCG contingency and the additional money allocated for the increase in generic prices gives an overspend of £223,352

The attached table and graph show the overspend for the PCG from April to November 1999. Whilst this situation is universal the PCG will have to consider the implications if the situation gets worse and how this is best managed within the overall PCG budget.

The individual practice figures will be tabled in Part II of the Board Meeting

Recommendations:

The Board is asked to comment on this paper

Date: **31 March 2000**

Paper Prepared by: **Kathryn Alder**

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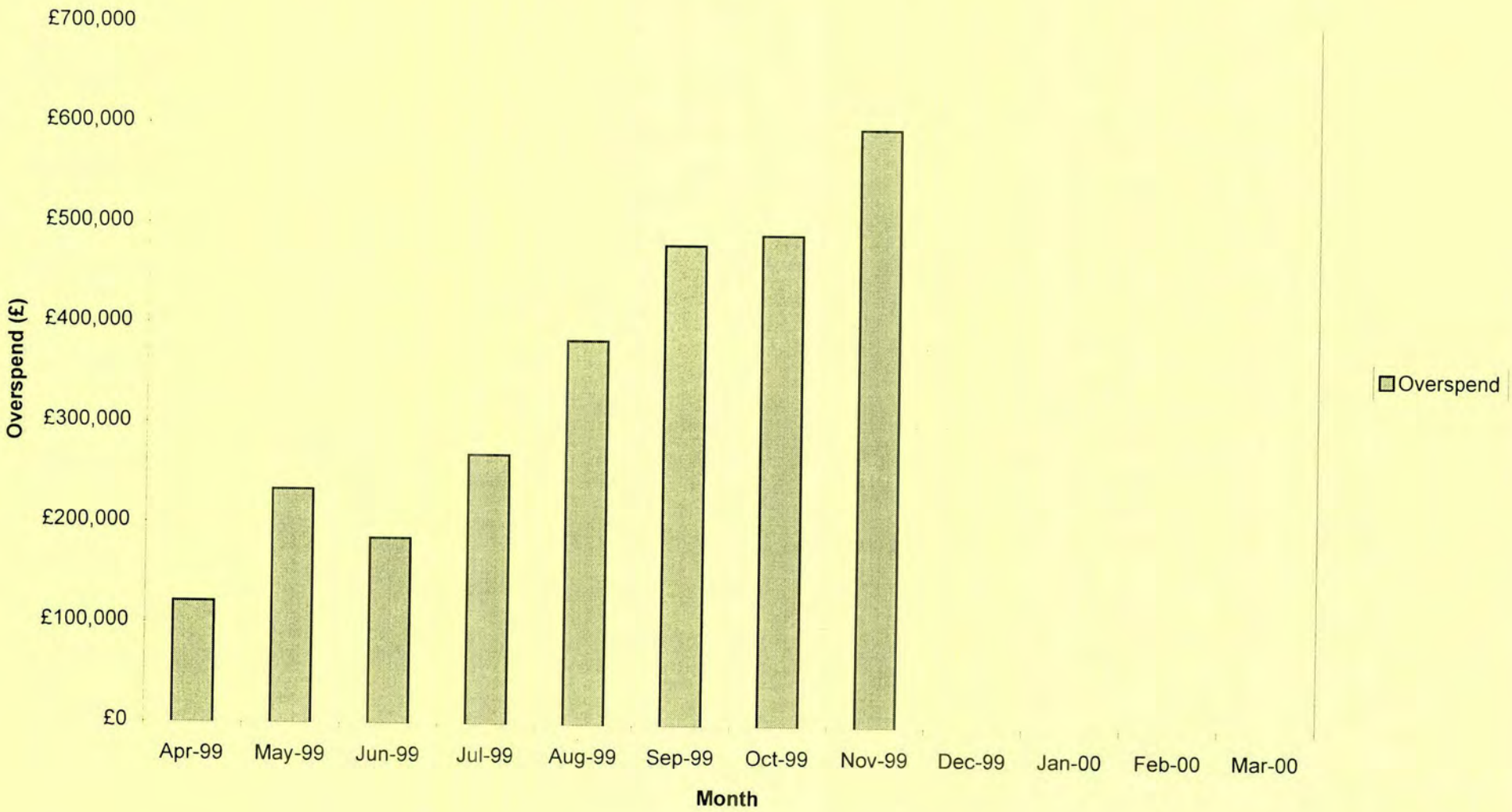
Table to indicate Portsea Island PCG overspend trend

year	Overspend
Apr-99	£120,677
May-99	£232,567
Jun-99	£184,145
Jul-99	£268,123
Aug-99	£382,729
Sep-99	£479,068
Oct-99	£489,356
Nov-99	£595,277
Dec-99	
Jan-00	
Feb-00	
Mar-00	
total budget	£12,473,948

These figures do not include the contigency reserve or additional money for increased generic prices

Graph to show Overspend Trend of Portsea Island PCG



Agenda Item No:

No: 11.3

PRESCRIBING

Background & Summary

The Prescribing Sub Group met on Tuesday 25 January and Thursday 17 February 2000. A copy of the meeting notes are attached.

Recommendations:

The Board are asked to approve these minutes.

Date: **29 March 2000**

Paper Prepared by: **Colin Olford**

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PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PORTSEA ISLAND PRIMARY CARE GROUP
Prescribing Sub-Group Meeting

Notes of the Meeting held: 25 January 2000 at Chichester Road Surgery

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Present: Colin Olford Kathryn Alder Liz Phillipou Vicky Turner Elizabeth Fellows Simon Harris Tim Wilkinson John Thornton

No	Discussion	Action
1.	**Apologies for Absence**	
2.	The group had no interests to declare	
3.	**Matters Arising** Colin had received his reply from Penny Humphris after expressing his concerns about the rising generic drug prices. Colin has replied to letter. It was agreed to investigate and to get more accurate figures for nursing and Residential homes numbers. agreed to check the figures for	KA/ EF
4.	**Prescribing Figures** The group discussed the latest prescribing figures.	
5.	**Generics Update Additional Money** Kathryn circulated a paper prepared by Tracy Green proposing four options. There was a long discussion regarding the advantages and disadvantages for each option. The group agreed that changing the incentive scheme and asking practices with large savings to return these to the PCG, were not feasible options. They also expressed their concerns that it was difficult to make a decision as it was highly likely that the overspend of the PCG could get worse and predictions were difficult due to delayed data from the PPA and the further impact of increased generic prices. The group agreed that they would, if possible, like to wait until more information was available before making a final decision. The group was divided between allocating the money to individual practices or adding the money to the contingency reserve. Colin and Kathryn agreed to circulate a paper to the members of the Sub-group for their comments before the paper is discussed at the next Board meeting.	KA/CO

Latest Guidance on Budget Setting/ Template from Katie

There is no new guidance from last year. Kathryn was asked by the group to confirm with Katie the following points from the guidance: KA/TW

- Whether money for nurse prescribers should be top sliced from the budget and how much this should be.
- What are community unit nurse prescribers?
- How many nurse prescribers there are likely to be in the PCG over 2000/2001?

Tim and Kathryn agreed to write a paper outlining the principles for prescribing budget settings.

6. **Jarman at ED level**

Kathryn and Vicky are to investigate linking this with additional funding to practices. KA/VT

Information sharing

Following on from our last meeting in December we had agreed that graphs comparing practices on cost for each of the therapeutic areas would be a good idea and to share this information with other practices in the PCG. Kathryn agreed to present this at the next Steering meeting and then send a letter out with Colin asking practices for their agreement on this. KA/CO

7. **AOB**

Tim agreed to represent the group on the District Formulary Steering group. TW

8.

The meeting closed at 3.00

Dates of the next meetings

These were set for Thursday 17 February 12.30 and Tuesday 21 March 12.30 at Chichester Road Surgery.

9.

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

PORTSEA ISLAND PRIMARY CARE GROUP
Prescribing Sub-Group Meeting

Notes of the Meeting held: 17 February 2000 12.30 at Chichester Road Surgery

Present: Colin Olford, Kathryn Alder, Tim Wilkinson, Vicky Turner, Elizabeth Fellows, Simon Harris, John Thornton

No	Discussion	Action
	Apologies for Absence	
1.	Elizabeth Phillipou	
2.	**Minutes of the last meeting** Minutes of the last meeting were agreed as a correct record	
3.	**Declaration of interests.** The group had no interests to declare	
4.	**Matters arising** The PCG Board accepted the paper proposing that the additional funding for the increased generic prices is allocated to individual practices. Money will be allocated to the practices based on their prescribed generic rate at the end of March 2000. **District formulary (Tim Wilkinson)** Tim reported from his district formulary meeting. The meeting was an introduction and the plan will be to review areas of the existing formulary and current guidelines. The next meeting is to be arranged in March. Colin voiced concerns over the guidelines. Tim reassured him that individual consultants would be asked to review and where necessary write guidelines. Ann Dowd had been asked to join the District Formulary Steering group, as a representative of the Trust. Tim agreed to continue to represent the PCG at this meeting.	TW

5. **Prescribing Budgets 2000/2001**

Tim explained his principles to the group.
expressed his concerns that using the equity model and applying additional funding for Jarman, may be trying to address "need" twice.

The equity model was discussed and a meeting will be arranged with Martin Wilkinson from Finance. K A

Prescribing Budget Calculation 1999/2000

Kathryn circulated the prescribing budget calculation 1999/2000 using Tim's' principles, to all present for discussion. Kathryn then talked through the papers with the group.

John requested for more information about prescribing indicators for individual practices. K A

After some discussion the sub-group agreed to wait until they knew exactly what the allocation figures were.

6. **Any other business**

i) Practice visits

These were discussed and it was agreed that Kathryn would ask individual practices, if they would like Colin or their Constituency GP to attend. K A

ii) Asthma

John reported back form his asthma strategy group. There were concerns about problems with the dosage adjustments when changing patients on for Beclomethasone CFC inhalers to Q-var.

Date of the next Meeting

The date arranged for the next meeting on the 21 March has been cancelled and will be held on the 4 April 2000 at Chichester Road Surgery 12.30pm. The equity model presentation will be held on the 16 March at the Chichester Road Surgery 12.30pm.