Title: 9a 14

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

GOSPORT PCG - GP STEERING GROUP MEETING

Health Education Room, Gosport Health Centre, 13 January 2000 12.30 - 2pm

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AGENDA

1. **Apologies for Absence**

2. **Sex Sense**

   Gordon Atkins will attend for this item

3. **Drug Action Team**

   Bevin Manoy will attend for this item

4 **Notes of previous meeting and matters arising**

   - Proposal for a Local Development Scheme (DDRB)
   - Use of GP beds (Report attached)

4. **Mental Health Strategy** (Draft Exec. Summary attached)

5. **Prescribing update**

6. **AOB**

7. **Date of next meeting**

   2 March 2000, 12.30pm GWMH

*** Please note the change of venue for this meeting**

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

GOSPORT PRIMARY CARE GROUP

Notes of the Meeting held on the 4 November 1999 at Gosport War Memorial Hospital

Present:	Dr Barton	Pat Rimmer
	Dr Young	John Kirtley
	Dr Harrison	Hazel Bagshaw
	Dr Bassett	Peter Ifold
	Dr Lynch	Kathryn Rowles
	Dr Pennells	Dr Hildebrand
	Dr Beale	Dr Davidson
	Dr Grocock	Rose Butcher (items 2/3)
	Jayne Colebourne	Liz Ross (item 2)
	Surgeon Commander Peter Nichol	

No	Discussion	Action

1 Apologies

Dr Burgess

2 Care Management

Liz Ross and Rose Butcher presented a consultation paper on District Nurses as Care Managers, which set out a number of options for the future organisation of the service in Gosport and Fareham. The scheme has been very successful but is only available to a limited number of practices. The existing arrangement has also highlighted a number of key issues that need to be resolved, including a tendency for district nurses to hold long-term cases and the amount of time it takes complete the care management assessment process.

Four options were suggested as a way forward, which included:

- Developing a Care Management Team, with mixed grades for Gosport, which links with the Social Services Duty Team.
- Continuing with practice attachment but offer time-limited case holding by the district nurse.
- Ceasing Care Management altogether and absorb existing staff involved within the Trust, as vacancies occur.
- Amalgamating the available money to fund one full time DN Care Manager to work across all Gosport and Fareham practices.

Comments on the four options presented were invited. Dr Barton and Dr Pennells indicated that District Nursing Care Management had revolutionised the management of patients with continuing care needs in their practices and had enabled earlier discharge of patients from Gosport War Memorial Hospital. Concern was expressed concerning the financial contribution from Social Services in supporting this initiative. The question as to whether there might be a more cost-effective alternative to using skilled nursing time to enter data onto the care management system was also raised. The general view seemed to be that option one might be

the preferred choice for piloting a new arrangement in Gosport because it enabled fast tracking of clients. Liz Ross invited practices to send any further comments they might have to her. All

2 Integrated Nursing

Rose Butcher provided an overview of an integrated nursing project that she has been involved in as a joint initiative between Portsmouth Health Care Trust and the Pennells/Evans practices. She explained that the purpose of the project was to provide more effective care to patients by pooling the knowledge and skills of the whole nursing team. Rose explained that the initial focus for joint work has been on diabetes and tissue viability. Joint standards and protocols have been developed in these clinical areas together with joint training initiatives.

Rose indicated that the main difficulties, which have affected team organisation, concerned finding the time for nurses to meet together, misconceptions with the term 'integration' and cultural differences between the Trust and practices involved. The benefits, however, have included a better understanding of individual roles, increased continuity/standardisation of care, more effective use of skills, a patient centred approach to problem solving and a greater ability to manage the workload across the team.

Kathryn Rowles mentioned that a report on the outcomes of a recent workshop event in Gosport, which focused on effective joint working between community and practice nurses, would be submitted to the PCG Board meeting in December for consideration.

4 Notes of previous meeting and matters arising

The notes were agreed as correct.

- **Local Development Scheme (DDRB)**

John Kirtley reminded the Group that Dr Hildebrand had initially explored some of the options suggested for using Gosport GPs allocation (£6,792) for the development of a local scheme. He indicated that Dr Peter Davidson (Sen. Registrar in Public Health) has since agreed to prepare a proposal focusing on adults with learning disabilities. Dr Davidson referred to an initial paper he had produced. He indicated that there are currently 448 adults with learning disabilities in Fareham and Gosport that are known to the Service. Based on the level of funding available, the fee per patient would be approximately £33. Dr Davidson agreed to produce a detailed plan by January 2000. PD

- **Physiotherapy**

Pat Rimmer presented a summary of physiotherapy activity for the period April – September 1999 for all Gosport practices. He highlighted the variation between new referrals and the length of time patients waited for routine appointments. The current funding allocation for physiotherapy across the district is based on 22 referrals per 1000 registered population. John Kirtley mentioned that Fareham PCG had agreed additional investment in physiotherapy services. It was suggested that further costed PR

analysis based on different referral targets was needed before a decision could be reached to invest further funding in physiotherapy services in Gosport.

- **Waiting times/access funding**

Pat Rimmer shared a paper that outlined the bids likely to be funded against the £313,000 district allocation for reducing waiting times. He pointed out that Gosport had not been successful in securing some of this funding but the schemes that have been approved will have local impact. Pat indicated that he was waiting for further details about these schemes, particularly in relation to the roll out arrangements for Portsea Island pilot initiatives for glaucoma and diabetic retinopathy monitoring. He also mentioned that a process had now been agreed for approving future proposals against available funding. Dr Pennells suggested that a local 'think tank' was needed to ensure that good ideas could be worked up as a development plan in readiness for submitting future bids. BP/PR

- **Winter pressures**

Dr Grocock provided an update on winter pressure issues, focusing on the use of GP beds at Gosport War Memorial Hospital. He indicated that every effort to increase bed usage was needed or questions might be asked. It was agreed that this was an issue that Gosport Medical Committee needed to discuss further. GosMC Dr Hildebrand also suggested that it might be possible to relax the criteria for use of GP beds for certain groups of patients. He agreed to provide an update of the current position. JH

5 Reprovision of Services from Haslar

John Kirtley outlined the key issues that have been raised by the PCG in response to the Health Authority's outline proposals for Haslar, particularly in relation to A&E services and ambulance provision. The Group was asked to consider whether GPs in Gosport wished to plan a 'walk in' Minor Injuries/Illness facility locally, as part of the reprovision of Haslar services and whether such a facility should be linked to or be separate from a nurse led satellite unit. The GPs present indicated that they did not necessarily favour a satellite unit in the area or saw an active role in running it, but they would wish to be involved in shaping the development of such a service. It was suggested that NHS Direct could be effectively utilised. However, there were concerns regarding the implications that a satellite Minor Injuries unit might have on GP workload, particularly Out of Hours provision. John Kirtley indicated that he would be happy to discuss this issue further with GosDoc, if required.

6 Primary Care Trusts (PCTs)

John Kirtley presented a brief paper on PCTs, which outlined the criteria for Trust approval, as set out in national guidance, and summarised the local position. He indicated that there are a range of issues that the Community Trust has to address to accommodate this development locally. East Hants PCG has expressed an interest in becoming a PCT by April 2001 and that Portsea Island PCG may wish to pursue a similar timetable. John pointed out that the cost effective management of PCTs would depend, to a large extent, on economies of scale and the critical

mass of services that can be provided/managed by a new Trust. He indicated that if either Gosport or Fareham PCG wished to pursue a PCT application, both would need to consider whether a merger of the two organisations was an essential requirement.

7 Prescribing update

Dr Bassett and Hazel Bagshaw provided an update on various prescribing issues.

- The D&T Committee does not support Orlistat, Clopidogrel and Dornase Alpha. GPs can continue to prescribe these drugs but the cost will be met from the practice's prescribing budget. Hazel Bagshaw agreed to circulate an audit report produced by East Hants PCG, which sets out the benefits and disadvantages of prescribing Orlistat. HB
- A district protocol has been agreed to allow the prescribing of atypical anti-psychotic drugs. The cost will be met using modernisation funding. £100,000 has been ear marked for PHCT and £200,000 for PCGs.
- The D&T Committee is preparing a paper that will put forward proposals on how savings, accrued through long term disinvestment in some areas, can be used to support new drug developments.
- PHT pharmacy has been asked by the PCGs to undertake a costing exercise on TTO drugs. Each PCG has been approached for some funding to support this.
- The cost of some generic drugs has escalated due to supply shortages caused by the change-over to patient dispensing packs and the relocation/closure of manufacturing companies.
- Practices were encouraged to continue to work towards achieving their incentive scheme targets.
- A series of tables, covering the period August – July 1999, were presented by Peter Ifold, which showed the actual spend, cumulative spend, a spending profile and the budget variations for each practice.
- Hazel Bagshaw presented an analysis of the first quarter costs (April – June 1999) relating to the 10 BNF drug categories. She indicated that Gosport is a high spender in 8 of the 10 categories compared with the 3 other PCGs.
- Dr Bassett asked for volunteers to form a Working Party to consider prescribing budget allocation and other issues for 2000/2001. Hazel Bagshaw added that the PCG would shortly be required to produce a prescribing growth plan for the next financial year.

8 AOB

No other business was raised.

Date of next meeting
13 January 2000 – Gosport Health Centre, Health Education Room, 12.30pm

Portsmouth and South East Hampshire Health Authority

Paper for Fareham and Gosport Primary Care Groups

Proposed Local Development Scheme for the Care of Adults with Learning Disability

1. Background

This scheme has arisen as a result of the suggestions made by the NHSE in *Allocation of DDRB £60million to GP's* (HSC 1999/107) in April this year. Of the £60m, £5m was allocated to fund "Local Development Schemes". The allocation to the PCGs is approximately £9000 to Fareham and £6000 to Gosport. The schemes are supposed to reflect the extra workload involved in caring for certain patient groups. Payments under the scheme can be made to those doctors who provide care to the standard or in ways specified in the scheme. The HSC gives model examples of schemes.

People with learning disability have increased health needs, which are often not met by primary or secondary care services. Fareham and Gosport have a greater number of people with learning disability and very high levels of health need than the other parts of the district.

The Scheme offers at least three potential benefits:

- Improved health care to a vulnerable group of people
- The opportunity for the PCGs to create an innovative and proactive project which should be well received by health and social care organisations locally
- Additional funds for primary care from central government.

2. Aim

To provide a system of enhanced care for adults with Learning Disability

3. Methods

- Establish the numbers of clients in the area and their level of disability, from available data sources.
- Literature search for the evidence of increased healthcare needs and effectiveness of enhanced primary healthcare for people with learning disability.
- Find examples of similar schemes elsewhere.
- Review national guidance.
- Document current service by primary and secondary care.
- Consider the wishes of patients, carers and professionals.
- Examine methods of monitoring and evaluating the scheme.

I have, so far begun the literature searches and had meetings with Tim Tayler in Locks Heath and John Kirtley. I propose to meet them and Jonathan Hildebrand again with the results of the literature review and estimation of prevalence.

4. Recommendations

I intend to bring evidence-based recommendations to the PCGs by January 2000. These might include increased capitation payments for specified patients. item of service payments to any GP providing a defined service. additional payments to a few GPs to provide a service, or a nurse-run service. An individual practice or the PCG could administer the latter.

5. Implementation

The two PCGs may well need to approve a common scheme to operate across both boroughs. Funding is recurrent and was available from April 1999. The schemes are implemented through PCGs. The Health Authority is asked to send a copy of proposed plans to the NHSE and the Regional Office.

I would hope that a scheme would be available for implementation by the PCGs by March 2000. It would be evaluated after six to twelve months

Peter Davidson
SpR in Public Health

3 November 1999

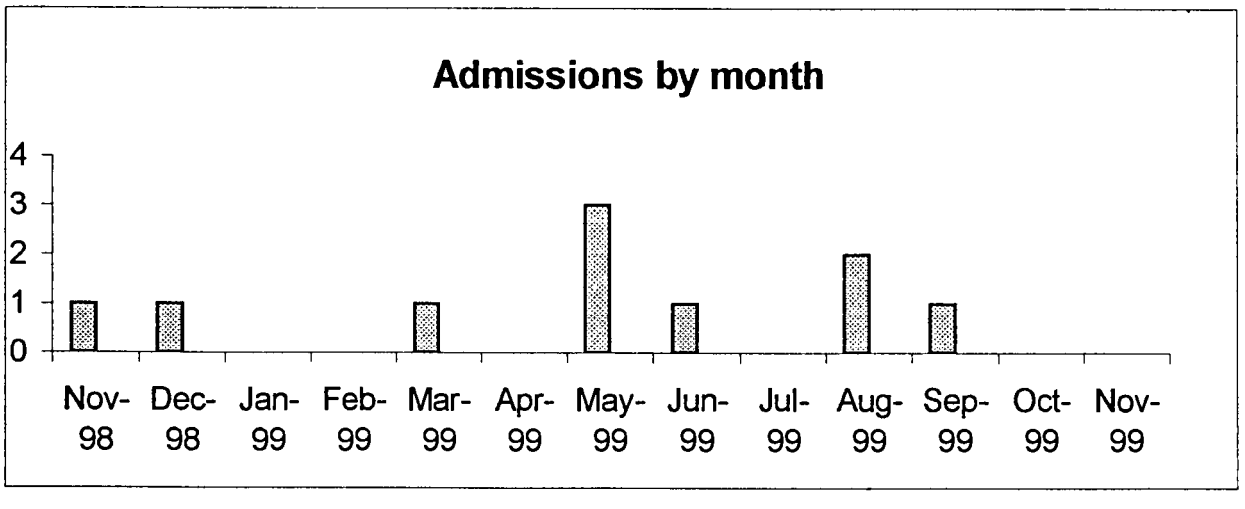
Report on use of GP beds at the Gosport War Memorial Hospital for post acute orthopaedic and surgical patients

1. This report was produced at the request of the Gosport PCG GP Steering Group. It aims to update members of the group on the use made of the option of post acute care provision at the GWMH and suggest ways of increasing the number of patients that could utilise this option.

2. Patients registered with all but two of the practices in Gosport PCG have been able to be admitted to GWMH following orthopaedic procedures since October 1998, subject to admission criteria (appendix 1). Patients who have had surgical procedures performed have been eligible for admission since May 1999 (see appendix 2 for admission criteria).

3. There have been 10 transfers of post-acute orthopaedic patients over the past year. There were 6 women and 4 men transferred. The month of transfer is given in figure 1. The average length of stay was 14.7 days – admissions ranged from 3 days to 26 days. 147 bed days were utilised in total. All patients were discharged to their home address.

Figure 1



4. One admission was not judged to have met the criteria as no home assessment had been performed (however having a home assessment was not included in the criteria). A transfer summary was sent with all patients and sufficient medication was sent with all but one patient. All patients received physiotherapy, whilst seven out of the ten received occupational therapy.

5. Social services were involved in half the admissions, and in three of the five cases there was a delay in discharge. This delay varied from three to fourteen days.

6. All admissions were acceptable to the GP and were felt to be appropriate by the ward team

7. Whilst the scheme has worked well for the patients that have used it, the number of patients seen over the past year has been disappointingly small. There are several possible reasons:

- Not all practices participate - the number of patients transferred could be increased by the two practices joining the scheme. Alternatively, agreement could be reached so that a participating practice is responsible for patients whilst they are inpatients at the GWMH.
- Ward staff at QAH, ST Mary's and Haslar may be unaware of the scheme
- The criteria (appendices 1 and 2) are too stringent

8. I have discussed these factors that are possibly leading to a low uptake with Barbara Robinson, Service Manager, PHCT and Ann Haste, Clinical Manager, Sultan Ward. They feel that the criteria could be relaxed considerably without any significant workload implications for the GPs providing medical care on Sultan Ward as they are confident that patients could be managed by nursing staff.

9. The suggested revised criteria for orthopaedic and surgical patients are given below:

A patient would have to fulfil all the criteria listed below before transfer is discussed:

A. No intravenous line
B. Haematologically stable
C. Not suffering from an unstable medical condition requiring intensive investigation or management
D. Can require ongoing physiotherapy and/or occupational therapy
E. Not confused (orientated in time, place and person)
F. Would be medically fit for discharge in the next 28 days.

10. In addition, Barbara Robinson has undertaken to visit all the acute wards involved in the scheme, to remind them that the option to transfer is there. If the revised criteria are acceptable, she will also discuss them with the ward staff and the revisions will also need to be discussed with the consultants involved in the scheme

11. The GP Group is requested to give consideration to adopting the revised criteria for an initial period of 6 months.

JH

Appendix 1

Criteria for admission of orthopaedic patients to GP beds at the Gosport War Memorial Hospital

1 Introduction

There are 24 primary care beds at the Gosport War Memorial Hospital (GWMH). One option being considered in order to maximise their utilisation is to admit Gosport patients from selected acute specialties who are nearing the end of an inpatient episode at Queen Alexandra or St Mary's Hospitals.
There would need to be strict referral criteria in order to prevent inappropriate transfers. In addition there would need to be a written agreement that should a GP decide that the patient required care in an acute unit, transfer back to QA or St Mary's would be automatic.

2 Specialty

The suggested initial specialty is orthopaedics.

3 Criteria

A patient would have to fulfil **all** the criteria listed below before transfer is discussed:

1. No intravenous line
2. Haematologically stable
3. Apyrexial (can be taking oral antibiotics)
4. No discharging wound
5. Not recently commenced on anticoagulation (e.g. following DVT)
6. Not suffering from an unstable medical condition
7. Not catheterised
8. MRSA free
9. Can require ongoing physiotherapy / occupational therapy
10. Mobile (able to transfer from bed to chair independently)
11. Not confused (orientated in time, place and person)
12. Would be medically fit for discharge in the next seven days

4 Procedure for transfer

If a patient fulfils the criteria, is from Gosport and wishes to transfer to the GWMH the consultant would make the decision to contact the patient's GP. This would be done by a member of the medical team who should discuss the case with the GP. If the GP is not available, then another GP from the same practice should be contacted.
Transfers should occur between 9am - 1pm, Monday - Friday (excluding Bank Holidays).

5 Transfer back to acute unit

The decision to transfer a patient back to QA or St Mary's will be made by the GP (or nominated partner) responsible for the care of the patient. The patient will become the responsibility of the consultant whose care he/she was under before admission to the GWMH. Transfer back will be immediate.

JH - 10/98

Appendix 2

Criteria for admission of surgical patients to GP beds at the Gosport War Memorial Hospital

1 Introduction

There are 24 primary care beds at the Gosport War Memorial Hospital (GWMH). An option that has been chosen in order to maximise their utilisation is to admit Gosport patients from selected acute specialties who are nearing the end of an inpatient episode at Queen Alexandra, St Mary's, or Haslar Hospitals.

There would need to be strict referral criteria (see below) in order to prevent inappropriate transfers. In addition should a GP decide that the patient required care in an acute unit, transfer back would be automatic.

2 Specialties

The suggested specialties are gastro-intestinal and general surgery. Selected orthopaedic patients have been eligible for transfer since November 1998.

3 Criteria

A patient would have to fulfil **all** the criteria listed below before transfer is discussed:

1. No intravenous line
2. Haematologically stable
3. Apyrexial (can be taking oral antibiotics)
4. Not recently commenced on anticoagulation (e.g. following DVT)
5. Not suffering from an unstable medical condition
6. MRSA free
7. Can require ongoing physiotherapy / occupational therapy
8. Mobile (able to transfer from bed to chair independently)
9. Not confused (orientated in time, place and person)
10. Would be medically fit for discharge in the next seven days

4 Procedure for transfer

If a patient fulfils the criteria, is from Gosport and wishes to transfer to the GWMH the consultant would make the decision to contact the patient's GP. This would be done by a member of the surgical team who should discuss the case with the GP. If the GP is not available, then another GP from the same practice should be contacted.

Transfers should occur between 9am - 1pm, Monday - Friday (excluding Bank Holidays).

5 Transfer back to acute unit

The decision to transfer a patient back to Queen Alexandra, St Mary's, or Haslar will be made by the GP (or nominated partner) responsible for the care of the patient. The patient will become the responsibility of the consultant whose care he/she was under before admission to the GWMH. Transfer back will be immediate.

JH - 5/99

DRAFT

MENTAL HEALTH STRATEGY for PORTSMOUTH AND SOUTH EAST HAMPSHIRE

EXECUTIVE SUMMARY

INTRODUCTION

In April 1999, Portsmouth and South East Hampshire Health Authority, Portsmouth City Council Social Services Department, Hampshire County Council Social Services Department and Portsmouth Healthcare NHS Trust commissioned the Centre for Mental Health Services Development (CMHSD) to assist a multi-agency Steering Group in undertaking a strategic review of their mental heath services for adults. The first part of the draft strategy summarises the purpose and process for development of, and the context surrounding, the Strategy. Part Two sets out the service changes that the Strategy envisages, including service models and proposals for implementation. This Executive Summary follows that approach and highlights the key issues arising from the development of the strategy.

THE PURPOSE, PROCESS FOR DEVELOPMENT AND CONTEXT OF THE STRATEGY

The Steering Group set the following objectives for the review:

1. To appraise the work done by the Strategy Review Group to date in mapping out current provision, in assessing demand/need, and in proposing a joint service model;
2. To produce a final version of the strategy for the Steering Group, including specific proposals for change in service organisation and delivery that are realistic given the position from which Portsmouth & South East Hampshire begins and that reflect the needs of the local populations and communities;
3. To assist the Steering Group in drawing up a specific action plan, highlighting priorities, specifying areas where change is the most difficult and most easy to achieve and pinpointing development opportunities.

The review took place in the context of the following national policy initiatives: a public health approach to mental health and opportunities presented by the emphasis on combating social exclusion; The White Paper: "The New NHS" which introduced Primary Care Groups (PCGs), responsible for commissioning and providing of services; 'Partnerships in Action' - a consultation paper which offered options for new approaches between health and social services; 'Modernising Social Services' with its proposals around Best Value and national standards; and specific proposals for mental health services contained in 'Modernising Mental Health Services'.

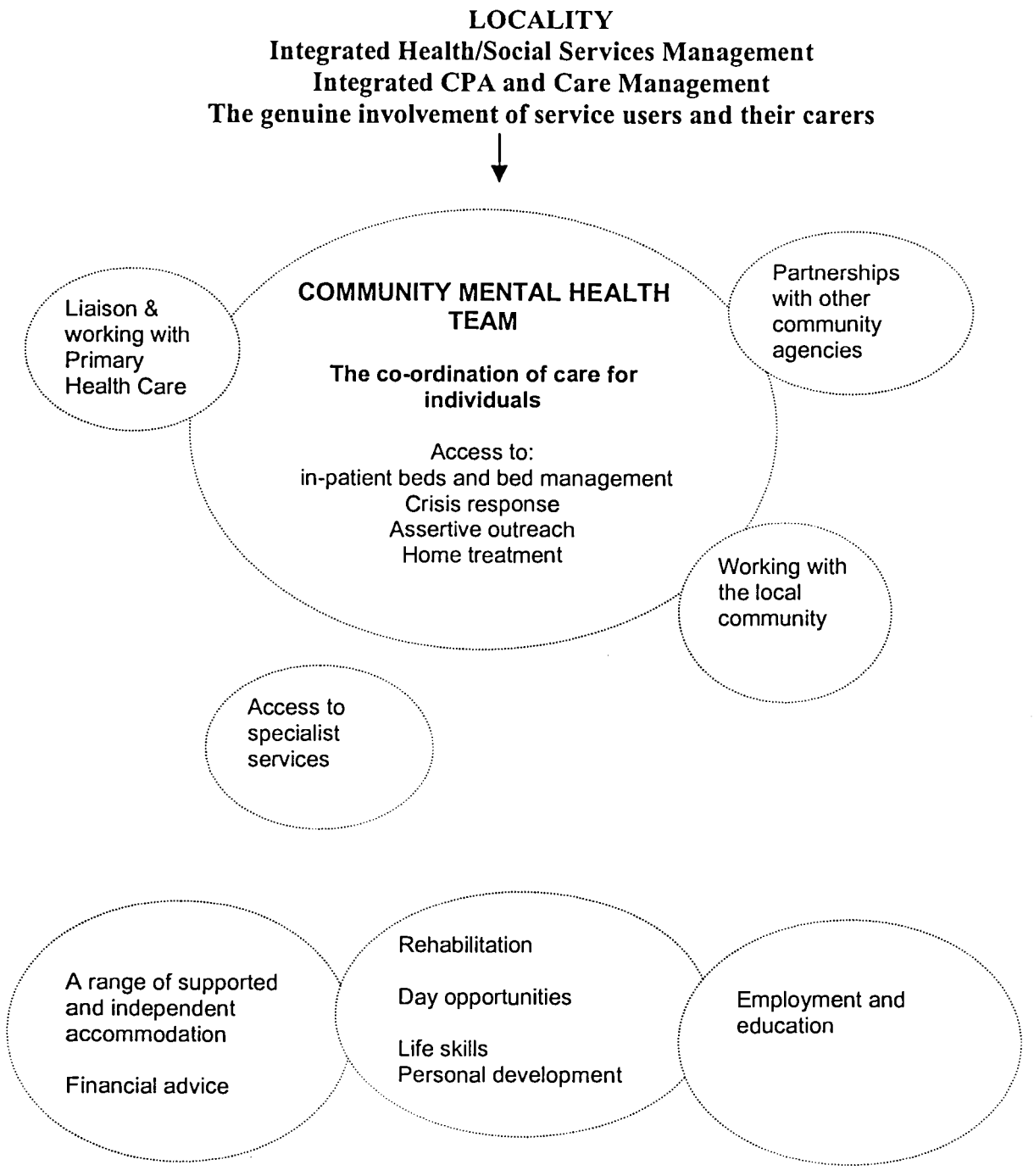
Locally, agencies had created a Strategy Review Group which produced a draft Joint Adult Mental Health Strategy and the Joint Investment Plan for Services for Adults with Mental Health Problems as well as two protocols intended to support the implementation of enhanced services. Despite the clarity of this documentation, the present review revealed a 'top down' approach to local service planning and provision, with an absence of implementation plans to ensure that changes are introduced within localities, and a lack of involvement of users and carers.

Detailed resource analysis concluded that overall expenditure by health and social services and current provision of acute and intensive care beds are standard for the overall population. The proposed Private Finance Initiative scheme will alter the distribution of inpatient facilities; the evidence suggests that Portsmouth City has need for a higher number of acute beds than the other two localities, and this supports an effort to renegotiate the planned bed distribution across localities.

THE STRATEGIC PROPOSALS FOR CHANGE

This part of the report sets out the service model, and proposals for implementation, for mental health services for adults in Portsmouth and South East Hampshire. The recommendations reflect the requirements set out in the Government's policy agenda. There are a number of cultural and structural changes required: enabling and empowering localities to implement the strategy, allocating resources to achieve implementation whilst ensuring equity and consistency across localities; user and carer consultation becoming integral to all service processes; agreement of transparent and delegated mental health budgets; a single point of recording access to services with straightforward care pathways; and sound joint working and care planning across health and social services. Many of the proposals in the draft strategy relate to service co-ordination and service management and this emphasis is reflected in this summary. For each of the three localities, specific functions for mental health services have been identified. These functions are summarised in Figure 1.

Figure 1: Locality Functions of Services



The proposed locality structure – including management arrangements - are set out in Figure 2. They are intended (a) to enable managers to deploy and deliver skills and resources where they are needed, when they are needed; and (b) to develop a structure where medical leadership and management accountability can be brought together.

Figure 2: Locality Structure and Management

POOLED or TRANSPARENT BUDGETS
Joint Commissioning
Health and Social Services resources through integrated CPA and Care Management

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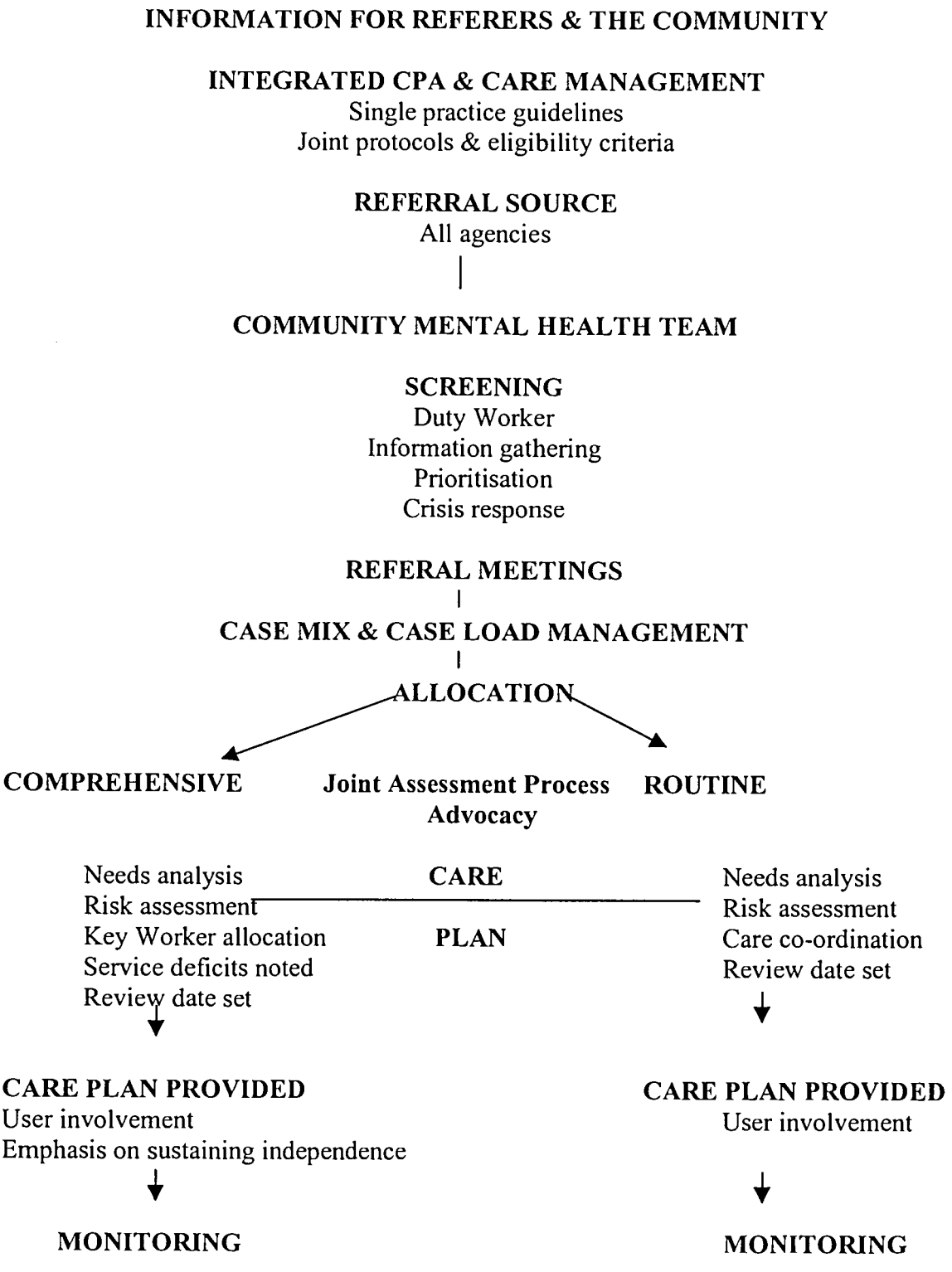
SINGLE LOCALITY MANAGER or MANAGEMENT FUNCTION FOR PROVISION
Leadership and Accountability
Responsible for the co-ordination & management of all local resources
In-patient services
Enhanced CMHTs
Agreed delegated responsibilities for commissioning
Liaison with Medical staff
Liaison with Voluntary Sector providers
Liaison with Primary Care Teams
Locality planning and implementation
Strategies for the involvement of service users and informal carers
Working arrangements with other agencies and providers
Audit and review

Community mental health teams continue to be the major focus for access to the mental health service system and for the co-ordination of care. However, the current configuration of CMHTs fragments the deployment of staff and resources. There is a recommendation therefore, to amalgamate existing CMHTs to produce two robust teams per locality. The proposed arrangements for care co-ordination are represented in Figure 3.

The draft also report makes recommendations in a number of specific service areas: in-patient care; flexible community and day treatment services for individuals with specific needs; and measures to meet 'real life needs' – employment, housing, social life, skills and personal development.

The creation of coherent locality structures with joint management, pooled or transparent budgets and clear responsibilities for strategy implementation and the leadership and management of mental health services has significant implications for existing organisations within Portsmouth and South East Hampshire. It implies the delegation of responsibilities currently held centrally by the Health Authority and Trust, and the adoption of closer partnership working with the two social services departments than hitherto. It is an important principle of the proposed arrangements that close relationships develop with the four PCGs, that proposed new Boards include PCG representation, and that localities are as far as possible coterminous with the ultimate configuration of PCGs and PCTs so that any future transfer of responsibilities can be facilitated.

Figure 3: Arrangements for Care Co-ordination



Where it is appropriate for services to be provided across more than one locality, then depending on the degree of specialist expertise required, it is preferable for one locality to

Where it is appropriate for services to be provided across more than one locality, then depending on the degree of specialist expertise required, it is preferable for one locality to be the provider on behalf of the others. A full review of the organisational structure of mental health services within the Portsmouth Healthcare NHS Trust will therefore be required. However, the localities are currently at different stages in their development and may not be able to make progress at the same speed as each other. Two different initial models are therefore proposed, one for Portsmouth and another for the remaining two localities, but with the objective of ultimately achieving a common approach across all three localities as they develop.

In the Portsmouth locality it is proposed to develop a semi-autonomous, unified mental health Board, with single management, which will be responsible for strategy implementation and the co-ordination and deployment of all local mental health resources. The role of this Board would be: strategy implementation; co-ordination and development of all resources to ensure 'best value'; ensuring user and carer involvement to ensure services are in line with their views and needs; implementation of commissioning and providing arrangements; meeting the accountability arrangements of each of the partners (Portsmouth City, Health Authority, Primary Care Group, the Trust); bringing gaps in service to the attention of the District Strategy Group; commissioning and providing mental health services for the population. A set of priorities for the Board within the overall framework of the strategy has already been formulated.

The remaining two localities do not at present have the ability to move into a single management structure. This is in part the result of different management arrangements in Hampshire Social Services. Nonetheless, the strategy proposes that each locality will have its own Joint Board with the functions of: influencing and implementing strategy; providing integrated services within the locality; some agreed delegated responsibilities for commissioning; management of 'transparent' budgets delegated by Social Services and the HA/PCG (as fully pooled budgets not yet possible); incorporating user and carer views and needs into the management process; ensuring provision for the full spectrum of needs, not just the most severely mentally ill; developing the voluntary and independent sector as providers of services; monitoring of the quality of provision in the locality. As with Portsmouth, agendas for these Boards have been formulated.

It is proposed that the work of the Joint Commissioning Board and Adult Mental Health Strategy Steering Group should cease at the point of starting implementation of the new Strategy. They should be replaced by the Portsmouth & South East Hampshire Joint Strategy Group for adult mental health services, which will meet quarterly and take on the following responsibilities: specification of key requirements and service functions; supporting and monitoring locality implementation; recommending resource allocation – especially new resources – to constituent agencies, in consultation with localities and addressing issues around inequity; information-sharing; links to other care groups on strategic issues; development of district-wide services e.g. acquired brain injury, forensic services, eating disorders, early onset dementia, mother and baby, psychology services.

The strategy sets out the future direction for mental health services in Portsmouth and South East Hampshire. It requires debate within the Boards and Committees of the commissioning agencies, and with users, carers, GPs and other stakeholders who were not involved in the process. A number of areas – in particular the relationships between the statutory agencies and the proposed Boards – require further discussion and clarification.

Ultimately, of course, strategy is what people do, not what they write down. The locality arrangements are already taking shape, and locality implementation plans are being prepared. This local action is crucial to success, and it is in the sustained commitment to achieving these plans that the success of the strategy lies.

Gosport Primary Care Group

Prescribing Budget Setting

Introduction

With the devolvement of Prescribing Budget Setting to PCGs a meeting was held in December with the GP Prescribing Lead to initiate the budget setting process for 2000/01. It was agreed that two distinct budget setting methodologies (see below) were available for consideration by the PCG and that the final budgets would be set using one of these or a mix of these approaches. It was with this in mind that extra information was requested from the practices this year to ensure that the process was well informed.

Subsequent to this meeting it has been agreed by the Pan-PCG Prescribing Group that the HA will retain funds centrally for nurse prescribing (possibly 0.75%) and for a contingency reserve for population changes and expensive drugs. This will be topsliced from the Prescribing allocation.

Budget Setting

Method 1

- Starting point:
  1999-2000 budget minus allowance for expensive drugs and transitional relief
  = BASIC BUDGET
- Adjust basic budget for:
  - List size changes (October 1999) ASTRO PUs
  - Nursing home residents (October 1999) + 20 ASTRO PUs
  - Residential home residents (October 1999) + 10 ASTRO PUs
  - Temporary residents

  = CORRECTED BUDGET
- Apply minimum uplift (dependant on information and allocation from HA)
- Compare basic budget and uplifted budget against an equity target produced by HA.
- Remaining cash minus PCG contingency reserve to be distributed to the practices according to morbidity data and deprivation scores.

Variable factors

- Size of uplift. A small uplift will leave more cash for local distribution according to needs of the practices and vice versa.
- Deprivation scores
- Morbidity factors

Method 2

A national weighted capitation formula has been developed primarily by the University of York and incorporates separate sub formulae for HCHS, GMSCL and Prescribing. Colleagues at the Health Authority will use this formula to calculate an equitable share of Prescribing resources both by PCG and by practice. The timescale

for completing this work is the end of January. It is proposed that a meeting will be arranged by the HA to share the details behind this approach with PCGs.

Conclusion and Recommendations

This paper updates the group on the position to date.

The practice budgets to be set will be informed by the two approaches identified above and it is suggested that the final allocation criteria may well include the following:

- 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 average
- An adjustment for practices whose populations have changed significantly

The position will become clearer when more information on the 2000/01 allocation is available. It is recommended that a small group consisting of, as a minimum, the PCG GP Prescribing Lead, the Prescribing Adviser and the Finance and Information Manager plus any other interested parties meet to take the work forward and bring budget proposals to the next meeting of this group.

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