PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

Meeting of the Gosport Primary Care Group Board File Ga 14

Thursday 16 December 1999 at 1 pm, Council Chambers, Gosport Town Hall

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AGENDA

1. **Apologies for Absence**

2. **Minutes of the Meeting held Thursday 21 October 1999**

   To receive for approval the minutes of the meeting held on Thursday 21 October 1999 — Attached

3. **Finance and Activity Report**

   To receive a report for the period up to 31 October 1999 — Attached

4. **Prescribing Update**

   To receive a report: Mrs H Bagshaw — Attached

5. **Referrals outside Service Agreements**

   To confirm arrangements for considering referrals — Attached

6. **Strategy for Adult Mental Health Services**

   To consider the strategy for Adult Mental Health Services, following a joint review of services — Attached

7. **Building Effective Primary Care Nursing Teams**

   To receive a report: Mrs Rose Butcher and Mrs C Kelly — Attached

8. **Clinical Governance**

   Update from Dr J Warner

9. **Lay Member Update: Mrs J Charman**

   - Ambulance Services
   - Health Improvement Day

10. **Royal Hospital Haslar: Update**

    To receive a report — Attached

11. **Any Other Business**

12. **Date and Time of Next Meeting**

    To confirm next meeting at 1 pm, ~~Thursday 16 December~~ Thursday 17 Feb, Council Chambers, Gosport Town Hall

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

GOSPORT PRIMARY CARE GROUP

Minutes of the meeting held on Thursday 21 October 1999 at Gosport Town Hall

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Present:	Dr J Barton (Chair)	Mrs C Kelly
	Dr P Burgess	Mr J Kirtley
	Mrs R Butcher	Dr R Pennells
	Mr M Cremer	Dr D Young
	Dr J Grocock	
	Mr C Hardy	
	Dr W Harrison	
Community Health Council:	Dr M Ottaway	
In Attendance:	Mr P Ifold	

No **Discussion**

1 **Apologies for Absence**

Apologies were received from Dr D Lynch, Mrs J Charman and Dr J Warner.

Dr Barton welcomed Mr Mel Cremer as the new Non-Executive member to the Gosport PCG Board.

2 **Minutes of the meeting held Thursday 19 August 1999**

The minutes of the meeting held on Thursday 19 August were agreed as a correct record.

With reference to Item 6 of the minutes relating to Clinical Governance, Mrs Butcher enquired if there had been any feedback from Dr Warner regarding Risk Management which was to be debated further. Mr Kirtley suggested that Dr Warner should be contacted direct to provide an update on this.

3 **Financial Report**

Mr Ifold presented the Finance and Activity Report for the period up to 31 August.

The HCHS statement at Appendix 2 currently showed a small underspend of £6,000. This small variance can be expected to continue due to the block contracts in place with the main NHS service providers. The estimated year end position for this budget was break-even.

Mr Ifold asked the Board to note that two budgets relating to the Royal Hospital Haslar had been transferred back to the Health Authority to manage.

Mr Ifold added that since the last Board meeting, an extra allocation of £4,000 had been added to the HCHS budget following a further analysis of the PCG baseline funding. This allocation is currently shown within "Other" at Appendix 2.

With reference to the budget allocation for Private Providers, Mr Ifold explained that Grants to Voluntary Organisations totalling £60,000 are related to two service agreements specific to Gosport. Grant allocations covering the wider District continue to be managed centrally by Portsmouth Health Authority. Mr Ifold clarified that Grant allocations are recurring expenditure but can be reviewed.

The GMS statement at Appendix 3 shows an underspend of £6,000. Reserves (Growth) are in place to fund potential A&C staff pay awards and for a local Development Scheme in Gosport. Mr Ifold advised the Board that he anticipated a GMS underspend at year end and an application would be made to carry this sum over to the next financial year.

Referring to the Prescribing Report at Appendix 4, Mr Ifold explained that the report is based on three months actual and two months estimated figures. July figures received since the report was prepared indicate increased overspends against budget for some practices. Mr Ifold advised the Board that in view of this, it was proposed to use some of the underspend from the Management Budget shown at Appendix 5 to pay for extra Community Pharmacist sessions to work with practices on their prescribing. Mr Ifold clarified that the PCG Management Budget is broken down separately between the Gosport and Fareham PCGs.

With reference to Appendices 6 and 7, Mr Ifold advised the Board of the continuing difficulties in obtaining reliable activity information from some providers. Particular concern was expressed about the lack of data for Portsmouth Healthcare Trust. Looking at the data available from Portsmouth and Southampton Hospitals Trusts, the Board noted the underperformance in both elective and emergency activity for Portsmouth Hospitals. The Board discussed the current limitations and quality of information. Mr Ifold confirmed that this was a problem affecting all PCGs locally. With reference to "targets", Mr Ifold clarified that these were largely based on last year's figures.

Referring to the Waiting List information at Appendix 7, Mr Ifold asked the Board to note that information was now provided for Royal Hospital Haslar and Salisbury. It was noted that the waiting list position is reasonably static.

Mr Ifold concluded with a summary of the potential sources of additional funding which have been identified for PCGs in the District. Where appropriate, the PCG would prepare bids against the available allocations. Mr Kirtley commented that the funding available to PCGs and bidding processes had been clarified and that the PCG had recently been asked to submit a bid for funds from the SaFF Primary Care Initiative. Mr Kirtley advised that this bid would focus on Physiotherapy services.

The Board discussed the £204,000 IT Modernisation Funds held by the Health Authority including funding for the NHS Net project. Mr Kirtley clarified that project arrangement for linking to the NHS Net was being provided centrally from Health Authority IT staff.

The Board noted the overall financial position as at 31 August and the potential sources of additional funding.

4 Primary Care Investment Plan (PCIP)

Mr Kirtley introduced the Primary Care Investment Plan (PCIP) and Development Proposals. It was explained that the initial plan was presented to the Shadow Board in January and national guidance had required the PCG to produce a more detailed plan by the end of September 1999, covering a three-year period.

Each practice covered by the Gosport PCG had now submitted a detailed practice plan including development proposals. The development proposals for the PCG as a whole are summarised in the updated PCIP. Mr Kirtley explained proposals for years one and two were mostly well developed and costed but that some practices had identified longer-term developments, as yet at a formative stage only, but it was important to include all development proposals in the plan to facilitate future planning and financial programming.

With reference to the current financial year, Mr Kirtley explained that the Board was asked to approve a recurring commitment of £88,000. This sum includes an additional £42,000 for staff investment proposals, in addition to the £20,000 approved for staff within the first stage PCIP. Referring to non-recurring commitments, the Board was asked to approve the sum of £57,000 including funding for "millennium" staff costs. Mr Ifold advised that the Health Authority would be asked to make arrangements for the significant balance anticipated against non-recurring allocation to be carried forward to the next financial year.

In accordance with national requirements, Mr Ifold explained that the PCG Board was required to approve the proposed use of GPFH Savings, totalling £56,554, by the former fundholding practice, Dr Pennells and Partners.

Dr Pennells reported to the Board that the Health Authority intended to withhold £2,663 closure costs from their balance of fundholding savings. Mr Kirtley commented that, as outlined within the Financial Report, PCGs as a whole were due to share additional funding arising from the cessation of the GP Fundholding Scheme which would more than offset this smaller sum.

Mr Hardy asked the Board to note that Section 11.3 of the PCIP, "District Nurses as Care Managers", made reference to a review of the service. He advised that analysis and options would be available within the next two months. Dr Pennells and Mrs Butcher agreed that the scheme worked well and allowed patients to be "fast-tracked" and to address both social and health needs in one assessment

Mrs Kelly requested information about funding for a practice nurse to attend the Nurse Forum meetings. Mr Kirtley agreed to discuss the details further with Mrs Kelly.

The Board approved the Primary Care Investment Plan as the basis for developing primary care within the PCG.

The revised financial programmes for a recurring commitment of £88,000 and a non-recurring commitment of £57,000 were agreed.

The Board approved the use of Fundholding savings by Drs Pennells and Partners totalling £56,554.

5 Communication

Mrs Kelly had requested this item on the agenda due to concerns about the opportunity for informal debate as some Board members were unable to participate in the GP Group Meetings held on alternate months to the formal Board meetings. Dr Barton commented that it was important that the GP Group did not become too unwieldy by increasing the numbers attending and that it had been intended that the Practice representatives would pass on relevant information at practice level.

The Board agreed a suggestion that on concluding the agenda for the formal Board meeting, there would be an opportunity for informal discussions and updating on items not on the formal Board agenda.

6 Service Reviews

Mr Kirtley introduced the item on service reviews and explained the requirement for the PCG to look at services commissioned at practice level. Criteria applied to the reviews reflected the national performance framework. Three services had been identified for review.

(i) Physiotherapy
It was noted that the investment in Physiotherapy commissioned by Dr Pennells and Partners was for the benefit of the wider locality and that the current level of service was supported by some non-recurring funding from GP Fundholder savings. In order to maintain the current service Mr Kirtley referred to the additional funding required, discussed earlier as a bid against the SaFF Primary Care Initiative. It was agreed the bid should be submitted to at least maintain the current service level.

(ii) Rapid Access Prostate Clinic
As this clinic is accessible to all Gosport patients and continues to minimise waiting times, Mr Kirtley advised the Board that the service meets the criteria and should continue.

(iii) Ultrasound
The board was advised that this practice-based, privately provided service does not meet the agreed criteria. Subject to a review of local provision of

ultrasound, this specific practice-based service should cease.

The following recommendations were agreed:

Physiotherapy
To aim to maintain the current level of recurring investment in physiotherapy and note that current use requires a commitment of additional funding, available within the 1999/2000 Service and Financial Framework for primary care initiatives.

Rapid Access Prostate Clinic
To maintain the current service.

Ultrasound
That notice should be given that the practice based privately provided service will cease. However, cessation of this service to be linked to a current review of ultrasound services with Portsmouth Hospitals Trust and Royal Hospital Haslar and proposals to improve access to ultrasound for all practices.

7 Clinical Governance

In Dr Warner's absence, Mr Kirtley updated the Board regarding the Clinical Governance workshop. It was explained that unfortunately this was cancelled for October but has been rescheduled for Thursday 9 December. Details are to follow. A Clinical Governance lead from each practice will be invited to attend, together with representatives from other professions to ensure a multi-disciplinary approach.

Mr Kirtley advised that during the workshop, Dr Warner will explain the background to the process of completing a practice profile. This is in addition to the initial practice stocktake completed by each practice. It is hoped that the practice profile will enable all members of the practice team to contribute to the process of developing Clinical Governance.

8 Meeting Dates for 2000

Mr Kirtley referred to the list of proposed Board meeting dates for the following year. Meetings will continue to be held at the Gosport Town Hall, subject to room availability.

The Board agreed the proposed timetable of dates set out in the agenda papers.

9 Any Other Business

None

10 Date and Time of Next Meeting

The next Board meeting will be held on Thursday 16 December at 1pm at the Gosport Town Hall.

The meeting was formally closed at 2.50 pm

Portsmouth and South East Hampshire Health Authority

Gosport Primary Care Group

Primary Care Group Finance and Activity Report

1. Introduction

This report covers financial and activity issues for the period up to 31 October 1999. There has been little if any improvement in activity information from providers at PCG level since the last report and this has been omitted from the report on this occasion. In its place has been included some information on Out of Area Treatments (OATs). Since the last report the mid-year financial review has been held with the Health Authority and an update has been included on this.

The attached appendices are summarised below:

Appendix 1 - Financial Summary Statement
Appendix 2 - Hospital and Community Health Services Statement
Appendix 3 - General Medical Services (Cash Limited)
Appendix 4 - Prescribing Statement
Appendix 5 - Management Budget
Appendix 6 - Out of Area Treatments
Appendix 7 - Waiting Lists

2. Overall Financial Position

The overall financial position with regard to the devolved budgets is shown at Appendix 1. When appropriate it is intended to include further information on areas such as Haslar and Out of Area Treatments (OATS).

As at the 31 October 1999 the overall delegated budgetary position is an overspend of £4k.

3. Hospital and Community Health Services (HCHS)

The large majority of the budget on this programme area is in service level agreements with NHS Healthcare Providers and the nature of the block agreements means that expenditure equates to the budget. The individual allocations depend upon each provider supplying an analysis of their overall service level agreement between PCG's and the Health Authority. This analysis has not been supplied by all providers yet and therefore some of the budgets are still provisional.

The lower part of Appendix 2 shows the position with Private Providers and Grants to Voluntary Organisations. Since the last report additional allocations have been received in respect of unused GPFH Closure Costs (£12.2k) and Modernisation Funds "earmarked" for Human Resource issues (£13.7k) and these are included within "Other".

There is a small underspend of £8k after seven months.

4. General Medical Services

Appendix 3 shows the position on cash limited General Medical Services (GMS). After seven months this element is showing an underspend of £11k.

Reserves (Growth) consists of a small balance held to fund potential excess pay award costs relating to Admin. & Clerical staff and a sum for Local Development Schemes allocated under HSC 1999/107.

5. Prescribing

Appendix 4 identifies the position on Prescribing. This report is based upon five months actual expenditure plus an estimate for the sixth and seventh months. The position to date is an overspend of £50k. This is an increasing cause for concern. The overspend is largely due to changing prices associated with generic drugs and patient pack dispensing which together with delays in receiving information from the Prescription Pricing Authority means it is extremely difficult to report on an accurate financial position.

6. Management

Appendix 5 summarises the position on management expenditure. Due largely to vacancies at the beginning of the year the position to date reflects an underspend of £27k.

7. Out of Area Treatments (OATs)

Appendix 6 summarises the position on OATs for the first six months of this year. The budget for this element is topsliced from the PCG budget based upon activity levels two years previously and therefore the level of activity undertaken this year will impact on the 2001/02 budget. The current budget which is based upon 1997/98 activity is shown for comparision.

8. Waiting Lists

Attached at Appendix 7 is some summarised information on Waiting List numbers for the first seven months of this year. Care needs to be taken when comparing month on month figures as Haslar and Salisbury figures were not available for the first three months.

9. Mid Year Financial Review

The 1999/2000 mid-year financial review has been held with the Health Authority and the following points were agreed:

GMS - The projected underspend of £100k will be carried forward.

Prescribing - It was agreed that the PCG would cover the projected overspend within the existing contingency reserve.

Management - The underspend to be returned to the HA; this is currently projected at £33k.

Other - It was agreed that the anticipated underspend on GPFH savings (£66k) could be carried forward to 2000/01.

10. Conclusions

The financial position as reflected in this report is generally satisfactory at 31 October 1999 but for the position on Prescribing which is a cause for concern.

The mid-year financial review has been held with the Health Authority and the main conclusions have been identified in this report.

11. Recommendations

The Primary Care Group is requested to:

+ £40K

- Note the financial position at 31 October 1999.
- Note the results of the mid-year financial review.

Peter Ifold
Finance and Information Manager
Fareham Primary Care Group

6-Dec-1999

GOSPORT PRIMARY CARE GROUP
Summary Statement as at 31 October 1999

Appendix 1	Appendix	Financial programme			Cumulative year to 31/10/99			Current month		
		£000's Budget	£000's Movement	£000's Budget at 31/10/99	£000's Budget	£000's Actual	£000's Variance	£000's Budget	£000's Actual	£000's Variance
HCHS	**2**	17470	14	17484	10184	10176	8	1454	1453	1
General Medical Services	**3**	1316	0	1316	670	659	11	95	94	1
Prescribing	**4**	7093	0	7093	4030	4080	(50)	613	634	(21)
Sub Total		25879	14	25893	14884	14915	(31)	2162	2181	(19)
Management	**5**	284	5	289	169	142	27	25	20	5
TOTAL		26163	19	26182	15053	15057	(4)	2187	2201	(14)

GOSPORT PRIMARY CARE GROUP
HCHS Statement as at 31 October 1999

Appendix 2

	Financial programme			Cumulative year to 31/10/99			Current month		
	£000's Budget	£000's Movement	£000's Budget at 31/10/99	£000's Budget	£000's Actual	£000's Variance	£000's Budget	£000's Actual	£000's Variance
NHS Service Level Agreements									
Portsmouth Hospitals NHS Trust	9493	4	9497	5540	5540	0	791	791	0
Portsmouth HealthCare NHS Trust	6458	(4)	6454	3765	3765	0	538	538	0
Southampton University Hospitals Trust	1046	0	1046	610	610	0	87	87	0
Southampton Community NHS Trust	1	0	1	1	1	0	0	0	0
Salisbury Healthcare NHS Trust	89	0	89	52	52	0	7	7	0
Winchester & Eastleigh NHS Trust	19	0	19	11	11	0	2	2	0
North Hampshire Hospitals NHS Trust	6	0	6	4	4	0	1	1	0
Royal West Sussex NHS Trust	82	0	82	48	48	0	7	7	0
Poole Hosital NHS Trust	13	0	13	8	8	0	1	1	0
Royal Free Hospitals NHS Trust	11	0	11	6	6	0	1	1	0
Frimley Park NHS Trust	15	0	15	9	9	0	1	1	0
Hammersmith Hospitals NHS Trust	13	0	13	8	8	0	1	1	0
Worthing & Southlands NHS Trust	3	0	3	2	2	0	0	0	0
Guys & Thomas's NHS Trust	36	0	36	21	21	0	3	3	0
Royal National Orthopaedic NHS Trust	17	0	17	10	10	0	1	1	0
St Georges NHS Trust	12	0	12	7	7	0	1	1	0
Great Ormond Street NHS Trust	16	0	16	9	9	0	1	1	0
Kings Healthcare NHS Trust	15	0	15	9	9	0	1	1	0
Moorfield Eye Hospital NHS Trust	6	0	6	4	4	0	1	1	0
University College London Hospital NHS	22	0	22	13	13	0	2	2	0
Sub - Total	17373	0	17373	10137	10137	0	1447	1447	0
Private Providers									
E Graham - Ultrasound	7	0	7	4	4	0	1	1	(0)
General ecrs	14	0	14	8	0	8	1	0	1
Grants to Voluntary Organisations	60	0	60	35	35	0	5	5	0
Other	16	14	30	0	0	0	0	0	0
Sub Total	97	14	111	47	39	8	7	6	1
TOTAL	17470	14	17484	10184	10176	8	1454	1453	1

GOSPORT PRIMARY CARE GROUP
General Medical Services Cash Limited Programme 1999 - 2000 as at 31 October 1999

Appendix 3	Full year programme			Cumulative year to 31/10/99			Current month		
	£000's Budget	£000's Movement	£000's Budget at 31/10/99	£000's Budget	£000's Actual	£000's Variance	£000's Budget	£000's Actual	£000's Variance
Premises									
Cost rents	103	0	103	60	57	3	9	9	0
Improvement Grants	10	(5)	5	0	0	0	0	0	0
Sub total	**113**	**(5)**	**108**	**60**	**57**	**3**	**9**	**9**	**0**
Staff									
Main staff - Recurring	946	0	946	551	552	(1)	78	78	0
Main staff - Non Recurring	6	0	6	4	4	0	1	1	0
Training	24	0	24	14	10	4	2	2	0
Relief	44	0	44	26	21	5	4	3	1
Sub total	**1020**	**0**	**1020**	**595**	**587**	**8**	**85**	**84**	**1**
Computers									
Maintenance	29	0	29	13	13	0	1	1	0
Purchase	19	21	40	2	2	0	0	0	0
Sub total	**48**	**21**	**69**	**15**	**15**	**0**	**1**	**1**	**0**
Total	**1181**	**16**	**1197**	**670**	**659**	**11**	**95**	**94**	**1**
Reserves									
Reserves (Growth)	53	0	53	0	0	0	0	0	0
Reserves (Other)	82	(16)	66	0	0	0	0	0	0
Sub total	**135**	**(16)**	**119**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL	**1316**	**0**	**1316**	**670**	**659**	**11**	**95**	**94**	**1**

( ) indicates an overspend

GOSPORT PRIMARY CARE GROUP
Prescribing Report 1999 - 2000 as at 31 October 1999

Appendix 4	Full year programme			Cumulative year to 31/10/99			Current month		
	£000's Budget	£000's Movement	£000's Budget at 31/10/99	£000's Budget	£000's Actual	£000's Variance	£000's Budget	£000's Actual	£000's Variance
Indicative allocation									
Dr Anderson & Ptrs	1024	0	1024	592	614	(22)	90	94	(4)
Dr Bassett & Ptrs	628	0	628	363	356	7	55	55	0
Dr Beale	146	0	146	84	97	(13)	13	16	(3)
Dr B Collins & Ptrs	839	0	839	485	493	(8)	74	77	(3)
Dr Coonan & Ptrs	832	0	832	481	479	2	73	77	(4)
Dr D Evans & Ptrs	599	0	599	346	364	(18)	53	57	(4)
Dr Hajiantonis & Ptrs	521	0	521	301	300	1	46	49	(3)
Dr Knapman & Ptrs	1034	0	1034	598	599	(1)	91	91	0
Dr Lacey & Ptrs	413	0	413	239	249	(10)	36	38	(2)
Dr Pennells & Ptrs	937	0	937	541	529	12	82	80	2
Gosport PCG Sub Total	**6973**	**0**	**6973**	**4030**	**4080**	**(50)**	**613**	**634**	**(21)**
Gosport PCG Reserve	120	0	120	0	0	0	0	0	0
GRAND TOTAL	**7093**	**0**	**7093**	**4030**	**4080**	**(50)**	**613**	**634**	**(21)**

( ) indicates an overspend

An estimate has been made for September and October's expenditure for which figures are not yet available.

GOSPORT PRIMARY CARE GROUP
Management Budget as at 31 October 1999

Appendix 5	Full year programme			Cumulative year to 31/10/99			Current month		
	£000's Budget	£000's Movement	£000's Budget at 31/10/99	£000's Budget	£000's Actual	£000's Variance	£000's Budget	£000's Actual	£000's Variance
Pay	239	7	246	144	123	21	21	17	4
Non Pay	45	(2)	43	25	19	6	4	3	1
TOTAL	284	5	289	169	142	27	25	20	5

GOSPORT PRIMARY CARE GROUP
OUT OF AREA TREATMENTS

Activity for the period April to September 1999

Appendix 6

Summary of Total Activity and Notional Costs

			YTD Total	Projected FOT	YTD Target	Annual Target
Elective	Activity	Inpatient	21	42		
		Outpatient	32	64		
		Other	2	4		
		Total	55	110		
	Notional Cost £	Inpatient	28688	57376		
		Outpatient	3857	7714		
		Other	0	0		
		Total	£32,545	£65,090		
Emergency	Activity	Inpatient	70	140		
		Outpatient	0	0		
		Other	0	0		
		Total	70	140		
	Notional Cost £	Inpatient	109044	218088		
		Outpatient	0	0		
		Other	0	0		
		Total	£109,044	£218,088		
Tertiary	Activity	Inpatient	16	32		
		Outpatient	10	20		
		Other	0	0		
		Total	26	52		
	Notional Cost £	Inpatient	22546	45092		
		Outpatient	2112	4224		
		Other	0	0		
		Total	£24,658	£49,316		
Total	Activity	Inpatient	107	214		
		Outpatient	42	84		
		Other	2	4		
		Total	151	302		
	Notional Cost £	Inpatient	160278	320556		
		Outpatient	5969	11938		
		Other	0	0		
		Total	£166,247	£332,494	£129,500	£259,000

NB Costs expressed at 1998/99 prices

GOSPORT PRIMARY CARE GROUP
PROVIDER TRENDS REPORT

Appendix 7 (i)

WAITING LISTS - ALL PROVIDERS ALL SPECIALTIES
ELECTIVE AND DAY CASES

	Apr	May	Jun	Jul	Aug	Sep	Oct
The Royal Free Hampstead Hospital NHS Trust	1	2	1				
The Royal National Orthopaedic Hospital NHS Trust	2	2	1	1			
Frimley Park Hospital NHS Trust		1	1	1	1	1	2
Southampton University Hospitals NHS Trust	87	79	83	95	90	104	83
Portsmouth Hospitals NHS Trust	523	570	538	542	516	520	520
Guy's & St Thomas' NHS Trust			1	2	1	2	
St George's Healthcare NHS Trust				1			
Winchester & Eastleigh Healthcare NHS Trust	1	1	1	1	1	1	1
Portsmouth Healthcare NHS Trust		1	1				
North Hampshire Hospitals NHS Trust		1	1	1	2	2	1
Salisbury Healthcare NHS Trust					16	16	16
Great Ormond St Hospital for Children NHS Trust		1	1	1	1	1	1
The Royal West Susex NHS Trust				2	1	1	1
University College London Hospitals NHS Trust				1		1	1
Royal Brompton & Harefield NHS Trust (Harefield)	8	6	5	5	4	4	4
Royal Brompton & Harefield NHS Trust (Royal Brompton)	8	4	4	5	5	7	6
Royal Hospital Haslar				757	798	851	816
Total	630	668	638	1415	1436	1511	1452

GOSPORT PRIMARY CARE GROUP
SPECIALTY TRENDS REPORT

Appendix 7 (ii)

WAITING LIST - ALL PROVIDERS ALL SPECIALTIES
ELECTIVE AND DAY CASES

	Apr	May	Jun	Jul	Aug	Sep	Oct
General Surgery	38	48	28	124	136	165	147
Urology	26	22	22	36	64	87	87
Renal Transplant	2	1					
Renal General Surgery				1	2	1	
Trauma & Orthopaedics	151	160	170	509	486	481	460
ENT	56	72	61	182	176	166	165
Opthalmology	167	170	179	233	233	240	229
Plastic Surgery				57	59	55	66
Cardiothoracic Surgery	13	9	8	10	9	10	9
Paediatric Surgery	17	18	22	24	18	23	14
Cardiac Surgery	20	18	18	22	19	23	19
Thoracic Surgery	1	3	2	7	5	5	4
Anaesthetics				26	29	37	44
Pain Management	23	21	16	16	16	10	13
General Medicine	4	3	4	9	8	12	14
Gastroenterology		8	12	58	74	89	86
Clinical Haematology				4	6	7	10
Rehabilitation	1	1					
Cardiology	44	39	33	25	27	27	25
Medical Oncology					1		
Neurology	1						
Rheumatology	7	3	2	3	2	2	2
Paediatrics				4			
Elderly Medicine		1	1				
Gynaecology	59	71	60	65	66	71	58
TOTAL	**630**	**668**	**638**	**1415**	**1436**	**1511**	**1452**

Note
Waiting list figures for Haslar have been included from July only and for Salisbury from August

GOSPORT PRIMARY CARE GROUP

PRESCRIBING UPDATE

NATIONAL ISSUES.

The rise in prescribing costs may be attributed to a number of factors.

Generic Drugs

There has been a rise in the cost of these drugs as a result of supply shortages, caused by one manufacturer closing and two other firms relocating during 1999.

Patient Pack Dispensing

The last government introduced this concept but the implementation has only just begun. Generic drugs are now being packed in 28s rather than in bulk packs. Costs have possibly increased to meet the set-up of such production changes. Prices have increased by as much as 700% in some cases arising from the changeover from bulk packs to patient packs.

Pharmacy Price Regulating Scheme

The cost of branded goods has been reduced by 4.5%. However, manufacturers have a degree of flexibility in applying the price reduction. Their overall basket of drugs must show a decrease of 4.5%. Consequently, price decreases of varying amounts have been applied often to drugs not affecting Primary Care. The NHS Executive believes some benefit from the scheme should be experienced but this will not offset the increase in generic costs.

Data Availability

The Prescription Pricing Authority is currently only now analysing prescriptions dispensed in September 1999. This is mainly due to all the changes caused by fluctuations in generic costs and availability. Therefore the accurate data required for use in budget setting and monitoring is not available, without considerable delay.

LOCAL ISSUES

High Cost Areas

Cardiovascular system and central nervous system have been identified as high cost areas within the Gosport PCG. The Prescribing Adviser is closely monitoring these areas in order to promote cost effective prescribing across the PCG. The prescribing of ulcer healing drugs and non-steroidal anti-inflammatory drugs are also being closely monitored as costs are rising in these areas.

Hospital Driven Prescribing

Secondary care continues to benefit from discounted drug costs, which are not available to primary care. This issue is constantly being brought to the attention of secondary care via the Pan PCG group. However, GPs are constantly being requested to prescribe expensive drugs at a cost to the PCG. The use of expensive specialist drugs not accepted by the Drugs and Therapeutics Committee is not recommended and consequently closely monitored. An allowance is made within each practice budget for the prescribing of expensive hospital driven drugs. Certain drugs are ringed fenced and are funded from a "top slice" from the Health Authority prescribing allowance.

Prescribing Incentive Scheme

This scheme aimed to encourage practices to create savings by increasing generic prescribing. Unfortunately, the current situation outlined above has somewhat undermined any savings. The repeat prescribing protocol and therapeutic monitoring may help to redress the situation. Most of the practices have signed up to the Heart LEAP Project. It is highly likely that a number of practices will be entitled to receive incentive payments which will require funding from the PCG budget.

FACTORS AFFECTING PERFORMANCE AGAINST BUDGET

Budget Setting

The budget increase from the Health Authority was lower than in previous years. This has been reflected in the practice budgets for this financial year.

Population Mix

The proportion of the elderly, young families, variations in social class and the location residential care and nursing homes affect the prescribing cost of all the practices within the PCG.

Individual Factors

The prescribing habits of the individual GP affect the prescribing costs. Many GPs readily accept the help and advice of the Prescribing Adviser but some remain set in their ways. However, any changes require time and effort by all the GPs within a practice, and time within a busy GP's life is at a premium.

FURTHER WORK AND DEVELOPMENT

Access to electronic data from national sources is being developed to assist the work of the Prescribing Adviser in the analysis and dissemination of information to the practices.

Community pharmacists are working sessions within a number of practices to provide support, advice and analysis. These pharmacists work alongside and are supported by the Prescribing Adviser.

The Prescribing Adviser has worked with practice and district nurses within the PCG to improve wound management prescribing.

Pharmaceutical advice has been prepared to support the asthma HImP education meetings.

FINANCE ISSUES

Given the issues outlined above and in particular the changing prices associated with generic drugs and the delays in obtaining information from the Prescription Pricing Authority it is extremely difficult to predict the 1999/2000 outturn with any confidence. Currently information is available for the first five months, up to the end of August, and the delay in receiving information is expected to get worse by the end of the financial year.

Previously in the finance and activity report the position was reported for the seven month period and this was based upon five months information. Whilst the overall message is one of concern some practices, despite all the issues previously identified, continue to make an underspend and others continue to make improvements in the rolling annual growth rate.

The cumulative PCG Prescribing position is shown below for each month:

30 April 1999	Underspend £7,870
31 May 1999	Underspend £27,968
30 June 1999	Underspend £6,142
31 July 1999	Overspend £2,230
31 August 1999	Overspend £35,224

It can be seen from this summary that after a good start to the year the position appears to be steadily worsening and in fact the most recent figures, August, are the worse compared to the profiled budget.

In trying to interpret the likely year end outturn from these figures a number of outcomes are possible. Looking at the first five months expenditure and comparing it with the same period last year would suggest a year end overspend of around £80 - £90k.

This does not reflect the direction in which practices' rolling annual growth rate is going and if an attempt is made to reflect this then the position shows an underspend of around £50k.

The figures above show a worsening position and if the same projections are undertaken using three months figures - June to August - then the overspend on the former approach rises to £180k but with allowances for growth projections suggests a breakeven position.

Within these figures it is unclear whether or not we have seen the full impact of the generic price issues and conversely when we will see the impact, if any, of the pricing regulation scheme. One consistent message that comes from these figures however is that it is the same practices who remain as the outliers at either end of the range i.e. those that are most likely to achieve an underspend or an overspend. This can be seen in Appendix 4 of the finance report.

Hazel Bagshaw
Prescribing Adviser
Gosport Primary Care Group

Peter Ifold
Finance and Information Manager
Gosport Primary Care Group

2 December 1999

GOSPORT PRIMARY CARE GROUP

Referrals for treatment outside Service Agreements

1.1 Since 1 April 1999, PCGs have been responsible for commissioning and most secondary care services. In practice, PCGs locally have followed the Health Authority's previous commissioning arrangements. As a result, almost all elective and emergency referrals are covered by service agreements with providers.

1.2 However, there are four categories of referrals or treatments covered by these service agreements. This paper:

- Outlines the four categories
- Explains how referrals or treatments within categories are being managed.
- Proposes a way of reaching decisions about referrals outside of service agreements.

2.1 For NHS Trusts where there is no service agreement, elective referrals no longer require the Health Authority or the PCG to approve in advance. Emergency referrals or treatments at these Trusts did not previously require such approval and this remains the case now.

2.2 For these two categories the PCG and the Health Authority are managing the potential risk through retrospective monitoring and promoting best practice. Locally, PCGs are currently developing documentation that will further promote best practice. The Health Authority will provide regular reports to PCGs and significant issues will be brought to the attention of the GP Group and Board.

3.1 For some time, the Health Authority has identified a range of procedures that are "not normally purchased" and can only be accessed under specific circumstances. Access to these services remains restricted and is managed primarily through the clinical advice of receiving specialist clinicians, except in cases where there is some dispute. Access is also restricted to elective services provided by private providers with whom the PCG does not have a service agreement. Previously the Health Authority decision in these cases followed clinical advice from the Public Health Department.

3.2 Since 1 April 1999, in the absence of any new procedure for approval and advice, the PCG Chair has taken the decisions about referrals in these two categories. The GP Group has reviewed this position and support the following framework:

> GP referral for a procedure "not normally purchased" that is not accepted by receiving specialist clinician or to a private provider is sent to PCG manager at Fareham Reach through the existing "Safe Haven" confidential route.

PCG manager arranges a panel of up to 3 clinicians to consider the referral, ensuring the panel has all relevant clinical information on which to make a decision. The panel will be drawn from:

PCG Chair and Vice Chair, Health Authority Public Health Consultant. (Other Board members will sit if Chair/Vice-Chair patients are involved).

Panel decision is relayed to the referring GP.

Appeals against the Panel's decision to be assessed by the existing Health Authority panel.

4 The Board is asked to:

- Note the current arrangements for referrals outside NHS Trust service agreements.
- Approve the proposed framework for reaching decisions on referrals to private providers and for procedures not normally purchased.

Pat Rimmer
General Manager
Fareham & Gosport Primary Care Groups

2 December 1999

PORTSMOUTH & SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

GOSPORT PRIMARY CARE GROUP

Strategy for Adult Mental Health Services

Attached is a document setting out a strategy for Adult Mental Health services. This was produced following a joint review of services undertaken on behalf of the Health Authority, the two local Social Services Departments and Portsmouth HealthCare Trust.

The current commissioning responsibilities of the PCG do not include Adult Mental Health services. Primary care teams locally are, of course, included in the provision of Mental Health services.

A draft of this strategy was endorsed following a series of presentations in October which involved representation from all agencies, including PCG Chairs. The attached document reflects amendments agreed at the October presentations. The PCG's were asked to consider expressing formal support for this final version.

Other actions arising from the October presentations included:

- Locality teams should proceed with changes in services which they have identified in the strategy as priorities for action.

- A further document should be produced to clarify the accountability and budgetary arrangements for the devolution of the commissioning and provision of Mental Health services to localities, referred to in the strategy.

- The Joint Strategy Board proposed in the strategy should be the local implementation team for the National Service Framework for Mental Health.

Further consideration is being given to devolving commissioning responsibilities for Adult Mental Health services to PCGs. An important part of this process is to clarify the accountability and budgetary arrangements for this devolution. When proposals for devolution of responsibility for commissioning these services have been formulated by the Health Authority, they will be put to the PCG Board.

Recommendation

The Board is asked to agree the attached strategy as a basis for further planning and provision of local Adult Mental Health services.

John Kirtley
Chief Executive

THE FUTURE DIRECTION OF MENTAL HEALTH SERVICES IN PORTSMOUTH AND SOUTH EAST HAMPSHIRE

A STRATEGY FOR ADULT MENTAL HEALTH SERVICES

Portsmouth and South East Hampshire Health Authority
Portsmouth City Council Social Services Department
Hampshire County Council Social Services Department
Portsmouth Healthcare NHS Trust

October 1999

CONTENTS

Part 1 - THE PURPOSE, PROCESS FOR DEVELOPMENT AND CONTEXT OF THE STRATEGY

Part 2 – THE STRATEGIC PROPOSALS FOR CHANGE

PART 1

THE PURPOSE, PROCESS FOR DEVELOPMENT AND CONTEXT OF THE STRATEGY

1. Introduction

1.1 In January 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 embarked upon a strategic review of their provision of mental heath services for adults. The overall purpose of this review was to generate a strategic plan for the re-focussing and developing of mental health services for adults, appropriate to the particular needs of the population of Portsmouth, Fareham, Gosport, Havant, Petersfield and environs.

1.2 A multi-agency Steering Group that comprised representatives from Portsmouth and South East Hampshire Health Authority, Portsmouth Healthcare NHS Trust, Portsmouth City Council, Hampshire County Council, independent sector organisations and, latterly, representatives of service users and their informal carers, was established to oversee the process of the review

1.3 The process of the review has involved a wide range of staff from health and social services, independent sector organisations, as well as service users and carers. The Steering Group would like to thank them all for their time, and their commitment to the review.

1.4 The first part of this document 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. It must be stressed that much of the detail that will support implementation is contained in the working documents that were produced during the review, and in the locality action plans currently being prepared.

2. The Purpose of the Review

2.1 In April 1999, the Centre for Mental Health Services Development, King's College London (CMHSD) was commissioned to support the Steering Group in achieving the following objectives:

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 expose the Steering Group and local stakeholders to research evidence and good practice elsewhere in the country through documentary briefing;

3. 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;

4. 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.

3. The Process for the Review

3.1 The review deployed a number of methods to collect relevant information and perspectives on mental health services for adults in the area:

'Open Space' events in each of the three localities: Portsmouth City, Fareham and Gosport and Havant and Petersfield. The objective of the events was to set the agenda for the subsequent work of the review through identifying the questions which participants wanted the review to tackle in order to make a real difference to mental health services, in particular the experience of users in that locality;

Structured interviews with health and social services senior managers with responsibility for mental health services in Portsmouth and South East Hampshire;

Focus Groups with GPs and representatives from Primary Care Groups to ascertain their views;

Analysis of quantitative information concerning demography, finance and activity across mental health services.

Service Development Seminars with local stakeholders to address the key questions which emerged from the Open Space events and interviews and to advise the Steering Group on potential ways forward. The topics addressed by the seminars were:

- The style and culture of the service;
- Access to services and integration of care processes;
- Role and function of acute in -patient services;
- Flexible community and day treatment services for individuals with specific needs;
- Meeting 'real life' needs – e.g. for employment, housing, personal development.

4. National Policy Context

4.1 Established and emerging policies messages relating broadly to health and social care, as well as specific mental health policy initiatives, had to be taken into account in the review. This section highlights elements of the national policy context.

4.2 Policy initiatives not confined to mental health services include:

- **A Public Health Approach** – The government has given a much higher profile to Public Health and sees mental health as a key Public Health priority. A Minister for Public Health has been appointed, the Green paper – Our Healthier Nation was published in 1998 followed by the White Paper – Saving Lives: Our Healthier Nation, published in July 1999.

- **The Social Exclusion agenda** - this policy initiative addresses issues of poverty and marginalisation in society. This may be particularly applicable to mental health service users, who often find themselves disadvantaged by the current benefits system and the reluctance of employers to employ with people with a mental health problem. However,

the disability strand of 'Welfare to Work' and the prospect of benefit reform may offer the prospect of people with mental health problems gaining and/or retaining employment.

- **The White Paper: "The New NHS"** - This White Paper announced the modernisation of the NHS with the major change in structure being Primary Care Groups (PCGs), responsible for commissioning and providing services for populations of approximately 100,000. In addition the White Paper envisages:

- improving health and reducing inequalities
- breaking down the barriers between health and social care
- improving performance and clinical and cost effectiveness
- enabling staff to provide better services
- building public confidence in health services
- providing quality services

- **'Partnerships in Action'** - a consultation paper which offered options around pooling of budgets at a commissioning and operational level, and potential for the extending of powers of NHS Trusts to provide social care and of Social Services Departments to provide secondary health care.

- **'Modernising Social Services'** – this White Paper with its proposals around Best Value and national standards is only one of a number of policy initiatives to which local government is expected to respond under the rubric of modernising local government.

4.3 The emerging national strategy for mental health services centres around 'Modernising Mental Health Services'. Table One summarises the major themes of this document:

Table One

SAFE	SOUND	SUPPORTIVE
Good risk management	24 hour access	Involvement of patients, service users and carers
Early intervention	Needs assessment	Access to employment, education and housing
Enough beds	Good primary care	Working in partnership
Better outreach	Effective treatment	Better information
Integrated forensic and secure provision	Effective care processes	Promoting good mental health and reducing Stigma

4.4 The government has also initiated a review of the current Mental Health Act which will be published in late 1999. Home Office and Health Ministers are considering a more effective framework for the assessment and management of people with severe personality disorder.

4.5 The National Service Framework for Mental Health was published in September 1999. This focuses on the mental health of working age adults and has five broad areas: mental health promotion; primary care and access to services; effective services for people with severe mental illness; caring about carers and preventing suicide. There are service models defined for these areas and seven national standards are set. Each standard is supported by the evidence and knowledge base and relevant examples of good practice. Local implementation teams will translate the national standards and service models into local delivery plans.

5. Local Context

5.1 Portsmouth and South East Hampshire is a large geographical area served by a single Health Authority and a single Trust for mental health services. There are however some new influences, in particular influences emphasising delegation of decision-making, emerging with the creation of Portsmouth City Council and PCGs. There is corresponding decentralisation in Hampshire County Council with a new structure for community mental health designed to develop a specialist focus through specialist service managers.

5.2 The above agencies established a Strategy Group which undertook much thought and discussion, resulting in two relevant documents in draft form: the draft Joint Adult Mental Health Strategy; and Joint Investment Plan for Services for Adults with Mental Health Problems. There are also two important protocols intended to support the implementation of enhanced services: Operational Policy for Community Mental Health Teams and Protocol for the integration of the CPA and Care Management Process. The review process revealed a 'top down' approach to local service planning and provision, the absence of implementation plans to ensure the changes are introduced in a realistic way within localities, and a lack of integration of service users and carers into the overall process.

Needs Assessment

5.3 The Health Authority has also undertaken a needs assessment exercise. The full report of this review is available on request but the key messages are:

- Deprivation is associated with mental illness. Of the 14 most deprived wards in Portsmouth and South East Hampshire, seven are in Portsmouth City, with another six equally split between Havant and Gosport.
- Mental illness is more common amongst people who rent their accommodation. The percentage who rent across the whole Health Authority is 26% of the population. The highest percentage (33%) is found in Portsmouth City whilst the lowest is in Fareham (14%). Unemployment is also linked with mental illness. The unemployment rate is highest in Portsmouth City and lowest in Fareham
- Approximately 1 in 6 adults in the Health Authority will have a mental health problem in any given week
- Mental health problems can broadly be divided into neurotic and psychotic illness. In general neurotic disorders are less severe than psychotic ones. In the Health Authority area, 22,200 men and 33,670 women aged 16-64 would be expected to suffer from a neurotic disorder (including anxiety, depressive episode, phobias and obsessive compulsive disorder) in the course of a week. By contrast 720 men and 690 women in the same age

group would be expected to suffer from a psychotic disorder (such as schizophrenia or manic depressive psychosis) in the course of a year.

- A model that takes account of deprivation (the Mental Illness Needs Index) was used to predict the number of admissions by area. This is compared with the actual admission pattern and the adult population by area in table 2. Portsmouth City's expected percentage of admissions is greater than its proportion of the total adult population whilst the reverse applies for the other two localities. When the expected percentages are compared with the actual admission pattern, Portsmouth City's actual percentage is close to the predicted percentage, Fareham and Gosport's is below the predicted percentage whilst the actual percentage for Havant, East Hampshire (part) and Winchester (part) is higher than predicted.
- If admissions to the substance misuse service are excluded, people with diagnoses of depressive episode, schizophrenia and bipolar affective disorder (manic depression) accounted for 45% of all admissions in 1997/8. The percentage of bed days taken up by these patients was even greater at 61%.
- The average length of stay of adults with mental health problems admitted to Portsmouth HealthCare NHS Trust in 1997/8 was 28 days (34 days if admissions to the substance misuse service are excluded).
- The number of attendances of people who had deliberately harmed themselves at accident and emergency facilities in 1997/8 was 1,335 (or 2.5 per 1,000 population). The rate was highest in Portsmouth City (3.0 per 1,000) and lowest in Winchester (part) and East Hampshire (part) – at 1.0 and 1.3 per 1,000 respectively.
- The number of deaths from suicide and undetermined injury in Portsmouth and South East Hampshire was 50 in 1998. This number was made up of 35 men and 15 women.

Table 2

Comparison by locality of percentage of adult population, expected adult mental health admissions & actual adult mental health admissions

	Havant, East Hampshire (part) and Winchester (part)	Fareham and Gosport	Portsmouth City	Portsmouth and South East Hampshire Health Authority
% of total adult population	32%	34%	35%	100%
Expected number (%) of admissions*	199 (27%)	188 (26%)	340 (47%)	727 (100%)
Actual number (%) of admissions**	489 (31%)	360 (23%)	730 (46%)	1584 (100%)

* = Using Mental Illness Needs Index

** = For 1997/8

Totals may not equal 100% due to rounding

The Local Population

5.4 Portsmouth and South East Hampshire Health Authority has an estimated population of 545,000 which covers all of Fareham, Gosport and Havant Borough Councils, Portsmouth City Council, part of East Hampshire District Council and a small part of Winchester City Council. The three localities are similar in size, with 183,000 residents in Fareham/Gosport, 188,000 in Portsmouth City and 174,000 in Havant/Petersfield. Four Primary Care Groups cover the Health Authority's area. These are East Hampshire (215,000 residents), Fareham (105,000), Gosport (78,000) and Portsea Island (147,000).

5.5 Mental health of the individual is influenced by physical, psychological and social/ environmental factors. Socio-economic indicators provide a method of measuring deprivation in the community, linked with poor health and premature death generally and closely associated with demand for mental health services. The Hampshire localities have a similar socio-economic profile, which contrasts with the urban population of Portsmouth City. The Mental Illness Needs Index (MINI) ranks deprivation scores around an average of 100 for the country as a whole, using local authority wards as the basis for grouping populations. Fareham/Gosport and Havant/Petersfield score 91 and 94 respectively, suggesting that these SE Hants localities have lower levels of need than Portsmouth City which has a score of 107, (i.e. 7 points higher than the national average). All localities have pockets of deprivation, with the maximum levels represented by Charles Dickens ward (123) in Portsmouth City, Warren Park ward (107) in Havant/Petersfield and Town ward (104) in Fareham/Gosport. The net MINI score for population served by the HA is 98, which is a little below the average for the country as a whole. Overall, differences in provision between localities are largely justified by differences in need, determined through these deprivation levels.

Current services

5.6 The health authority invested £30.5 million on mental health services for its residents in 1998/99, equivalent to £56 per capita population. This level of spending is appropriate to the size and needs of the population, based on comparisons with other HA expenditure. Social Services committed a further £3.5 million (net of Section 28a funding) to adult mental health services which is also consistent with comparisons of other LA expenditure. Portsmouth City Council and Hampshire County Council spent £12 and £10 per capita respectively.

5.7 Current service provision is summarised in Table 3.

Table Three: Summary of Current Service Provision

	Portsmouth City	**Havant/ Petersfield**	**Fareham/ Gosport**	**Total**
Acute Beds	Solent Ward = 20 Ibsley Ward = 8 Ellen Cook = 7 Total = 35	King Villa = 22 Old Vicarage = 12 Total = 34	Meadows = 22 Total = 22	 Total = 91
Intensive Care	Solent = 10	King Villa = 8	Meadows = 8	Total = 26
Rehabilitation			Lee Grove House = 8 Rivendale = 14 Total = 22	Total = 22
Continuing Care	Foxleigh = 16	Woodlands = 18		Total = 34
Forensic				Fairoak = 14 Cheriton = 8 Total - 22
Total Inpatient Beds	61 beds	60 beds	52 beds	Total = 195
CMHT *(All Staff includes Consultant Psychiatrist and Senior Registrars)*	3 Teams: 35 wte CPN 29 wte SW 5 wte Consultants 90 wte All Staff	3 Teams: 21 wte CPN 9 wte SW 4 wte Consultants 49 wte All Staff	2 Teams: 21 wte CPN 16 wte SW 4 wte Consultants 59 wte All Staff	 76 wte CPN 54 wte SW 12 wte Consultants 197 wte All Staff
Day Hospitals	-	-	-	-
Residential Accommodation Places				
Registered Vol Private	563	20	93	676
Other Vol/Private	412			412
Supported Housing		47	33	80
Resettlement			19	19
Registered 24 hour care			12	12
Unsupported MH Tenancies		12		12
Total Places	975	79	157	1,267

5.8 The detailed resource analysis concluded that current provision of acute and intensive care beds was standard for the overall population. Assessment of non-acute provision is more problematic due to the range of service models across the country employed to meet the spectrum of mental health care needs. However, broad comparison would suggest approximately 350 non-acute beds and places to cover this spectrum across the whole of Portsmouth and South East Hampshire whereas Table 1 shows that 975 places are located in Portsmouth City with only 79 in Havant & Petersfield. The concentration of accommodation in Portsmouth City stimulates demand for mental health services in the locality, placing pressure on community services

5.9 The proposed Private Finance Initiative scheme will alter the distribution of inpatient facilities. Each locality will have a 30 bed acute/ICU facility and 14 medium stay rehabilitation beds, taking the total bed complement (excluding forensic beds) from 173 beds to 162. Current hospital utilisation rates show that Portsmouth City residents consume 44% of resources (in terms of occupied bed days) compared to 32% by Havant & Petersfield residents and 25% by people living in Fareham & Gosport. The reduction in future bed provision to a standard level of 44 beds in each locality does not, however, reflect this difference in need. Community services will need to be mobilised to provide alternatives to hospital admission, supporting the case for maintaining high numbers of CPNs and social workers in Community Mental Health Teams in Portsmouth compared to the Hampshire localities. The high current CMHT provision in the City is illustrated in Table 3 where Portsmouth City employs 90 wte staff with 49 wte in Havant /Petersfield and 59 wte in Fareham/Gosport. The Trust is examining ways of addressing this issue within the limited room for manoeuvre given the state of development of the scheme. All parties agree that the poor standard of accommodation in St James Hospital means that the scheme must not be delayed.

PART 2

THE STRATEGIC PROPOSALS FOR CHANGE

6. Introduction and Key Areas of Change

6.1 This part of the report sets out the overall service model, and proposals for implementation, for mental health services for adults in Portsmouth and South East Hampshire. It has been shaped by the views of stakeholders collected through the course of the review process, underpinned by practice models and research evidence contained in briefing papers prepared by CMHSD, and agreed by the Steering Group. The recommendations reflect the requirements set out in the Government's White Papers Modernising Mental Health Services and Partnerships in Action, as well as in the National Service Framework for Mental Health. This section sets out the key features of the changes that will be put in place, and subsequent sections set out the models of services for locality services, acute inpatient care, flexible community and day treatment services for individuals with specific needs, and 'real life' needs (employment, housing, personal development etc.). The final section deals with the process of implementation.

The Style and Culture of the Service

6.2 There are a number of cultural and structural changes required if services are to develop effectively and be able to meet the standards set out in the National Service Framework. This section summarises these changes and suggests markers which could be employed to confirm that these changes had taken place. Overall, they represent for the agencies concerned a shift from central planning and management of services to a balance between central and local. Already, the Steering Group for this review has started the process of creating this balance, and the detailed innovations in structure are dealt with later (see Section 11).

6.3 The task at the strategic level is to agree a programme for the devolution of commissioning to PCGs and localities, enable and empower localities to implement the strategy, to allocate resources to achieve implementation, and to ensure the degree of equity and consistency required by national policy. The proposed central multi-agency group – a Portsmouth and South East Hampshire Joint Strategic Group for adult mental health services that will be known as the District Implementation Team for the National Service Framework (see Section 11) - will set key strategic objectives and establish indicators. It should also 'model' the partnership working that is expected in the localities and facilitate the changes needed to achieve true partnership at the locality level.

User Consultation Integral to all Service Processes

6.4 The implementation of the strategy - and indeed all activities of the service - should reflect a commitment to developing a strong service user focus, and to ensuring that service users' views are integral to planning processes. In order to achieve effective involvement, resources must be made available for training and payment for time and expenses incurred. A network of service user groups in each locality should become part of the locality planning and management structures. Markers which would indicate progress will include: information made accessible to users to enable access and informed decision making; service users involved in all decision-making processes with the resulting

decisions demonstrating service user influence; training for service users to support consultation and service users represented in staff selection processes.

Carer consultation & Support

6.5 Similar considerations apply to carers. Markers here might include: involvement of carers in all decision-making; and availability of practical support for carers to enable involvement. A suggested local marker in the NSF is that carers are involved in service review and development.

Locality Implementation Plans

6.6 The task of each locality is to devise an implementation plan in response to the strategy and to ensure that proposals are feasible, affordable and supported by local stakeholders. Each locality must have effective processes for jointly managing pooled or transparent budgets for service provision, developing innovative solutions to meet local needs and for involving service users and carers in the planning and management of services. Markers might include: agreed locality implementation plan; acceptance of possibility of differences between localities; and clarity about responsibility for delivery. Section 11.3 considers some of the issues which will need to be resolved in relation to the devolution of commissioning responsibilities to localities.

Defined, Transparent and Delegated Mental Health Budgets

6.7 At both a strategic and local level, health and social care mental health budgets will as far as possible be defined, made transparent and delegated to localities. It is acknowledged that there will be differences between localities in the way this is achieved, because the agencies within each will have different approaches, timetables and policies. Markers might include: care managers having access to shared health and social services budgets; and care packages rapidly implemented that are needs based not resource led.

A Single Point of Access to Services with Straightforward Care Pathways

6.8 A single point of access is often identified as one of the key characteristics of an effective community-based service. At the same time, GPs wish to retain the right of referral to a consultant psychiatrist. These two positions are reconciled within the locality model in this document. The markers proposed here are: coherent joint health and social services eligibility criteria; and one named person responsible for care of each individual service user.

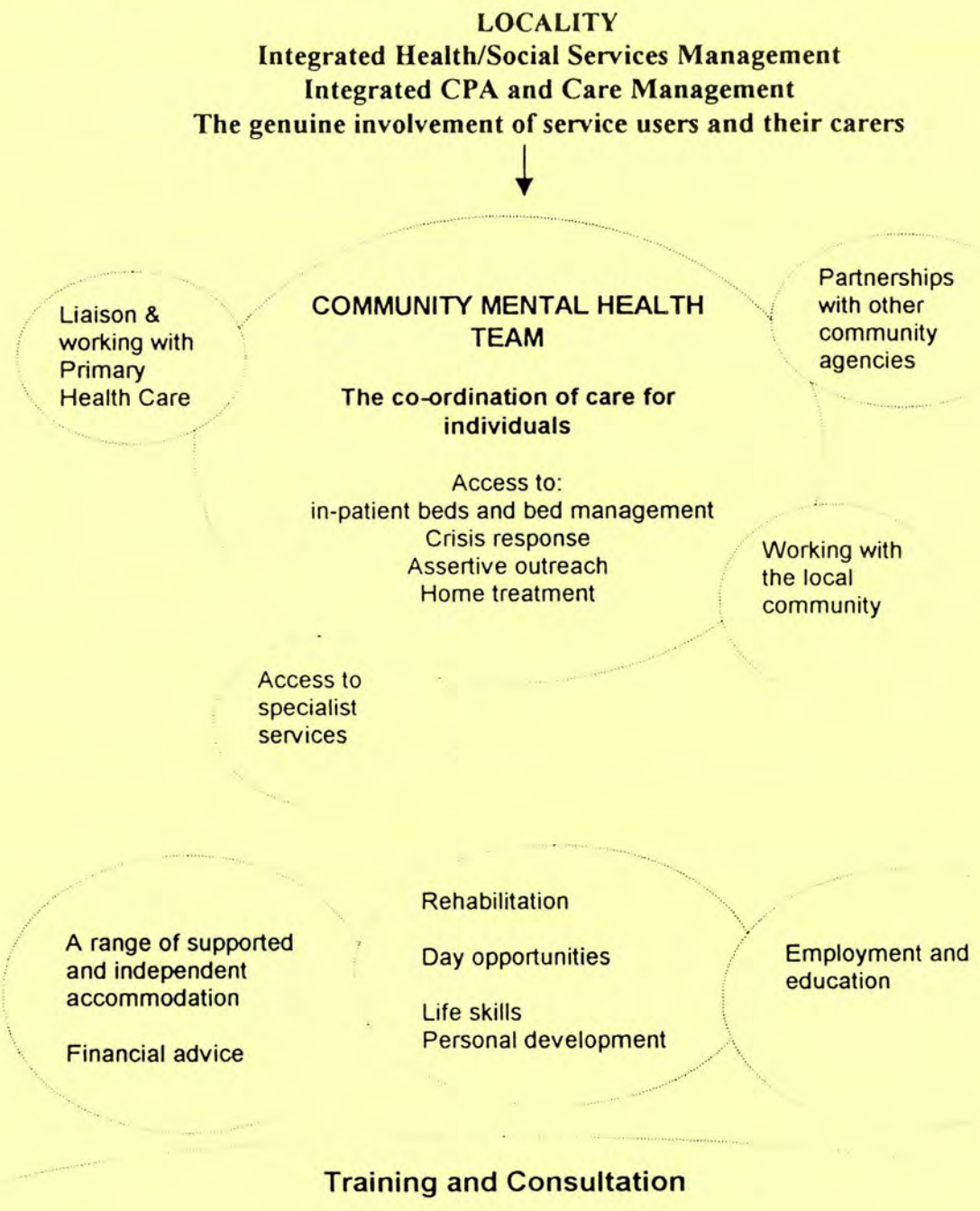
Sound Joint Working and Care Planning

6.9 The integration of CPA and care management is one of the ways of assessing local performance that will be measured at a national level. Integration can be taken to mean one assessment accessing both health and social care resources. The local markers proposed here are: full integration of CPA with care management; inter-agency procedures which are managed into the service and work effectively; clarity, understanding, and acceptance of the differing roles, responsibilities and contributions of professionals & agencies; and effective joint training initiatives.

7. Locality Services

7.1 For each of the three localities, specific functions for mental health services have been identified. These are summarised in Figure 1:

Figure 1: Locality Functions of Services



Locality Structure and Management

7.2 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

|

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
Commissioning specialised provision
Medical staff
Professional staff
Liaison with Voluntary Sector Organisation providers
Liaison with Primary Care Teams

|

WORKLOAD MANAGEMENT

|

THE SUPPORT AND DEVELOPMENT OF STAFF

|

LOCALITY PLANNING AND IMPLEMENTATION
Strategies for the involvement of service users and informal carers
Developing networks
Working arrangements with other agencies and providers
Audit and review
Planning & Implementation

Community Mental Health Teams – configuration, roles and functions

7.3 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 for individuals. It is considered, however, that the current configuration of CMHTs fragments the deployment of staff and resources. This hinders the ability of managers and staff in their efforts to reduce barriers, to be flexible and creative in their response to the needs of individuals, and to achieve the optimum value from the available resources. There is a recommendation therefore, to amalgamate existing CMHTs to produce two robust teams per locality.

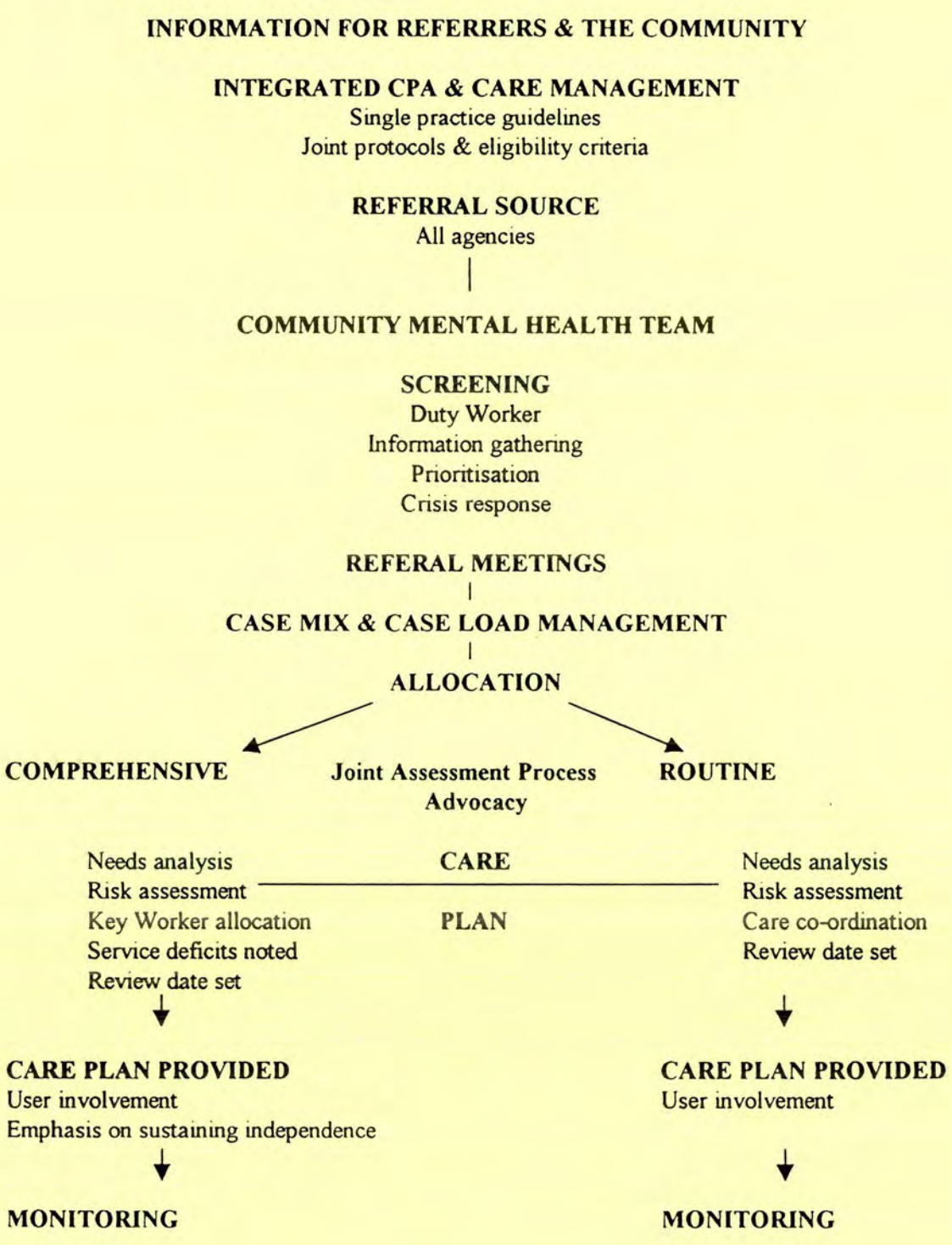
7.4 This service framework envisages the role and functions of the enhanced CMHTs as follows:

- The co-ordination and delivery of integrated care across of health, local authority and independent sector services;
- Managing the interface between mental health and other significant community services – with particular emphasis on the relationship with primary care;
- The development of a common, multi-professional, multi-agency approach toward those who use the services through a shared understanding of core objectives;
- The implementation of agreed Health and Social Services eligibility criteria against which local priorities are set;
- The management and allocation of pooled resources against known local need;
- A single point for recording entry into the mental health service system, for all referrals, and the predominant point of access, to include joint IT and case notes and recording systems;
- Single, integrated, practice guidelines for CPA and care management;
- Comprehensive assessment, care planning and care delivery;
- The management of risk;
- A local response for the assessment and management of crisis, including clear relationships with ASW duty;
- The provision of information to users, carers, professionals, other agencies and the community;
- Consultation with service users and carers;
- Training provision for other agencies and organisations

Arrangements for Care Co-ordination

7.5 There is a need for clearer arrangements for care co-ordination. The proposed model is summarised in Figure 3. GPs will retain the right to refer direct to consultant psychiatrists; these referrals will be logged with the team and discussed at referral meetings

Figure 3: Arrangements for Care Co-ordination



8. Acute In-Patient Care

8.1 'Modernising Mental Health Services' requires each District to provide: meaningful help on a 24- hour basis; the development of alternatives to hospital admission; and the effective co-ordination of inpatient care with community mental health teams. Standard five in the NSF states that each service user who is assessed as requiring a period of care away from their home should have timely access to an appropriate hospital bed or alternative bed or place, which is in the least restrictive environment consistent with the need to protect them and the public and is as close to home as possible. These requirements have implications for the characteristics of acute in-patient services.

The Characteristics of Acute In- patient Care

8.2 The development plans for in-patient units should respond directly to the increased pressures brought about by the rising levels of drug and alcohol abuse and increased levels of violence/challenging behaviour that are now commonly experienced on acute wards. Modern acute in-patient services should provide a safe and modern environment for patients and staff; including access to therapy, activity, treatment and emotional support and specific facilities and care services for women. In order to achieve this inpatient care has to offer:

A culturally appropriate service

- Staff groups which reflect the ethnic and cultural diversity of the localities.
- Training in cross-cultural frameworks for addressing the dynamics of extended families.
- Provision of spiritual support to people of *all* faiths.
- Female psychiatrists available locally.
- Users able to state a preference for the gender of their worker, including, psychiatrist, key worker, or named nurse.
- Access to advocacy

Restrained containment

- Containment to the degree required, at any given time.
- Personal space and opportunity for quiet.
- Pleasant environment.
- Protection from others.
- Hotel services which meet basic needs of people from all cultures and faiths

Intensive support

- Continuity of contact between the user and key worker
- Access to family and opportunities to work with them.
- Support groups, opportunities to talk things through with other residents.
- Personal support for each user – readily available (at all times).
- Practical help – to sort things out at home.

Necessary intervention

- Personal care plan (including a written copy on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis [standard five of NSF])
- Expert resources available, consultant, senior nurse, specialist help and treatment.
- Medical advice
- Physical treatments

8.3 Acute inpatient care is often the forgotten service when it comes to service development. The strategy proposes that significant attention is given to achieving the characteristics detailed in 8.2, as far as possible ahead of the move into new accommodation.

The Distribution of In-Patient and Intensive Care Beds

8.4 The future allocation of acute and intensive care beds for each locality has already been discussed in Section 5 of the Strategy.

Management Arrangements for Acute In-Patient Services

8.5 Ensuring the continuity of care across residential and community facilities and integrating the roles, functions and responsibilities of Community Mental Health Teams with those of the residential services will require the changes to current management and operational arrangements outlined in Section 7 above.

9. Flexible Community and Day Treatment Services for Individuals with Specific Needs

9.1 The priorities for service development for community and day treatment for people with complex needs have been agreed as:

1. Information sharing and communication.
2. Locality integration, joint working and liaison.
3. Crisis response and resolution, at home and in the community.
4. Assertive, intensive and continuous support to sustain community living.
5. Training and development of professional support staff.

Information sharing & communication, information technology and monitoring systems

9.2 It is proposed that a project leader be appointed whose task would be to develop an 'information shop' providing a single point of access for information for all services, but with a priority given to community and day treatment services. This 'information shop' would be co-ordinated across agencies to help service users, carers and providers to find the information they need about illness, access to treatment, and the services available locally and nationally. Connections with NHS Direct (noted in standard three of the NSF) will be important here. Locality mental health services have to be supported by the development of a long- term strategy for electronic recording for the storing and sharing of information – including electronic patient records as stated in the National Service Framework.

Locality based integration, joint working and liaison

9.3 Locality based integration, joint working and liaison between health and social services, and independent sector providers, are central to the strategy but implementation should be locality based. The provision of integrated services will have the capacity to respond to the changing needs of those with complex needs (e.g. assertive outreach, community crisis resolution, out of hours services). Effective implementation will be dependent upon the flexible and creative use of staff and local resources, together with effective joint working between staff from all agencies working with people with mental health problems.

9.4 To this end, it is proposed that:

- A review be undertaken of the use of all existing local resources and infrastructure including buildings, budgets, and accommodation relating to community and day treatment services;
- Mechanisms should be identified and convened to involve staff in discussions about the redefinition of roles;
- A joint information & communication strategy be devised to keep all staff across health social services and voluntary sector organisations involved in the provision of community and day treatment services abreast of developments, and to provide information about the proposed changes.

Crisis Response and Resolution in the Community

9.5 It is proposed to create one point of contact (person/team/telephone number) for crisis within the CMHTs providing:

- Responsibility for 'sorting it out'
- Fast response to deal with emotional turmoil (user and carer distress).
- Appropriate advice on aftercare.
- Support workers who have sufficient experience providing support into the homes of service users.
- Admission to hospital when it is the only option

9.6 This function will be provided by a sub-team also providing assertive outreach. The extension of crisis response and resolution to a 24 hour service will require collaboration between CMHTs.

9.7 Support for carers must to be provided at the same time as support for the service user in order to assist in meeting standard six of the National Service Framework (a proposed local milestone is carers being satisfied with the service they receive):

- Carers supporting carers on a one-to-one basis
- Crisis service to link up with carers in crisis

Assertive, Intensive and Continuous Support to Sustain Community Living

9.8 The assertive outreach and crisis response function will be integrated into CMHTs, provided by a dedicated group of multi-professional workers with the appropriate skills and training. This sub-team will engage with those who require intensive support but who

may avoid services, and will promote and sustain involvement in the community, i.e. recreational, educational, social, employment, cultural needs. The sub-team will also develop approaches for working with people with dual diagnosis. The work of the sub-team will bridge and integrate the individual's requirements for health care, social care and social inclusion. The sub-team will adopt the essential characteristics of an effective and sustainable assertive outreach function:

- deliver intervention 'in vivo'
- operate a no case closure policy
- have a limited caseload
- operate a team key working approach

The particular needs of young adults with mental health problems

9.9 When developing flexible community treatment services, it was acknowledged that there were particular issues that needed to be borne in mind if services were to be appropriate to the needs of young adults:

- They do not fit in with older service users and there is peer group stigma to engaging with mental health services, however, drugs and alcohol may be "cool";
- Family plays a powerful role and there are competing cultural pressures (youth, family, ethnicity, and religion).
- Young people have different routes of access into the service; alternatives are restricted, as they have reduced access to statutory services and welfare benefits.
- They are in the early stages of illness and have not become institutionalised or developed secondary handicap – they 'haven't learned to be ill' and services should be developed that will ensure their independence is supported and sustained.

9.10 In order to develop a good balance between staff with specialist skills & experience and generally trained staff, training should be targeted at people at points of access e.g. schools, colleges, youth groups, police, probation, counselling services. Alongside this initiative, recruitment should focus on staff with a cross section of life experiences. An early-intervention approach within CMHTs service should ensure a range of user-friendly points of referral to the service, and provide early intervention and access to relevant, acceptable services which have been underpinned by user defined priorities, and advocacy.

10. Real Life Needs – Employment, Housing, Social Life, Skills and Personal Development

Strategic level

10.1 The social model of service provision needs to be consolidated and extended. This would involve:

- A flexible, individually-focussed, rehabilitation model supported by improved implementation of CPA and care management;
- A locality-based strategy for the development of housing and employment;
- Appropriate training strategies.

10.2 At the heart of the model would be a commitment (with resources) to service user involvement in designing, commissioning and monitoring service provision. It would also include a training strategy for both users and professionals based on continuous improvement and a communications strategy to ensure that the service user as customer is able to access the information they need to make real choices and the advocacy support to articulate their needs and wishes.

Accommodation Strategy

10.3 A housing and accommodation strategy will be needed for each locality. However the general principle will be to enhance the range of choices by investing in floating support for ordinary housing and shifting from registered to unregistered options. The overall housing strategy must gain the support of Housing Departments and include a commitment to user-focussed monitoring of service quality.

Employment Strategy

10.4 Services must be individualised and co-ordinated to ensure accessibility and choice. In employment, as with housing, the involvement of users in determining their own support needs is crucial. There will also need to be consultation and partnership arrangements with the full range of agencies that deliver employment related services for example, the Employment Service, the Training and Enterprise Council(s), the Benefits Agency, local FE Colleges, and of course, local employers.

10.5 The overall mix should recognise that people come with different skills and at different points in their careers. Hence there should be a mix of support in open employment, prevocational training, work experience (including social enterprises and social firms) and voluntary work options. Each locality will need to build on the existing mix of services taking account of the local economy and the employment opportunities available.

10.6 There should be a single gateway into work (involving assessment and choice of pathways) which starts with the CPA and ensures that individuals have the continuing support of mental health service professionals while progressing to work and while in work. There must also be expert support and advocacy available to enable service users to negotiate the benefits system without putting their income at risk.

Training Strategy

10.7 Supporting a social model approach will require that all stakeholders commit to a process of development that improves skills, challenges attitudes and seeks continuous improvement. A steering group is proposed for devising and monitoring a training strategy that will support the implementation of the social model and monitor the effectiveness of training across the district. Key principles of the training and development strategy are:

- that learning is two way between users and professionals
- that learning is continuous and therefore part of a cyclical process

Local Implementation

10.8 Within the overall strategic approach which encourages co-operation, joint working and joint monitoring, the actual design and delivery of services require local groups of stakeholders who would have the responsibility for co-ordinating and supporting local accommodation, employment and training provision. Housing, Employment and Training fora for each locality would enable the particular needs of users in each to be addressed and local opportunities to be developed.

11. Structural Implications and the Process of Implementation

11.1 The creation of coherent locality structures with joint management, pooled 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 experienced.

11.2 It is an important principle of the proposed arrangements that close relationships develop with the four PCGs, that the 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. A further key principle of the new structure is that the locality is the central 'building-block' of the service system, and that separate structures constructed around more broadly-based specialist services must not compete with localities or undermine their leadership. Where it is appropriate for such 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 in implementing the proposed model. Two different structures are therefore proposed below, 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.

11.3 In relation to the commissioning of health services, the health economy is currently in a state of transition, and the mental health implementation process must be informed by, and co-ordinated with, other developments, which are in progress. Currently commissioning responsibility for a wide range of health services has already been devolved from the Health Authority to PCGs and discussions are underway, but not yet clear, regarding responsibilities for mental health services. Given the different starting points for the localities, it will be important that both the Health Authority and PCGs develop a shared conceptual framework for the staged devolution of mental health commissioning, which covers the whole district but which reflects the differing realities in the localities. This framework will need to ensure clarity in relation to:

- Lines of accountability
- Ensuring the appropriate "audit trail" for decision making
- Corporate governance arrangements
- Appropriate employment arrangements for any new staff (where necessary), etc

It is assumed that this agreed framework will spell out the development of devolution clarifying current, interim, and proposed final arrangements, and that these will be reflected in Accountability Agreements. Within this district wide approach, it will important for each locality, to clarify the roles and responsibilities of the various players (PCG, locality board, etc.) in relation to the various tasks which together constitute commissioning, i.e.:

- Strategy formation
- Service development planning
- Developing a commissioning framework and input to Service and Financial Framework
- Developing specifications
- Negotiating and concluding contracts/service agreements
- Monitoring contracts/service agreements
- Strategic review

Much of the groundwork for some of these tasks has already been completed through this review, and much will be directed by the National Service Framework. This envisages that the provision of services will most likely be best met in the medium term by NHS Trusts with a 'critical mass' of mental health services. In urban areas, single specialty mental health NHS Trusts are preferred. Some Primary Care Trusts might be given responsibility for local specialist adult mental health services, if a series of criteria are met. With regard to commissioning, the NSF states that Health Authorities will retain responsibility for commissioning highly specialist services but local specialist services should be commissioned through a unified local process. The arrangements for this are expected to evolve over time as health and social care communities make use of the new flexibilities (pooled budgets, lead commissioning, integrated provision) that are now to be permitted. Options specifically noted by the NSF are:

- A joint commissioning board, including Local Authorities, Health Authority and Primary Care Group
- A lead commissioner, which could be a Local Authority, Health Authority or Primary Care Group / Trust

Within these local and national parameters, clarifying local roles will ensure that all partners can participate with realistic expectations and understanding of their own input and of the process as a whole. The following paragraphs summarise the work already done by key stakeholders within each locality, and at the strategic level, to address future roles and responsibilities.

A locality mental health partnership for Portsmouth

11.4 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, compliance with the National Service Framework on a local level and the co-ordination and deployment of all local mental health resources (See Figure 4). Further discussion is required to determine the exact nature of relationships, which agency is most appropriate as the employer of staff and provider of facilities, and how commissioning and providing responsibilities are to be handled. However, structures emerging elsewhere commonly feature a Management Board with formal accountability to the Board, with service user and carer representation, and a jointly-appointed manager responsible for all staff and resources. Such a 'Partnership' organisation would provide

and commission all secondary mental health services for adults of working age currently provided for the population of Portsmouth, using pooled budgets delegated formally by the 'partner' organisations. It is suggested that the Portsmouth locality is sufficiently well developed in terms of services and inter-agency relationships to support the introduction of a single-management structure.

The Role of the Portsmouth City Board For Adult Mental Health (Primary And Secondary Services)

11.5 The role of the Board was agreed as follows:

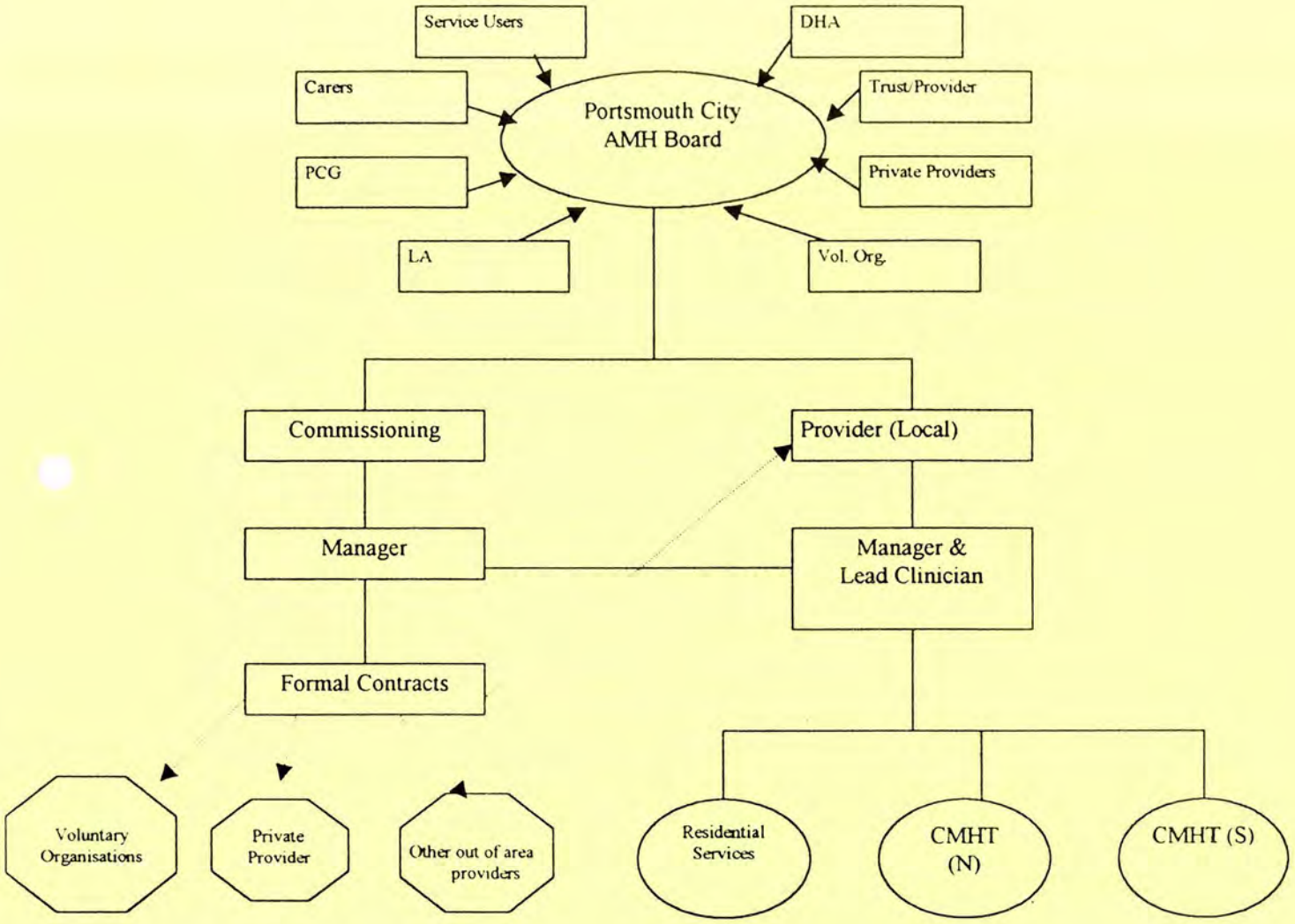
- Strategy implementation
- Work in partnership with the District Implementation Team for the NSF to progress local compliance with the National Service Framework
- Co-ordination and development of all resources to ensure 'best value'.
- Ensure user and carer involvement to ensure services are in line with their views and needs.
- Steer implementation of commissioning and providing arrangements.
- Meeting the accountability arrangements of each of the partnership organisations. (Portsmouth City Council, PSEH Health Authority, Portsea Island and East Hampshire Primary Care Groups, Portsmouth Healthcare Trust).
- Bring gaps in service to the attention of the District Implementation Team.
- Commissioning and providing mental health services for the population.

Priorities for Action

11.6 Top priorities for the Board were agreed as follows:

1. Priorities and timetable to be agreed by the Board.
2. Agree a communication plan.
3. Develop a service user and carer strategy.
4. Agree Project manager time and appoint to post.
5. Agree and appoint to CMHT management post
6. Develop primary care strategy – Dual Diagnosis
7. Develop/implement new building for CMHT plan
8. Develop centralised single duty /24 hour service
9. Staff training and development
10. Financial management budget plan and procedures
11. Bid to be pilot for IT integration
12. Agree operational policy and eligibility criteria

Figure 4: Proposed Model for the City



Joint Management for Fareham & Gosport and Havant & Petersfield

11.7 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, and the likelihood that the appointment of a single manager for each locality with both providing and commissioning responsibilities will not be possible in the short-term.

Summary of the structure and functions of the Hampshire localities

11.8 Each locality will have its own Joint Board or Management Group, with functions as follows:

- influencing and implementing strategy
- working in partnership with the District Implementation Team for the NSF to progress local compliance with the National Service Framework
- commissioning and delivering integrated services within the locality

- management of 'transparent' budgets delegated by Social Services and the HA/PCGs (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, whilst acknowledging the NSF requirement to ensure that gaps in current services for people with severe and enduring mental illness are addressed as the first priority for local health and social care systems
- developing the voluntary and independent sector as providers of services
- performance management/monitoring of the quality of provision in the locality

11.9 The proposed membership is:

PCG/GP representatives
Social Services (MH Service Manager)
PHCT (manager & consultant)
Chairs of 'issue groups', suggested as follows:

users
carers
employment
voluntary sector
accommodation (includes housing)
clinical services
law & mental health

11.10 There would be about 12 members in total with a chair & vice-chair to be elected from any agency. Top priorities for the Boards were agreed as follows:

- CMHT management and functioning
- the establishment of Mental Health Resource Centres
- promotion of partnership working
- a focus on prevention
- 24-hour cover
- clarity/transparency in management arrangements and budgets
- single access: 'my customer, my responsibility' principle
- real changes for users and carers
- change in the style of service delivery - turning it into a 'listening' service
- staff training

Portsmouth & South East Hampshire Joint Strategy Group for adult mental health services

11.11 It is proposed that the work of the Joint Commissioning Board and Adult Mental Health Strategy Steering Group, which currently lead the development of mental health services, should cease at the point of implementing the new Strategy. They should be replaced by a Portsmouth & South East Hampshire Joint Strategy Group for adult mental health services. This will be the District Implementation Team for the National Service Framework and will take on the following responsibilities:

- working in partnership with the three locality groups to progress local compliance with the National Service Framework
- specification of key requirements and service functions
- supporting and monitoring locality implementation
- recommend 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

11.12 The membership will be:

- HA - Consultant in Public Health Medicine and Mental Health Commissioning Officer
- PCC – Director of Adult Services
- HCC – Area Director of Mental Health Services, Commissioning Manager (Mental Health)
- Trust – Lead Clinician, Lead Manager, Trust Chief Executive
- PCGs- One nominee from each
- Portsmouth Voluntary Sector – CVS nominee
- Fareham and Gosport Voluntary Sector – Forum nominee
- Havant and Petersfield Voluntary Sector – Consortium nominee
- Locality Groups – Chairs
- Users – Current members of review process in time replaced by nominees from locality structures
- Portsmouth Carers – Carers group nominee
- Fareham and Gosport Carers – Carers group nominee
- Nominee from Havant & Petersfield carers

Standards for the Support of Service Users and Their Carers in the Implementation Process

11.13 The Portsmouth & South East Hampshire District Implementation Team will oversee the development and implementation of a set of set of core standards to facilitate and support and development of service user and carer input into:

- Strategic planning and locality implementation process.
- The development of formal user and carer evaluation of local mental health services.
- Staff training and development programmes.
- The selection of staff.

11.14 The above may require agencies represented on the District Implementation Team to identify and to pool budgets in order to provide financial support and payment for those attending participating in the above, as well as generating and sustaining user and carer support groups and information exchanges.

12. Conclusion

This 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. 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 this strategy lies.

Appendix One

Glossary of terms and abbreviations used in this document

- Secondary services is the phrase used in this document to describe health services provided by NHS Trusts, as distinct from primary care provided by General Practitioners and their staff

- Care Programme Approach or CPA is a helpful tool for planning and delivering effective mental health care for individuals. It can also be a useful tool for measuring the quality of many aspects of services, including that of inter-professional and inter-agency working. There are various levels of CPA depending on the needs of the individual and the severity of their illness.

- NHS Direct is a new advice line to be introduced nation-wide

- NSF – National Service Framework for Mental Health, published by the government in September 1999

- PHCT/Primary Health Care Team describes the range of professional staff working in or attached to General Practices to provide for a range of health care needs. Includes General Practitioners and community nursing staff.

- CMHT/Community Mental Health Team is a multidisciplinary team of health and social services professionals working together in a defined geographical patch. Some teams cover all adults and elderly people, whilst others specialise in one particular age group.

- PCGs or Primary Care Groups came into being on 1st April 1999. Bringing together GP practices in a defined area and other professional interests, the PCGs will have a key role in the commissioning of services. There is provision for different levels of PCG, ranging up to the creation of Primary Care Trusts.

- Multidisciplinary is the phrase used to describe services and approaches to care which involve different professional groups (disciplines) working together. CMHTs are an example of a service which is multidisciplinary.

GOSPORT PRIMARY CARE GROUP

BUILDING EFFECTIVE PRIMARY CARE NURSING TEAMS IN GOSPORT

1 Introduction

1.1 A representative group of 28 in Gosport attended an 'away day'on the 29 September 1999 to discuss how they could work more effectively together to improve patient/client care. The workshop sought to promote a 'bottom up' approach and commitment to the development of primary care nursing teamwork. The communication and co-ordination of this initiative has been through the Primary Care Group (PCG) nurses' forum.

1.2 This report provides a summary of the outcomes of this workshop. It defines the vision for improving primary care nursing teamwork in Gosport and sets out the key issues and actions identified to address them. The report also puts forward a number of recommendations to progress developments locally, which the PCG Board is asked to consider.

2 Background and local context

2.1 The concept of primary health care team working has been around since the early 1960's, yet in practice, it still presents problems, with GP practices operating independently to one mandate and Community Trusts to another.

2.2 The notion of 'integrated nursing teams', on the other hand, is a more recent phenomenon. Developments to support this are becoming increasingly widespread across the country and have largely been driven by changes in primary health care policy but also in recognition of a need to improve organisation and teamwork. The definition of 'nursing integration' is varied depending on local interpretation. But, in general terms, it refers to a team of nurses from different disciplines working in a primary care setting, who pool their specialist skills and knowledge to provide the most appropriate services and effective care for patients/clients. It is usual for nurses working in this way to agree shared standards of care, develop joint protocols, undertake joint audits and determine their joint training and development needs, which take account of the demands and objectives of the practice(s) in which they work or liaise. The need for active facilitation and team leadership has been cited as a key requirement to support integrated primary care nursing initiatives.

2.3 The decision to hold an 'away day' for primary care nurses in Gosport was influenced by a number of factors. First, primary care nurses embrace a range of disciplines/specialist practice and represent a significant proportion of the local primary health care workforce. They also have different accountabilities to their employer, which can hinder effective team working.

2.4 Second, primary care nurses in the area have expressed a desire to work together more effectively and to build on some of the good practice that has already been initiated. The Department of Health has also recently announced

that it will be setting up an external reference group to consider the integration of nursing services, in which practitioners would work more closely together. This will be undertaken alongside a review of specialist nursing practice in primary care, where there are currently eight different types of practitioner. Given this national interest and the evident change in policy that will follow, the need to adopt a more proactive approach to the development of effective primary care nursing teams would seem appropriate at this stage.

2.5 Finally, the implementation of Clinical Governance and Health Improvement Programmes offer primary care nurses an opportunity to make an effective contribution to the delivery of locally agreed action plans. The 'away day' provided an initial focus for this.

3 The vision for Gosport

3.1 Primary care nurses in Gosport defined their vision for building effective teams as 'a collective commitment to work together to provide the best possible care for patients', achieved through having:

- Shared goals
- Mutual understanding and respect for different professional roles, including recognition of areas of common ground,
- Shared communication and information systems for planning, implementing and reviewing patient/client care and service provision,
- Multi-professional training and clinical supervision
- Positive leadership.

4 Issues and action plans

4.1 A number of recurring issues emerged during the workshop, which were seen to be critical to the development of more effective teamwork and improvement in patient/client care in Gosport. Priorities for action to address these issues were identified. These are listed below under three main headings – Clinical Governance, Communication and Resources.

4.2 Clinical Governance

Key issues

- Standardise and develop joint protocols across primary health care teams and the PCG, in areas such as asthma and leg ulcer care.
- Improve understanding of different roles within primary care teams.
- Develop clinical leadership at practice level.
- Provide more effective support for professional staff through clinical supervision.

Action plan

a) Appoint someone to co-ordinator the development of joint protocols forward through multi-disciplinary working groups.
b) Collate and produce a portfolio of jointly agreed protocols.

c) Create further opportunities for multi-professional training at practice and locality level.
d) Provide designated funding to support clinical leadership programmes in primary care.
e) Support multi-disciplinary projects, which assist the implementation of clinical supervision in primary care.

4.3 Communication

Key issues

- Provide opportunities for primary care nurses to meet on a more formal and regular basis.
- Support local networks and access between primary care nurses working in Gosport.
- Improve the dissemination and sharing of information within primary care nursing teams.
- Improve continuity of patient care through sharing nursing records, where appropriate.

Action plan

a) Produce a guide to holding 'Effective Team Meetings'.
b) Develop a directory of primary care nurses working in Gosport, including contact addresses and telephone numbers.
c) Provide a designated Primary Care Nursing Bulletin Board in each Practice/Health Centre.
d) Promote the standardisation of nursing records in some areas of clinical practice, such as leg ulcers care, through project work and sharing existing examples of good practice in this area locally.

4.4 Resources

Key issues

- Ensure that primary care nurses, particularly practice nurses, are given 'protected time' to participate in multi-disciplinary meetings and other local projects.
- Provide local co-ordination to ensure that the actions agreed to promote effective primary care nursing teamwork and improve patient/client care are maintained.

Action plan

a) Identify sources of additional funding support to enable initiatives at practice and PCG level to be taken forward.
b) Appoint a primary care facilitator/co-ordinator to support primary care nursing teamwork initiatives.
c) Organise a further half-day workshop for primary care nurses in Gosport during March 2000 to review progress and agree further actions.

5 Recommendations

5.1 In order to progress the actions identified above, PCG Board members are asked to support the following recommendations.

- Give full support in taking forward this initiative in Gosport
- Identify a source of funding to appoint a primary care nursing project co-ordinator for 2 days/week over a six-month period to facilitate work on protocols and other initiatives specified above. Total cost approximately £5,750 at 100% reimbursement based on an H grade plus 10% on costs.
- Agree to explore further sources of funding, including a possibility of collaboration with Portsmouth Health Care Trust, to extend this project, pending the outcome of the initial 6-month evaluation.
- Identify a source of funding to purchase a notice board for each practice, where required, to establish a Primary Care Nurses Bulletin Board. Maximum cost £200.
- Identify an initial source of non recurring funding (at 100% reimbursement) to support practice nurse salary cost, to actively support involvement in multi-disciplinary team meetings and local working groups. Based on a maximum allocation of £500/year per practice,
- Agree, in principle, to provide funding support (finance permitting), for primary care nursing initiatives, which directly support the development and implementation of Clinical Governance.

Chris Kelly & Rose Butcher
29/11/99

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GOSPORT PRIMARY CARE GROUP

REPROVISION OF SERVICES FROM ROYAL HOSPITAL HASLAR: UPDATE

Attached, for information, is a report which will be considered by the Health Authority at its meeting on 9th December.

The report provides a useful update. The key points reflected in the report include the following:

Further definition of proposals for services to be provided locally are summarised in section 1.1 of the report. These include a large range of out-patient clinics, supporting diagnostic and imaging services, day surgery and access to some beds for rehabilitation and post-acute care.

An outline of the procedure, process and timescale for formal consultation on the proposals for future service provision is set out in section 2 of the report.

In section 3 of the report varying timescales for implementation of the different components of the services arrangements are noted. For example, longer timescales apply to the reprovision on in-patient facilities which are dependent on new development at Queen Alexandra Hospital and which are not likely to be available before 2005. At the other extreme, operational problems now declared by the Defence Secondary Care Agency concern the accreditation of junior doctor training will affect provision of accident and emergency services from August 2000.

John Kirtley
Chief Executive

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

THE FUTURE PROVISION OF HEALTH SERVICES IN GOSPORT AND SOUTH FAREHAM

1. PROGRESS ON DETAILS OF FUTURE SERVICE PROVISION

1.1. Work has been continuing on the preparation of detailed proposals for the future provision of services for the residents of Gosport and south Fareham. The services to be provided locally will include:

- outpatient clinics in a large number of specialties;
- diagnostic and imaging services, including endoscopies and other investigations;
- day surgery under local anaesthesia in general surgery, orthopaedics, urology and gynaecology;
- outpatient treatments including a range of therapy services;
- some inpatient beds for rehabilitation and post-acute care.

1.2. The Haslar Task Force and the Health Authority jointly organised an event on 22 October 1999, hosted by Gosport Borough Council, at which external experts came to help the group consider current thinking about ways of delivering accident and emergency services. Discussions covered the consideration of the main patient types presenting in accident and emergency departments, agreement on the criteria for a successful accident and emergency service, the building blocks for different types of service and the nature of pre-hospital care that can be provided by the ambulance service. It was agreed that further detailed discussion was necessary and could be helped by visits to other places to look at the kind of services that could be provided in Gosport. These are taking place to hospitals in London and Dorset on 7 and 9 December 1999. Following these visits, further discussions will take place to agree the model for accident and emergency services.

1.3. The Ministry of Defence has reached agreement with the Department of Health that, from April 2001, the money currently removed from the Health Authority's allocation to reflect the value of NHS services received from the Royal Hospital Haslar will transfer back to the Health Authority. Work is in progress to assess whether this will be sufficient to pay for the proposed replacement services. This financial arrangement will be matched by new arrangements from that date in which Portsmouth Hospitals NHS Trust will assume responsibility for the overall management of the clinical services provided from RH Haslar. New service agreements will reflect these responsibilities.

1.4. The Health Authority's interest in using some of the existing buildings on the RH Haslar site for future service provision has been lodged with the Defence Secondary Care Agency and the Ministry of Defence. Details of the precise areas required are being prepared and will be submitted imminently. For the inpatient beds, it is anticipated that capacity exists in Gosport War Memorial Hospital.

2. PUBLIC CONSULTATION ON PROPOSALS

2.1. The Health Authority is statutorily required to consult the public on the changes in service provision. It is a somewhat unusual consultation in that the decision to close the RH Haslar has been taken by the Ministry of Defence and so a reversal of that decision is not a matter for the Secretary of State for Health. The consultation is therefore about the pattern of future service provision and whether the health care needs of local people will be met by the proposals.

2.2. The detailed proposals for the future provision of services will be set out in a document to be published early in 2000. Copies of the document will be very widely circulated to organisations and to all individuals who have written personally to the Health Authority about services in Gosport since the publication of the outline proposals in May. The consultation period will last for three months and the Community Health Council will be conducting a series of public meetings across the Health Authority area at which the proposals will be presented and members of the public will be able to express their views and ask questions.

2.3. The responses to the public consultation will be considered by the Health Authority in May 2000, following which final decisions on patterns of service provision will be made.

3. TIMESCALE

3.1. It is important to note that the timescales for the implementation of the proposed future pattern of service provision will vary but it is essential that a complete picture of the eventual scale and nature of services in Gosport is agreed now. For example, reprovision of services requiring in patient beds at Queen Alexandra Hospital cannot be implemented in most specialties until the completion of the redevelopment of Queen Alexandra Hospital, which will not be before 2005. Models of service proposed in other areas may have a shorter timescale for implementation and are determined by a range of operational factors such as the ability to maintain current services. This applies particularly to accident and emergency services where the Defence Secondary Care Agency has indicated that, due to the withdrawal of accreditation for junior doctor training by the Royal College of Surgeons, it is unable to maintain an accident and emergency service at RH Haslar beyond 31 July 2000.