Fareham & Gosport Primary Care Trust (PCT)

PCT clinical governance arrangements

The following tool is designed to collate your views on your primary care trust's (PCT's) arrangements for clinical governance. It is intended to complement the data set and information required by the Commission for Health Improvement (CHI) in readiness for the review process.

This questionnaire is divided into the different areas of clinical governance. **Each section should be completed by the PCT lead for that area.**

Please read the guidance shown below on answering questions in the questionnaire.

This questionnaire is provided as an electronic file as well as in hard copy. Please complete and return the questionnaire **electronically**. It contains hidden codes to help CHI to process the answers: for this reason, please only enter text between the question and the question dividing line.

Once you have completed the questionnaire either:

Email to: cgr.trust@chi.nhs.uk

Or post to:

Phase 1 team
Commission for Health Improvement
Finsbury Tower
103-105 Bunhill Row
London EC1Y 8TG

The deadline for returning this document is **20 February 2004**

Name and designation of person collating this questionnaire

Name: **Fiona Cameron**

Designation: **Director Of Nursing And Clinical Governance**

Chief executive : **Ian Piper**

Signature: **Code A**

Date: **19/02/2004**

CHI guidance on answering questions in this questionnaire

How to answer questions that begin: 'please describe briefly the PCT's managed systems and processes for...'.
You should (as a minimum) answer this type of question using the following format:

(a) **Accountabilities and structure**:

Who is accountable for the managed system and, or process? Which directorate(s) are responsible for organising, or delivering the processes and, or activities? Which of the PCT committee is accountable for scrutinising the managed system and, or process?

(b) **Planning and priority setting**:

Who plans the activities? Who determines priorities? How are priorities set?

(c) **Communication:**

Who is responsible for communicating the priorities and plans? How are these communicated within the PCT?

(d) **Monitoring:**

Who is responsible for monitoring processes and, or activities? How are processes and, or activities monitored?

(e) **Evaluation:**

Who is responsible for evaluating outcomes? What is the PCT mechanism for evaluating outcomes? [eg what clinical governance improvements occur due to the system?]

(f) **Reporting:**

What is the mechanism for reporting activities and outcomes up through the accountability structure to the board and across the PCT?

How to answer questions that begin: 'Please describe briefly either one or two examples of...".

This type of question also appears frequently in several sections. You should (as a minimum) structure your answer to this type of question using the following format:

What was the objective(s) of the initiative?
Which staff and services were involved?
What activities did the initiative deliver (outputs)?
What clinical governance improvements occurred (outcomes)?

[NB Please do not provide the same example in different sections in the questionnaire.]

Wherever possible please describe current arrangements and examples:

Your answers should always describe your current managed systems and processes and examples of initiatives that have been completed or are well underway. Please do not provide instead, a description of what your PCT intends to do in the future, unless a question specifically asks for this.

1.0 Strategic intent

1.1 What are the PCT's main strategic priorities?

During the current year?

The PCT's strategic priorities are contained in the Trust's 5-year Strategy document "Working Together for our Future Health", which was published in the summer of 2003 after extensive involvement of and consultation with local partners.

This document outlines 8 key strategic priorities which underpin the objectives in the PCT 2004/2005 business plan, the Local Delivery Plan year 1 and are integrated in the PCT Improvement Plan developed to ensure progress toward 3 star and foundation trust status.

The Local Delivery Plan and Improvement Plan are monitored via the PCT Performance Monitoring Committee.

PCT Strategic Priority Areas
Quicker and convenient access and choice
Improving everyone's Health
Being a valued employer
Being approachable and accountable
Involving patients and carers
Integrating services
Managing resources well
Having clear governance arrangements

These priority areas reflect the PCT's purpose 'delivering improved health for local people' and values, which are:

- Putting the needs of patients at our centre.
- Listening to service users and carers.
- Improving the quality of patient experience.
- Valuing and motivating staff and contractors.
- Working in partnership with stakeholders and our community
- Being accountable for our actions, both organisationally and professionally.
- Managing our resources well and delivering targets.

During the next three years?

The strategic priorities outlined above are reflected in the refreshed Local Delivery Plan. For the next 3 years. This is informed by the strategies and plans emerging from National Service Framework Local Implementation Teams and building on the Business Plan 2003/04.
Over the next three years the PCT intends to deliver on these agendas using the additional resources contained in the Local Delivery Plan, coupled with the opportunities in the new primary care contracts, our status as a LIFT site and our whole system improvement programme Fit for the Future to radically change the way in which care is provided for local people. Our focus will be to ensure that social, primary, community and intermediate care services are developed to support independence and reduce the number of emergency and elective admissions to hospital.

All our work will be underpinned by our values, ensuring that safe and sustainable services are available for local people when they need them.

1.2 What are the PCT's main priorities for developing clinical governance during the next three years?

Clinical governance is central to all of the PCT undertakings and is embedded in the PCT values published in 'Working Together For Our future Health'. Since our inception in 2002 the PCT has worked to develop robust systems and processes to support clinical governance across provider, contractor and commissioned services.

In general terms the PCT priorities over the next 3 years will reflect those for the coming year outlined at Section 2.8 as well as taking account of both national and local requirements as they change. Some obvious areas for development build on work currently underway e.g. the roll out of the patient and public involvement strategy, workforce development arising from 'innovations through staff development and the nGMS contract quality indicators.

1.3 Please describe briefly the financial resources in your PCT for the current year (£):

HCHS:	£114,960,818
Other:	£ 16,709,883
Provider turnover:	£ 32,000,000

1.4 Please provide a brief profile of the primary and community care services provided directly by the PCT. Please feel free to attach a separate document.

District Nursing

The local service is managed by a service manager with responsibility for district nursing and twilight nursing. Team co-ordinators manage smaller groups of district nurses to meet their responsibility for the provision of nursing interventions to housebound patients. Each GP practice has attached district nurses. Community hospital services and social services are also closely linked to the D/N service. A clinical reference group, district wide, has locality representation and ensures good practice, developments and learning issues are shared widely.

Health Visiting

The Health Visiting Service is provided within Primary Care within the hours of 8.30 am – 5.00 pm. Some evening clinics and visits are operated. Each GP practice has an attached health visitor. The health visiting team comprises of Nursery Nurses and Health Care Support Workers as appropriate to the needs of the area. The service also works in close partnership with Primary Care professionals, local hospital Trusts, paediatric medical services, Child & Family Therapy, Education, Social Services, local authorities and various voluntary organisations.

Key components of the services are:

Children with Special Needs (Children 0 –19 years)

Health visitors work with all families who have Children with special needs ensuring that these families will be known to their health visitor and will have had contact with the health visitor.

Health visitors are supported by a Specialist Health Visitor for Children with Special Needs.

Child Protection

Health visitors work with the other relevant statutory and voluntary agencies to reduce the incidence of Child abuse by early detection and appropriate intervention.

Child Health Promotion (Children 0 – 16 years)

Health visitors develop a family centred public health role working with individuals, families and communities to improve health and tackle health inequalities in line with "Making a Difference".

Health visitors also offer a programme of Child Health Surveillance which includes the oversight of the physical, social and emotional health and development of Children; measurement and recording of physical growth; monitoring of development progress; offering and arranging intervention when necessary; prevention of disease by immunisation and other means; and health education.

School Nursing

The school nursing service operates in three areas:

Surveillance and Screening
Health Promotion
Special Schools

Surveillance and Screening Nurses work with individual schools to provide screening for hearing, vision and growth. There is also close liaison with health visitors and school paediatricians and referrals made to specialist services where indicated, working to agreed criteria.

The Immunisation Programme is also delivered by this group of nurses. The programme offers BCG to all young people and School Leavers.

Management of Enuresis is also supported by school nurse led clinics for Children aged 7+ across the district. They work closely with health visitors and GPs to provide a comprehensive service to promote continence.

Health Promotion Nurses work with colleagues in health and across agencies to deliver specific health promotion programmes aimed at achieving target in the Health Improvement Programmes. Examples include sexual health and relationships education, substance misuse, Sun Know How and Child accident prevention.

School Nurses in Special Schools provide nursing care to Children with disabilities during their school day at Heathfield and St Francis Schools, Fareham. They also support therapy programmes and medical sessions in school clinics.

All nurses offer education and training to schoolteachers and care staff on aspects of health care in the school setting such as management of anaphylaxis, epilepsy and enthral feeding.

Physiotherapy

Physiotherapists work as part of the multi-disciplinary team to promote patient independence and maximise patient care at home. Rehabilitation services have been developed recently as part of PCGs intermediate care schemes.

The physiotherapy service in Fareham and Gosport is provided to outpatients at Royal Hospital Haslar, Gosport War Memorial Hospital, Hill Park Clinic in Fareham and Portchester Health Centre. There is also a domiciliary service and some practice based physiotherapy services.

Primary Care physiotherapy accepts referrals from GPs for patients within Fareham and Gosport.

Occupational Therapy

The service in Fareham and Gosport is located within community hospitals, rehabilitation teams and Royal Hospital Haslar and functions in close partnership with Social Service colleagues. The model of service is patient centred and OTs follow patients between home and inpatient care.

OTs has the ability to assess the effect of and then to manipulate physical and psychosocial environments to maximise function and social integration.

The District OT Advisory Service is based within the Fareham and Gosport Team.

Intermediate Care and Rehabilitation

The Community Enabling Service development built on community services already operating in the Fareham and Gosport locality and is a resource for those residents of Fareham and Gosport who are aged 65 or over.

The aim of the services that make up the CES is that through a co-ordinated client centred approach, admissions to hospital are avoided when not deemed medically appropriate, that discharges are timely from hospital or residential home and that independence, well-being and a healthy lifestyle are promoted in all interventions.

Physiotherapists, Occupational therapists, Speech and language therapists, Community nurses, Social workers, podiatrists, pharmacists and domiciliary care providers work together to provide the support necessary to enable residents to remain in their own home. A goal orientated programme of rehabilitation is agreed with the individual, based on a comprehensive assessment of their health and social care needs and delivered across the continuum of the care plan for recovery.

Co-ordination and communication are key components of a positive patient experience and the team of service leads have worked hard to ensure a meshing of the roles, skills and abilities that they each have to offer.

Clinical indicators are used to identify the specific services required and the quality and outcomes of the service are regularly evaluated.

Inpatient Services

This has been developed at both Gosport War Memorial Hospital and St Christopher's Hospital through the development of rehabilitation beds. Investment in 2000/2001 provided for increased medical, nursing and therapeutic input to 41 beds across Fareham and Gosport.

In combination, the above services provide a sound basis for further developments of intermediate care within the Primary Care Trust.

Community Hospitals also provide continuing care services for older people, outpatient and diagnostic services in the shape of phlebotomy and radiology.

Podiatry

Podiatry services include routine and specialist clinics, and contribute to community rehabilitation and other intermediate care provision in Fareham and Gosport.

Assessment and treatment services are provided to improve mobility, independence and quality of life for patients; to help reduce incidences of ulceration and periods of hospitalisation and amputations. Education on foot health and help for patients to monitor their own conditions is also provided.

Locality services are provided from four Health Centres and an Outpatient Department across Fareham and Gosport.

A District wide clinical network exists to support and develop practice. The PCT service will be managed locally with dedicated time from a Service Manager.

Child & Family Therapy Services

The Fareham and Gosport Child and Family Therapy Services are based at Osborn Clinic, Fareham.

In partnership with other statutory and voluntary agencies the service offers a Mental Health Service for Children and young people 0 –16 and their carers. The team is multi-disciplinary consisting of Child & Adolescent Psychiatrist, Psychiatric Nurses, Child Psychotherapists, Clinical Psychologists, Family Therapists and Primary Mental Health Workers. Referrals are through primary healthcare teams, school nurses, teachers, Social Services and voluntary agencies. The team works closely with Adult Mental Health Services during the transition of adolescents into adult life.

1.5 Please provide a brief profile of the clinical and non-clinical services hosted by the PCT on behalf of other PCTs. Please feel free to attach a separate document.

Clinical

Learning Disabilities

The PCT hosts Learning Disabilities Services for all 3 PCTs in South East Hampshire and has Service Level Agreements with the 3 PCTs, 2 Social Service Departments and a number Registered Social Landlords.

The Learning Disability Service hosted by Fareham & Gosport PCT, providing a service to all three local PCTs, has 4 district components.

- Health Residential Care
- Social Care providing both registered homes and supporting people
- Respite Care
- Residential, Assessment and Community Health Care Services

The service has 3 Community Teams in Fareham & Gosport, Portsmouth City and East Hants, and in all employs over 500 Wte staff, including:

- Doctors
- Nurses
- Psychologists
- Therapists
- Support workers

The service also provides outpatient services and some outreach/in reach services.

Non-Clinical

Training and Development

The PCT hosts training and development services on behalf of East Hampshire and Portsmouth City PCT.

There is a Service Level Agreement between Portsmouth City PCT/East Hants PCT/Fareham & Gosport PCT.

1.6 Please describe briefly the clinical and non-clinical services commissioned by the PCT.

Clinical

The following clinical services are commissioned by the PCT:

Acute hospital services (including specialist services) from NHS Trusts and private providers. The Trusts main acute providers are Portsmouth Hospitals NHS Trust and Southampton University Hospitals NHS Trust
Non-acute specialist services from a range of providers
Adult Mental health services from West Hampshire NHS Trust

Community services, such as District Nursing and rehabilitation from neighbouring Primary Care Trusts (i.e. Southampton City and Mid Hampshire PCTs).
Hampshire Ambulance Service provide emergency and non-urgent patient transport services.

In addition, the dissolution of Portsmouth Healthcare NHS Trust and the formation of Portsmouth City, East Hampshire and Fareham and Gosport Primary Care Trusts led to the development of PCT 'hosting' arrangements for some district community services. Fareham and Gosport PCT therefore commissions the following services from East Hampshire and Portsmouth City PCTs:

East Hampshire PCT	**Portsmouth City PCT**
Elderly Medicine	Community paediatrics
Elderly Mental Health	Psychology and counselling
Community Dental	Speech and Language Therapy
	Substance mis-use services
	Family Planning
	Sexual health
	Acute physiotherapy
	Smoking cessation

The PCT has three-year service level agreements with the majority of providers from which it commissions clinical services for Fareham and Gosport residents. These agreements are reviewed annually by the lead PCT. Specialist services are commissioned on behalf of the PCT by the Central South Coast Specialist Services Confederation.

Non-Clinical

Occupational Health

A Service Level Agreement to provide Occupational Health Services to all employees exists between the PCT and the Portsmouth Occupational Health and Safety Services. The service, to promote and improve the physical and mental well-being of staff, is provided by Portsmouth Hospitals Trust and incorporates an extensive Employee Assistance Programme for confidential counselling and advice that is accessible to all employees and their families. This specialist service ensures that any medical checks required due to new appointments, ill health referrals or vaccination updates can be dealt with in a timely manner. There is particular benefit to ease workloads where staff are covering for vacancies and the absence of colleagues.

Medical Staffing

The PCT employs a very small number of medical staff, currently 2 substantive and 2 locum consultants, and purchases medical staffing services through Personnel Specialist Service provided by East Hants PCT via a Service Level Agreement. This service ensures that medical staffing expertise is present whenever new consultants are appointed and manages the business functions for medical staff within 3 neighbouring PCTs that were previously part of Portsmouth Health Care Trust. As well as developing and maintaining medical staffing policies the services is responsible for developing and implementing national initiatives for medical staff.

Financial Services

The PCTs main financial services i.e. Payroll and Creditor payments are provided by a Financial Services agency hosted by Winchester and Eastleigh NHS Trust. A formal Service Level Agreement is monitored.

Estates

The PCT has an Service Level Agreement with Portsmouth City PCT for the provision of capital, planning and estates services. The Service Level Agreement is reviewed by the PCTs Finance Director.

The PCT has a nominated lead estates manager who attends the PCT Management Team meetings to provide support.

A PCT Estates Strategy was formally approved by the Board in January 2004.

Communication and Media

The PCT has a Service Level Agreement with East Hampshire PCT for the provision of communication and media services. There are regular meetings with the media and communications team and the PCT Chief Executive. The media and communication staff support publications, briefing/Newsreach and media briefing The Service Level Agreement is managed by the Director of Public Health.

Information Communication Technology

A Service Level Agreement is in place with Portsmouth Hospitals Trust and a named lead individual links to the PCT.

The service reports quarterly to a district group with representatives from the PCTs. At PCT level reporting is through the Operational Management Team. Board level responsibility is with the PCT's Finance Director.

1.7 Please identify the committee and staff responsibilities for ensuring the PCT complies with its duties under the Race Relations (Amendment) Act. Has the PCT published a race equality scheme? [If so, when was it published and how was it disseminated to staff?]

An Equality and Diversity Group has been established to monitor and implement the PCT's obligations under the Race Relations (Amendment) Act. The Personnel Panel then monitors the activity of this group.

A Race Equality Scheme was communicated to staff in June 2002 following receipt of Board approval. This document has now been published on the PCT's website. The Trust Board is receiving training on Diversity Awareness in February 2004.

2.0 PCT Wide Issues

Clinical Governance

2.1 Please identify the designated lead(s) for clinical governance in your PCT.

NAME	TITLE	PROFESSIONAL BACKGROUND	TRAINING	TIME
Fiona Cameron	Director of Nursing and Clinical governance	Nurse	Strategic leadership clinical governance PGD professional and Policy studies	60%
Ann Dalby	Team Development Facilitator	Nurse	PGC Clinical Governance	80%
Caroline Harrington	Risk and Litigation Manager		Diploma Clinical risk Management	100%
Nicky Heyworth	Clinical governance Manager	Nurse	Clinical Audit	100%
Justina Jeffs	Clinical Governance Manager		Clinical Audit	100%
Andrew Paterson	PEC Clinical Governance Lead	GP	Appraiser training Strategic leadership clinical governance	10%
Ann Turner	Complaints Manager		Complaints/convenor training – various.	100%

Clinical governance is central to the roles of these individuals and as a result almost all activities can be viewed as developmental.
In terms of training all members of staff have significant experience in a variety of relevant clinical governance areas.

2.2 Please describe briefly how does the PCT communicates corporate priorities for clinical governance across the PCT (e.g. newsletters, cascade briefing etc).

Briefing – An all staff monthly briefing is used to communicate key issues determined by the Executive and Management Team, which are then cascaded via regular monthly staff meetings. These also go to all independent contractors.

News reach – Monthly newsletter including information from staff, for staff and delivered to all PCT sites. These also go to all independent contractors

Your Health – Quarterly information provided to the population of Fareham & Gosport regarding PCT issues. Delivered by Royal Mail to all households within the PCT catchment area.

Hazard Notices – a system is in place to ensure all Safety alert Bulletins are distributed immediately to appropriate individuals (including contractor services) and records kept of actions taken.

Health and Safety Newsletter – Devised quarterly by the Risk Manager and distributed across the PCT

Awards for Excellence - Annual staff awards recognising staff innovation and clinical excellence.

Clinical Governance Development Plan – copies distributed to Board, PEC and provider service managers as well as clinical governance leads in neighbouring PCT's.

There is a Clinical Governance element to the Business Plan, which is widely shared with teams to underpin team objective setting.

Provider services –quarterly service review. These are circulated within the PCT and have contributions via service managers from all levels of the organisation.

Target - These days are especially designed for general practice to enable timeout for practice teams, in particular, in relation to audit, effectiveness and other clinical governance developments.

In addition there are team away days, team meetings and special briefings as required. A web site is also in development and expected to be operational by Mar. 04.

2.3 Please describe briefly the PCT's managed systems and processes for developing clinical governance across its community health services (e.g. district nurses, therapists etc) and provider arms. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

Managed systems and processes across provider services.

The Director of Nursing and Clinical Governance is accountable for the managed systems and processes reporting direct to Chief Executive. The post holder provides support to the PEC Clinical Governance lead and manages the quality function within the PCT. The clinical governance committee is supported in its work by a number of sub groups, medicines management, clinical effectiveness, audit and care group. All managers are accountable for Clinical Governance in their respective areas.

The PCT Clinical Governance Committee is responsible for the development, management and scrutiny of all clinical governance activities in the PCT including:

- Ratification of all clinical policies
- Receiving reports on clinical risk
- Supporting Clinical Governance development
- Managing the Clinical Governance development planning process
- Reporting to the Board.

- Monitoring clinical risk via incident reporting and sub committees of the CGC

Representation is from commissioning, public health, pharmacy adviser, clinical governance team, a lay individual, a non-executive director and Learning Disability Services.

Planning takes place in a variety of ways and the Clinical Governance Committee takes account of national and local imperatives. Individual services develop Clinical Governance Plans reflecting relevant NSFs/local needs/results of audit, external reviews.
The Clinical Governance Committee has developed a Clinical Governance Plan, which takes account of these along with contractor issues, business plan priorities, national guidance and the PCT values. Priorities are set at service, organisation and national level and integrated within the PCT Clinical Governance Development Plan. Planning is also informed by the work of the Clinical Audit Research and Effectiveness, Medicines Management, Clinical Incident Reporting, sub groups.

The final Clinical Governance Development Plan is signed off by the Clinical Governance lead and the Chief Executive. It is presented to the Board and cascaded within the organisation.

The Clinical Governance Development Plan is monitored by the Strategic Health authority via the Outturn and Annual Reports.

Provider Service Clinical Governance Development Plans are monitored quarterly as part of the service review process.

The Clinical Governance Committee monitors ongoing audits/actions plans.

Informal evaluation of outcomes and lessons learned take place at team meetings and via service reviews. Formal evaluations are part of the complaints and Critical Review Process processes. Some evaluation is driven nationally e.g. Patient survey, Staff survey, and Child protection audit.

The notes of Clinical Governance Committee are also sent routinely to Board and Risk Management Committee. The Board also receives a quarterly quality report specific to risk and complaints.

2.4 Please describe briefly the PCT's managed systems and processes for developing clinical governance among independent contractors, for example GPs, dentists, etc. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

Dentistry

The Head of Primary Care and PCT Dental Adviser are accountable for this process. Supported by a clinical governance manager with a lead for Primary Care. The PCT Dental Adviser co-ordinates this process on a district-wide basis and liaises closely with the PCTs. There is no formal Dentistry Clinical Governance Group at present, but the reporting mechanism of clinical audit work being done in dentistry is through the PCT Clinical Governance Committee.

Priorities are set by the Head of Primary Care, the PCT Dental Adviser and general dental practices. A baseline Clinical Governance assessment has been sent to all dentists, in this financial year and the results of this will help to set priorities. There are close links with this work and the deanery to ensure that results are fed into the educational system for dentists.
A variety of communication methods exist led in the main by the PCT Dental Adviser. There is also a Local Dental Committee (LDC), which meets regularly, as well as an Oral Health Advisory Group, which is attended by the PCT Chief Executive.

Monitoring is via complaints, practice visits and the LDC.

The Baseline assessments have been analysed and the PCT Dental Adviser and the deanery have been looking at the results. A report on progress will go to the Clinical Governance Committee. A Clinical Governance Support pack has been developed from this baseline assessment and is being sent to all the dentists in the area and there are plans to turn it into a CD-rom. The support pack covers the following areas:

- Practice Visits
- Guidelines on good practice
- Intravenous drug and inhalation sedation guidelines
- Practice visit guide
- Useful resources

Activities are reported through the Clinical Governance Committee. Minutes from this committee are reported to the Trust Board.

Optometry

The optometric advisor and Head of Primary Care are accountable for this process supported by a Clinical Governance Manager. Co-ordination of the process on a district-wide basis and liaison with the PCTs lies with the Optometric Adviser. There is an Optometric Clinical Governance Group that is chaired by the optometric adviser and includes representatives from F&G PCT, East Hants PCT and Portsmouth City PCT. Minutes of this group are sent to the PCT Clinical Governance Committee.

Priorities are determined by both national and local drivers and activities to meet these negotiated between the Local Optometric Committee and the PCT's. A baseline Clinical Governance assessment has been sent to all optometrists in the area and the results of this will help to set priorities. There are close links with this work and the Local Optometric Committee (LOC)

The Baseline assessment will be analysed and the optometric adviser and the Optometric Clinical Governance Group will be looking at the results, and reporting to the Clinical Governance Committee on progress.

The optometric adviser and the head of primary care are responsible for communicating priorities and plans.

Activities are reported through the Clinical Governance Committee. Minutes from this committee are reported to the Trust Board.

Community Pharmacy

The Executive Lead for Prescribing and the broader Medicines Management issues is the Director of Public Health. The PCT has a Medicines Committee and prescribing/medicines management issues are reported to the Board.
The Community Pharmacy Clinical Governance Facilitator, co-ordinates this process on a district-wide basis and liaises closely with the PCTs. There is a Community Pharmacy Clinical Governance Group, which meets bi-monthly, and the minutes of this group are reported to the PCT Clinical Governance Committee. The Community Pharmacy Clinical Governance Group is chaired by the Pharmaceutical Advisor for Portsmouth City and includes representatives from F&G PCT, East Hants PCT and Portsmouth City PCT.

Planning and priority setting for Prescribing and Medicines Management has been reviewed since accountability for this area was assumed by the DPH in June 2003.

The Community Pharmacy Clinical Governance Group set priorities and determine activities. A baseline Clinical Governance assessment has been completed by community pharmacies in the area and the results of this have helped the group determine local priorities. The Primary Care Development Manager is a member of the Group, and has a responsibility for the new community pharmacy contract.

A member of the Local Pharmaceutical Committee is also a member of the PCT Professional Executive Committee.

The PCT has two pharmacy advisers who work closely with the community pharmacy clinical governance facilitator and community pharmacists.

General Practice

The PCT Clinical Governance GP Lead and the Director of Nursing and Clinical Governance, are responsible for this process. A Clinical Governance Manager, supports them with regard to all aspects of Clinical Governance.

Each practice has an identified clinical governance lead and these individuals meet together regularly to ensure a coherent approach across practices.

Many of the priorities for Clinical Governance are set through the PCT Local Implementation Teams (LITs) from their National Service Frameworks action plans and GPs are represented on these. The new General Medical Services (nGMS) contract has also provided a platform for auditing work through the Clinical Quality Indicators.

The Local Implementation Teams are responsible for monitoring progress against their action plans and the nGMS Quality and Outcomes subgroup will be responsible for assessing progress against the Clinical Quality Indicators.

GPs play an active role in the management of the PCT with leads identified for prescribing, commissioning, health improvement and clinical governance. These leads participate in the Professional Executive Committee (PEC) and the PEC chair and the clinical governance lead are also board members.

2.5 Please describe briefly either one or two examples of PCT initiatives to improve the quality of services provided by community health service staff (e.g. district nurses, therapists etc) and provider arms in the last 12 months.

Swallowing Assessment Training for Qualified Nursing Staff at Gosport War Memorial Hospital

This initiative was a direct result of the Commission for Health Improvement (CHI) investigation recommendations re Gosport War Memorial Hospital. It was noted that out of hours a patient might no receive a timely swallowing assessment as the speech and language therapy service who would normally undertake these assessment do not provide an out of hours service in community hospitals.

The overall objective of this initiative was therefore to provide out of hours cover provided by nurses who had been trained to undertake swallowing assessments. The training was initially aimed at a small number of qualified nursing staff with a view to extending the training utilising these individuals to support ongoing training.

The training has resulted in a number of qualified nursing staff developing competency to assess swallowing and the programme will continue.

'Innovation Through Staff Development' a strategy for nurses, allied health professionals and psychological therapists.

The above strategy has been in development since the inception of the PCT with the aim of integrating national and local priorities for these staff groups in a coherent way, which ensured engagement of staff at all, levels in the organisation and retained a focus on patient experience.

A steering group has managed the process and the development work has been facilitated by an implementation group comprising nurses from all disciplines, representatives from psychological therapy and physiotherapist, OT's and podiatrists. In addition an advisory group of Non-executive, lay and expert individuals was set up to provide advice and guidance to both the steering and implementation groups. The outputs from the development of the strategy are significant in terms of the sharing of good practice. However four specific themes, enhancing the quality of care, strengthening leadership, working in new ways, strengthening education and training have been identified and implementation plans developed to take forward work in these areas.

Particular areas of development have been in the area of clinical supervision systems and the use of Essence of Care benchmarking in some services.

2.6 Please describe briefly either one or two examples of PCT initiatives for improving the quality of services provided by independent contractors (e.g. GPs, dentists etc) in the last 12 months.

GP with a Special Interest

Fareham benefits from additional PCT funding in relation to three GPs with a special interest.

The purpose of these services is to improve access and reduce waiting times for services.

The services are locally based in practices in the Fareham area.

a) Ultrasound – 750 per annum
b) Gastroscopy – 350 per annum
Sigmoidoscopy – 250 per annum
c) ENT assessment – 336 per annum

A Service Level Agreement exists between the PCT and the GP providers of a) and b). A Service Level Agreement exists with Portsmouth Hospitals Trust for c).

Gosport is well served by outpatient clinics at Royal Hospital Haslar and Gosport War Memorial Hospital.

Promoting Independence and Accelerating Discharge

The spectrum of services provided continues to be developed through further pilot projects, in particular:

- Vulnerable people's nurse based on the Runcorn model
- Acute 'Inreach' nurses working to ensure patients are returned to the care of their GPs as quickly as possible after an acute episode of care.

Strengths and weaknesses

2.7 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of developing clinical governance.

Clinical governance committee

This committee was set up very early in the life of the PCT and reports to the PCT Board on all matters of clinical governance. It has representation from primary and community services, from commissioning and public health as well as a non-executive lead and lay representation.

The group has been responsible for supporting a variety of projects associated with clinical governance, in particular GP appraisal, TARGET education days for Primary care and provision of support to GP's dealing with potentially violent patients.

The main outputs from the group however have been the engagement of staff in the development of both service and PCT clinical governance development plans and their subsequent review, ratification of clinical policies and monitoring of clinical risk issues.
The clinical governance development plans provide an excellent indication of areas for further development.

Essence of Care (EoC)

The objectives associated with the development of EoC in the PCT were around improving patient experience in particular in relation to urinary continence. Initial workshops to launch the tool were aimed at Community hospital and district nurses, however other disciplines have since expressed their interest.

Essence of Care link nurses have been identified with a view to refining the process and eventually benchmarking with other areas. A number of areas for developing practice have also been identified.

2.8 Please identify the PCT's priority areas for developing clinical governance in the next 12 months.

The main priorities can be seen to be derived from the PCT clinical governance outturn report 2003/04, baseline assessments in contractor services and provider service clinical governance development plans.

ELEMENT	PRIORITY
Processes for Quality Improvement	
Risk management	Engagement and support of independent contractors with risk assessment and risk incident reporting
Clinical Audit	Development of robust audit systems and processes and annual audit programme 2004/05
Research and effectiveness	Roll out clinical governance training to contractor services
Complaints	Development of pan PCT training resource with training and development department. Use of feedback from complaints to improve all PCT services.
Patients Experience	Patient experience impact monitoring. In crease ability to identify feedback from patients and the impact on services.
Use of Information	Develop provider service activity date requirements with ICT
Staff Focus	Develop workforce plan
Leadership, Strategy and Planning	Development of a Leadership Framework for the PCT

Commissioning and purchasing

Name and designation of person responsible for completing this section

Name: **Inger Hebden**

Designation: **Director of Strategic Development**

Name and position of the designated lead(s) for commissioning

Name: **Inger Hebden**

Position: **Director of Strategic Development**

Is this a PCT lead or board level lead? Board level.

2.9 Please describe briefly the PCT's managed systems and processes for commissioning clinical healthcare services. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The commissioning of clinical healthcare services for the registered population of Fareham and Gosport is undertaken by the Directorate of Strategic Development. The Directorate is managed by the Director of Strategic Development who is responsible for ensuring the delivery of the commissioning agenda. The Director is supported by the Head of Commissioning and Planning.

The Primary Care Trust has developed a comprehensive planning structure for ensuring the commissioning of quality, easily accessible clinical healthcare services. Local and District Implementation Teams (LITs / DITs) have been established to oversee the delivery of the National Service Frameworks for CHD, Diabetes, Children, Mental Health, Cancer and Older People. In addition, in conjunction with the PCTs main acute provider, Portsmouth Hospitals NHS Trust (PHT), specialty taskforces ensure the delivery of the national waiting times targets and explore whether, through modernisation, more efficient and effective services can be provided.

The contracting of acute services with the PCT's main providers (Portsmouth Hospital Trust and Southampton University Hospital Trust) is undertaken via regular Service Level Agreement review meetings, similarly Adult Mental Health Services are contracted from West Hampshire Mental Health Trust. The District-wide Commissioning Group provides a forum for local PCTs to discuss commissioning issues and where necessary, to agree a consistent approach. All other locally provided services are provided by the PCT.

The delivery of targets including the CHI star rating information is monitored by the PCT's Performance Monitoring Committee and Professional Executive Committee. Both Committees' report to the PCT Board.

The PCT's commissioning priorities are contained within its Business Plan and Local Delivery Plan. The development of the 2003/04 Business Plan has occurred through the Trust's normal business and planning structures and as a result, it incorporates national Local Delivery Plan targets and local service priorities and plans developed and prioritised

through existing planning mechanisms, such as the LITs and DITs. These groups consist of representatives from a range of statutory and voluntary organisations, as well as lay members, which ensures that the service priorities and key objectives for delivery are owned by the Trust and its key stakeholders.

As part of the wider business planning process, PCT service managers also identify service priorities for delivery within the next financial year. The Business Plan and Learning Disabilities priorities are agreed and approved by the PCT Professional Executive Committee and PCT Board.

The PCT's Business Plan sets out the PCT's priorities for delivery over the next twelve months. Following approval by PEC and ratification by the Board, the PCT's Business Plan is circulated to PCT Managers for dissemination to staff and to the PCT's stakeholders. The Business Plan forms the basis for the development of department plans, personal objectives and for agreeing personal development plans.

The Director of Strategic Development has responsibility for ensuring that the PCT has robust performance management systems. The commissioning of clinical healthcare services against agreed priorities for delivery are monitored via the PCT's Performance Management Committee. Quarterly performance monitoring reports are presented to the Committee, which operates as a sub-committee of the PCT Board.

The PCT has identified lead managers who are responsible for ensuring the delivery of the Local Delivery Plan priorities through local planning structures. The lead managers provide the information required by the Performance Management Committee to monitor the Trust's performance.

The PCT also monitors the delivery of the service level agreements with its main acute providers, Southampton University Hospital Trust and Portsmouth Hospital Trust, through regular Service Level Agreement review meetings.

The PCT monitors performance against its clinical priorities for delivery within the financial year through the Performance Management Committee. The Committee ensures that where necessary, action is taken to address poor performance.

The quarterly performance reports demonstrate progress against the delivery of the priorities (which include CHI indicators and Local Delivery Plan targets). The PCT's performance informs the PCT's star rating.

Quarterly performance monitoring reports are produced for the PCT Performance Management Committee. The PCT Performance Management Committee is a sub-committee of and reports directly to the PCT Board.

2.10 Please describe briefly the PCT's managed systems and processes for commissioning non-clinical services. [nb Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

See also 1.6

Shared Communication and Media Service

The Director of Public Health (DPH) has the executive lead for communications within the PCT and is responsible for agreeing the Service Level Agreement with East Hampshire PCT, as the host provider of the shared Communications and Media Service. The Service Level Agreement, which identifies PCT priorities are agreed annually through meetings held with the Head of Service Quality East Hampshire PCT and the Communications Managers. The priorities for the Service Level Agreement agreed during 2003/4 were informed by discussions with the PCT Chief Executive, PCT Chair and the Non Executive Director, with a lead for Communications/PPI.

The PCT's Public Involvement and Communications Manager meets regularly with Communication managers to update on progress and key activities relating to their individual work programmes.

Communication and Media issues are incorporated as part of the PCT's Patient and Public Involvement Strategic Framework and annual action plan. This is developed and monitored through the PCT's PPI Steering Group, which meets on a quarterly basis. It is chaired by the DPH and membership includes a Director or senior manager representing PCT provider services, clinical governance/nursing and service planning/commissioning, and a member of the Communication and Media Services Team. The Steering Group is a sub committee of the Board.

PALS

The Director of Public Health (DPH) is responsible for agreeing the Service Level Agreement with East Hampshire PCT, who employs the 1.4WTE PALS Co-ordinators who work across the 2organisations.

Portsmouth Hospitals Trust (PHT) is also in the process of setting up a shared admin hub to support the PALS Service across the 3 local PCTs and acute hospital. PHT are in the process of drafting a Service Level Agreement for providing this part of the PALS service with the PCT.
A PALS Steering Group is currently being established to monitor and oversee the development of PALS across the 4 NHS organisations in Portsmouth SE Hampshire.

The priorities and activities of the PALS Co-ordinators are agreed through meetings held with the Head of Service Quality East Hampshire PCT and the PALS Co-ordinators. Quarterly PALS reports for Fareham & Gosport PCT are produced and sent to the DPH.

Priorities and activities relating to the PALS Service in Fareham & Gosport is incorporated as part of the PCT's Patient and Public Involvement Strategic Framework and annual action plan. This is developed and monitored through the PCT's PPI Steering Group, which meets on a quarterly basis. It is chaired by the DPH and membership includes Executive Director leads representing all functions. PALS is a standing item on the

Steering Group agenda and quarterly reports are discussed as part of this process. The Steering Group is a sub committee of the Board.

2.11 Please describe briefly one example each of how the PCT involves its community health service clinical staff and GPs in the commissioning and purchasing of:

a) General Hospital Care

- The District Cancer Implementation Team (DIT) is a multi-disciplinary group with clinical and managerial representatives from primary care, community services and the PCT's main acute provider, Portsmouth Hospitals NHS Trust and is linked to the PCT PEC. The main aims of the DIT are to ensure the local delivery of the Cancer Plan and to ensure the provision of high quality, accessible cancer services. The group identifies and jointly agrees national and local priorities for investment in cancer services, which are considered by PCT's as an integral part of the Learning Disabilities process. The PCT has a lead cancer clinician who is a General Practitioner and involves community staff in the commissioning of cancer services (i.e. in the development of care pathways and reconfiguration of service delivery).

  The DIT jointly agreed the following as the highest priorities for investment within 2003/04:

  Provision of two-view mammography. Evidence has shown implementation of 2-view mammography increases detection rates.

  Reduction in radiotherapy waiting times from 12 weeks in September 2002 to 4.6 weeks in October 2003. This ensures patients receive faster access to treatment, improving prognosis.

  Consistent delivery of the maximum two week from urgent GP referrals to first outpatient appointment through collaborative work between primary and secondary care.

  Development of a palliative care pathway and investment in palliative care services to enable increased numbers of terminal patients to die at home.

  The impact of the recent investment will be carefully monitored and evaluated.

b) Mental Health Services

The Mental Health Locality Implementation Team (LIT) and its sub-groups is the primary vehicle for the implementing the Mental Health NSF, which includes the commissioning, and purchasing of mental health services for the Fareham and Gosport locality. The aim of the LIT is to be inclusive, enabling representation from a wide spectrum of stakeholders. The sub-group structure enables the participation of clinical staff within areas of specific interest.

The Primary Care Mental Health Sub-group for example, includes GP and community health service staff representation and is currently developing registers in Primary Care of those people with a severe and enduring mental illness (SEMI). It is thought that between 30 and 50% of those people with SEMI are only in contact

with their GP but that the rate of concurrent physical illness and premature death is much higher than the general population.

The SEMI register will be a first step to identifying this population within Primary Care with the aim to improve patient care. It will also enable improved assessment of need in this population to inform future service development in line with the Mental Health NSF. Clinical governance improvements will be monitored within the New GMS contract Quality and Outcomes Framework.

c) Primary care services (where commissioned from another organisation)

Dental Access Centre

This service operates to provide a dental service to individuals who might not otherwise have access.

It has become primarily an emergency service which supports/signposts patients to more planned dental support.

The service works 50% providing emergency treatment and 50% on follow-up through to completion of treatment. The service then endeavours to find ongoing dental support for patients.

The Dental Access Centre (DAC) also operates the booking system for the 'Mini PDS'. General dental practices opt in to this service and receive payment from the PCT.

The Dental Access Centre service provides for a 1-hour slot daily for 4 patients to receive emergency care across the patch.

Patients are not registered with either of these services.

The service is commissioned from East Hampshire PCT.

d) Support services (Estates)

LIFT Project

Local Implementation Finance Trust. This project will enable the PCT to develop services / buildings in appropriate locations. The estates department is working closely with the PCT, neighbouring PCT's and public sector partner organisations including voluntary sector and independent contractors to produce a second draft Strategic Service Development Plan (SSDP).

Work on first tranch schemes has commenced, with GPs and Community Nursing staff contributing as members of the Project Board and Evaluation Teams.

Rowner Health Centre – Detailed briefing and design will be complete by Feb 04 with a view to starting on site post April 04.
Rowner road Surgery – site acquisition is proceeding and is expected to complete by the end of March 04.

The PCT is a third wave LIFT Project in partnership with East Hants PCT.

2.12 Please describe briefly either one or two examples of how local health needs are reflected in the Local Delivery Plan for the current financial year.

Summary Of Key Health Care Needs

A summary of health needs (which included a population profile, health status/major causes of death and lifestyle factors) was incorporated as part of the Executive summary/background section of the Learning Disabilities 2003 – 2006. The purpose was to provide a baseline position and a focus for identifying broad areas of action cited in the Plan to deliver key targets.

The health needs summary was produced by the Director of Public Health and taken from existing published data sources.

The health need data has been used as the rationale to support a focused partnership approach to health improvement across Fareham & Gosport to reduce CHD, Stroke and Cancer mortality. This has resulted in the development of locality health improvement plans through the LSPs. Activity will be targeted at initiatives to increase physical activity (e.g. Walking your way to health), Healthy Eating (e.g. 5 a day fruit and vegetables), smoking cessation and educational campaigns (e.g. accident prevention and sun awareness).

A more substantial focus on health needs will be incorporated as part of the Learning Disabilities for 2006 – 2009, showing trends from the baseline position as a result of implementing the priorities set out in the 2003 –2006 Plan.

Community Enabling Service

The Community Enabling Service (CES) co-ordinates the health and social care services that configure around a patient to provide rehabilitation and support along the continuum of their recovery from ill health, trauma or debilitation.

The development of the CES was the inspiration of the health and social care community services already operating within the Fareham and Gosport locality that met with commissioners to debate the implementation of the intermediate care standard within the Older Persons NSF.

A single point of access is provided along with a central co-ordinating team and a patient held record. This works to ensure that the spectrum of services provided meets the agreed goals of the individual and can be easily adjusted as they change over time.

The CES co-ordination team take the referrals and placing patient's needs as a priority, liaise with a wide variety of health and social service professionals, patients, carers, homes and ambulance transport to synchronize a joint approach. The team have a role in balancing patient safety and negotiating an appropriate response speed for the assessment of patient needs in line with changing service waiting list capacities. They provide patient held records, maintain a central database of patients, monitor patient progress through services, call appropriate review meetings and ensure services are accessed in a timely way. Flexibility of service delivery ensures that treatments are taken to the patient wherever they are and move with the patient from hospital to their home.

Each of the CES link services has representation on an Operational Group that meets monthly to oversee operational issues, plan training events, and consider future developments.

Line management remains within each service or member organisation.

The spectrum of services provided continues to be developed through further pilot projects:-

- Vulnerable people's nurse
- Acute inreach nurses

The Community Enabling Service aims to achieve the standard for Intermediate Care set down by the government in the National Service Framework for Older People. It co-ordinates an approach allowing health disciplines, social services and voluntary organisations to work together enabling the provision of support necessary to: -

Prevent unnecessary hospital admission
Enable early discharge from hospital
Prevent premature or unnecessary admission to long term residential care
Enable a person to remain safely in their own home
Promote independence, well-being and a healthy lifestyle.

Provide inpatient rehabilitation for patients in rehabilitation beds at Gosport War Memorial and St Christopher's Hospitals. Co-ordination and communication are felt to be the key to a positive patient experience and service leads have worked hard to ensure integration of the roles, skills and abilities that they have to offer. There is professional accountability with one another; helping to ensure that all aspects of care are covered during the period the patient is using the service.

The Community Enabling Service provides the opportunity for inter-disciplinary training and the cross fertilisation of ideas creating diversity and innovation in service delivery. This is a 'virtual' team comprised of a network of health and social services, voluntary and private sector service providers.

The older persons NSF LIT monitors the service development funding for which is reflected in the Learning Disabilities.

2.13 Please describe briefly either one or two examples of PCT initiatives to improve the quality of services purchased from a general secondary/tertiary care provider in the last 12 months (e.g. main general hospital provider or a tertiary provider or a private sector hospital or a diagnostic and treatment centre).

Chronic Pain

The Chronic Pain Taskforce was established to explore more efficient and effective ways of service delivery through modernisation. The Chronic Pain Taskforce is led on behalf of the District by Fareham and Gosport Primary Care Trust.

Referrals to the Chronic Pain service had increased beyond available clinic capacity, resulting in lengthening waiting times for first outpatient appointments. As patients are

referred by GPs but also by Orthopaedics, Rheumatology and Oncology, this was also resulting in increased demand on these services, which were having to provide on-going management whilst patients were on the waiting list to be assessed by the Chronic Pain Service. Research showed that patients could benefit from specialist physiotherapy treatment and that many of the patients referred to the service had chronic back pain but had not received recent specialist physiotherapy treatment. The provision of specialist physiotherapy treatment as an integral part of the Pain Management Programme could potentially reduce the need for all patients to be seen by a chronic pain consultant.

The objectives of the initiative were to:

Reconfigure the chronic pain service to ensure all referrals were triaged by a physiotherapy specialist. The physiotherapist would ensure that where appropriate, patients receive specialist physiotherapy treatment.
Address capacity issues and reduce waiting times

The Chronic Pain Taskforce has clinical and managerial representatives from PCTs, physiotherapy and the acute chronic pain service.

The initiative will be evaluated following an 18-month pilot. The expected outcomes are:

Reduction in the number of patients who need to see a consultant
Reduction in the overall waiting times for GP referrals
Improved patient outcome after treatment interventions, with reduced need for further procedures and earlier discharge from clinic
Improved treatment pathways for patients with back pain, with more effective access to specialist pain management
Improved multi-disciplinary working

The patient pathway has improved by ensuring patients are now able to see the most appropriate health professional. It is also expected that patient outcomes will improve, with reduced need for further procedures and earlier discharge from clinic.

2.14 Please describe briefly either one or two examples of PCT initiatives to improve the quality of services purchased by **mental health** secondary/tertiary care provider in the last 12 months.

The Fareham and Gosport PCT LIT has representation within the HIOW Mental Network and has adopted the Performance Improvement Framework developed by the network to facilitate the implementation of the Mental Health NSF.

The Performance Improvement Framework consists of an action plan for each of the 45 target areas as designated within the DOH 'Autumn Assessment'. The process has been approved by the LIT and the allocation of individual targets for action within sub-groups is the responsibility of the LIT Commissioning Subgroup.

The Mental Health Network has strong links with National Institute for Mental Health in England and has developed an annual work programme to address wider strategic planning issues such as service redesign and workforce planning.

The result is that local service development, such as the 2003/04 investment to increase the capacity of the Assertive Outreach Team, is evidence based and has enabled a

service that meets the needs of the locality and complies with national criteria as specified within the DOH Policy Implementation Guide.

Strengths and weaknesses

2.15 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of commissioning clinical and non-clinical services.

Clinical Services:

Intermediate Care Services

The further development of local intermediate care services for older people to:

Prevent, where appropriate, acute hospital admissions and to facilitate early discharge
Reduce acute emergency admissions
Reduce delayed transfers of care
Provide additional rehabilitation, closer to home

Joint planning with partnership agencies through the Older Persons Strategic Planning Forum, consisting of managerial and clinical representatives from the PCT (Commissioning and service managers), EMI services, Elderly Medicine and Hampshire Social Services. The development of a strategy for the further expansion of local intermediate care services and the joint agreement of commissioning priorities for 2003/04 in line with local and national priorities. Strategy informed by Stakeholder workshop to identify priorities for service development.

Local intermediate care services have enabled local people to receive comprehensive rehabilitation and/or support services either within their own homes or a local intermediate care bed without the need for an acute hospital admission. The further development of intermediate care services was agreed as a local priority for the PCT within 2003/04.

This led to the formation of the Older Person's Strategic Planning Forum and the development of a Strategy for the future development of local intermediate care services. The Strategy identified the further development of local intermediate care services with a single point of access, underpinned by a single assessment process, agreed care pathways and integrated health and social care records.

Commissioning priorities for 2003/04 included:

Development of a single point of access to local intermediate care services
The further development of EMI services as an integral part of the Community Enabling Service
The development of an integrated falls service
Health promotion initiatives i.e. Runcorn pilot in primary care

The further development of intermediate care services will:

Enable patients to receive individualised rehabilitation / care packages either within their own homes or community intermediate care beds
Reduce delayed transfers of care
Reduce acute emergency admissions

The initiatives implemented within 2003/04 will be carefully monitored and evaluated and will help to inform commissioning priorities for 2004-06.

Non-Clinical Service

Developing PALS across Portsmouth & South East Hampshire

The objectives were to develop a model of PALS across 3 PCTs which would be:
Easily assessable to patients and the public
Flexible enough to fit in with each organisation's culture and systems but which also sits within a larger PALS network to ensure economies of scale, standardisation of procedures and cross fertilisation of best practice

The initiative was led by the PALS Co-ordinator appointed in August 2002 who was employed and hosted by East Hampshire Trust on behalf of Fareham & Gosport PCT and Portsmouth City PCT.

The initial project proposal (produced January 2003 involved extensive consultation with a wide range of staff from the three PCTs and other local stakeholders e.g. CHC, PHT. The final model for PALS was agreed by the three PCTs, in conjunction with PHT in June 2003 and has resulted in the appointment of additional PALS officers/co-coordinator staff within existing resources (November 2003) and the planned creation of a shared administrative function using one 0800 number (from March 2004). A PALS Steering Group has now been established to oversee the strategic development and performance of the PALS Service. Membership includes representation form each PCT and PHT.

The new model of PALS provision ensures strong links with PALS across the local health economy and with other statutory bodies/partner organisations are enhanced to enable seamless patient/user focused services.

2.16 Please identify the PCT's priority areas for developing commissioning in the next 12 months.

The PCT's priorities for developing commissioning over the next 12 months are:

The implementation of national guidance: NSFs, NICE, Patient Choice, Payment by Results, nGMS, Improving Working Lives, Foundation Trusts, new Consultant's contracts.

Delivery of key Local Delivery Plan priorities and CHI indicators i.e. access targets, reduction in emergency admissions, development of mental health crisis resolution and early intervention services, smoking cessation.

Delivery of local priorities within the PCT's business plan: Improved access to dental services; expansion of the local intermediate care service; review of local service provision across Fareham and Gosport (linked to the PFI reconfiguration); the development of learning disability services; Healthfit. The continued provision of high quality, easily accessible services for local residents, (through the shift of services from secondary to primary care).

Continued delivery of the PCT's Service Improvement Plan: To ensure three star status by 2005/06.

Health improvement/public health

Name and designation of person responsible for completing this section

Name: **Kathryn Rowles / Noreen Kickham / Fiona Cameron**

Designation: **Director of Public Health / Director of Nursing & Clinical Governance**

Name and position of the designated lead for health improvement/public health

Name: **Kathryn Rowles / Noreen Kickham**

Position: **Director of Public Health**

Is this a PCT lead or board level lead? Board

2.17 Please describe briefly either one or two examples of PCT initiatives to assess or develop public health skills within the local community, e.g. health visitors, etc?

Post Natal Depression

Following the development of a postnatal depression strategy, health visitors locally identified the need for a resource health visitor for postnatal depression.

The health visitor postnatal depression coordination group agreed the essence of the role, which was to:

- Provide up to date expertise
- Support colleagues
- Identify training needs
- Lead on training and development
- Lead on the development of services for women with postnatal depression
- Facilitate supervision groups
- Lead on audit
- Liaise with other disciplines and agencies on postnatal depression matters.

The initiative has meant initially an increase in the workload of health visitors, as the strategy allows for more focused work. This however, does not necessary lead to a long-term increase in workload. Improvements include increased awareness among health visitors about postnatal depression and an increase in the awareness among mothers on health visiting caseloads.

Local Authority Public Awareness event – Health is Everybody's Business

A Workshop event to develop awareness and promote the importance of the wider public health role of Local Authorities was organised on the 3 February 2004.

The PCT's Director of Public Health and Officers from the two local Borough Councils jointly planned the workshop, which involved 56 participants including local Councillors, Local Authority Officers and PCT Board members.

The workshop enabled participants to gain a better understanding of the health needs of Fareham & Gosport residents, what the key influences on health are and how Local Authorities contribute to keep people healthy. Participants were provided with an opportunity able to work through a scenario focusing on partnership approaches to reducing accidents in the elderly.

Workshop evaluation reflected the importance of partnership working to improve health and address local needs. Participants endorsed the approach as a mechanism to address key local priorities. A further event focusing on obesity/healthy eating is now planned for the autumn 2004.

2.18 Please describe briefly your managed systems and processes for dealing with the following. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

a) Communicable Diseases In The Population:

The Director of Public Health (DPH) has the executive lead role and responsibility for health protection issues, including communicable disease control in the PCT.

The Health Protection Service is delivered by Hampshire/IOW Health Protection Agency on behalf of the PCT through a Memorandum of Understanding agreed by the DPH with the Director of the Health Protection Agency and the local team, led by a Consultant in Communicable Disease Control.

Communication links regarding communicable disease/health protection issues are included on agendas of PCT's Clinical Governance team.

Monitoring of delivery of the Memorandum of Understanding is undertaken by the DPH through quarterly meetings with the local Consultant in Communicable Disease Control. Strategic development issues relating to the delivery of Health Protection services across the wider health community are addressed through the Hampshire/isle of Wight Public Health Network (DsPH and Director of local Health Protection Agency).

PCT DPH responsible for reporting activities relating to health protection the Board, PEC and Clinical Governance Committee.

b) Infection Control Within Community Health Services:

The PCT has a lead director for Infection control in line with the document 'Winning Ways'. The Director of Nursing and Clinical Governance is the accountable lead and scrutiny is provided by the clinical governance committee and by the Chief Executive.

In terms of planning there is a Memo of Understanding between Health Protection Agency and PCTs jointly. A Service Level Agreement exists between the PCT and Portsmouth Hospitals Trust for an infection control service and includes annual audit/advice/ plus outbreak support.

Access to the service is clear to all via policies and procedures in all locations. There is 24 access to Clinicians for advice. Infection control is also a feature of the PCT induction programme.

There is an annual infection control audit and issues would also be picked up in general risk assessments. In addition Risk/incident reports highlight issues of concern and these are discussed at Health and Safety and Clinical governance meeting

The Director of Nursing & Clinical Governance works with the Director of Public Health to ensure compliance with the standards in 'Winning ways'.

Monitoring is via reports to the PCT board where appropriate.

c) Immunisation and vaccination:

Public Health Directorate take the lead for PCT Immunisation and Vaccination Co-ordination in collaboration with Planning/Commissioning colleagues in the PCT. The Memorandum of Understanding with the Hants & IOW Health Protection Agency reflects the Agency's 'expert advice role'. A District Immunisation and Vaccination Group provides strategic direction for local activity and identifying annual priorities. Priorities and plans are communicated through a variety of mechanisms including:

- Staff Briefings
- Newsletters/circulars from Health Protection Agency
- Continuing professional development for key staff groups.

District Flu Immunisation Group provides a good example of co-ordinated approach to plan development, implementation and monitoring. PCT Lead Manager identified to co-ordinate local PCT implementation and monitoring and campaign evaluation. Analysis of both campaign process and outcomes is undertaken to identify areas for improvements. These include working with practices with low uptake.

Reporting of Immunisation and Vaccination is reported through the following mechanisms:

Performance Monitoring Committee (where CHI and Local Delivery Plan target monitoring is reported)

- Performance Monitoring Committee reports to the PCT Board.

d) Health screening programmes, e.g. cancer, etc:

The Head of Commissioning and DPH are responsible for screening programme delivery within the PCT.

A review of screening programmes in Portsmouth and South East Hampshire was undertaken by the PCT's DPH (August 2003) to inform service planning and development needs. The review took account of national aims, clinical effectiveness evidence and local responsibilities for programme management, service management, population coverage, performance management and quality assurance.

Planning and prioritisation of investment in new screening programmes (e.g. extension of breast screening, Downs Screening) is reflected in the PCT's Local Delivery Plan, which is agreed by the PEC and Board.

Through the Hampshire/Isle of Wight Public DPH network, there is an identified structure to support the strategic development of screening programmes across the wider health community.

There are pan PCT arrangements across Portsmouth & South East Hampshire in place for both commissioning and securing public health input to screening programmes.
There are groups established across the Portsmouth & South East Hampshire health economy for breast and cervical cancer screening – responsible for overall co-ordination, development and monitoring implementation of national standards.

Breast Screening Project has moved forward, see Learning Disabilities LBHU Audit.

e) Emergency incident planning (including environmental hazards):

F&G PCT Risk Management Committee oversees Emergency Planning arrangements within the PCT. The Joint Health Emergency Planning Group (JHEPG) is a multi-agency group with representation from each of the SE Hampshire PCTs, Social Services, Portsmouth Hospitals Trust, Hampshire Ambulance and Hampshire County Council. It is responsible for ensuring 'joined-up' working across health & Local Authority colleagues (JHEPG Terms of Reference are Appendix A of the Joint Emergency Planning & Major Incident Response Policy). The JHEPG minutes are noted by the RMC and issues requiring specific discussion are then reported to the Board via RMC minutes.

The Emergency Planning Relationship Diagram for Fareham & Gosport PCT is in the 2003 Risk Management Committee Annual Report.

The Director of Nursing & Clinical Governance is the Lead Director with responsibility for Emergency Planning at Board Level. The Risk & Litigation Manager is the Emergency Planning Liaison Officer (EPLO). Both attend JHEPG and Risk Management Committee. The EPLO also represents the 3 local PCTs at the Hampshire & Isle of Wight Emergency Planning meeting, which brings together all health organisations across the StHA region. The Directors of Public Health receive minutes of the JHEPG and link in with The Lead Director and EPLO informally on Policy, training and exercise issues.

Priorities for Emergency Planning are focussed on Government initiatives, such as CBRN & Counter Terrorism issues. The annual Emergency Planning Risk Assessment is carried out jointly by the JHEPG members and by the local PCT EPLOs through joint completion

of the Controls Assurance Standard Emergency Planning. The annual priorities are recorded on the Emergency Planning Action Plan, which also captures lessons learned from training and live exercises as well as 'real' incidents.

Priorities and plans are communicated by the Lead Director and EPLO at RMC and by the Lead Director and DsPH Executive Team (e.g. admin support at Netley Strategic 'Gold' Command). Communication also feeds into the Board via ad hoc Emergency Planning Board Reports, the annual Controls Assurance Report and the Risk Management Committee Annual Report. External communication channels between local PCTs, West Hampshire Trust, PHT and Hampshire Ambulance, as are communications with Local Authority and Hampshire County Council who are all represented at the quarterly JHEPG. An annual meeting between Health and Council Emergency Planners has been established, which ensures countywide communications remain strong.

The PCT's Emergency preparedness is monitored by the plan, train, exercise, and review cycle and through the annual Controls Assurance assessment. The PCT takes every opportunity to test communications (PCT 6 monthly test, and PHT communications test), and take part in live exercises with other health and non-health organisations (LIVEX 2002, Black Knight, Triton). The EPLO also facilitates (with the Emergency Planning Development Manager) PCT training for Directors and Senior Managers within the PCT and jointly with the other two PCTs in the SE Hampshire patch. The Strategic Health Authority will use the Controls Assurance Emergency Planning Standard to inform the quarter 4 performance monitoring for 2003-04.

All training and exercising produces lessons and the need to update policies, plans and action cards. Long-term actions are added to the Health EP Action Plan, which is monitored, by the JHEPG and feeds into the PCT's RMC.

Evaluation is mainly through peers and joint evaluation of exercises and training (e.g. Black Knight, LIVEX, Service Manager training), and Controls Assurance assessments are evaluated by the Health Emergency Planning Adviser (HEPA). Locally the EPLOs and EP Development Manager meet regularly, as do the Lead EPLO (currently Fareham & Gosport) and EP Development Manager. Emergency Planning is also a standard item for discussion between the Lead Director and EPLO during supervision, and issues for management discussion are fed into the Executive Management team by the Lead Director.

The reporting structure for emergency incidents is set out in the Emergency Planning Relationship diagram (see Risk Management Committee Annual Report). The RMC is responsible for overseeing the Emergency Planning function for the PCT, and the Board notes the RMC minutes.

2.19 Please describe briefly either one or two examples of how the PCT has used information on patient or population health needs to improve the quality of services provided by community health services and, or independent contractors.

Director of Public Health and Public Health Team lead health needs assessment (HNA) process for PCT. HNA activity is focused on providing 'whole population' information to inform PCT core functions e.g. Annual Public Health Report, Development of Public Health dataset and supporting HNA dimension of service reconfiguration/planning activity in the PCT. Examples include:

Local Delivery Plan - which includes HNA as a core component to inform Plan.

Partnership Plan - HNA tool to inform multi-agency working with local authorities, voluntary sector etc.

Service Reprovision Fareham & Gosport - HNAs is core component informing service model development. This includes both 'whole' population approach to needs and service activity modelling.

Public Health Data/Annual Health Report widely disseminated through:

- Presentations to Board and multi-agency groups
- Document dissemination
- Staff Briefings.

Annual monitoring of Needs Assessment data undertaken as part of core Public Health function.

Walking Your Way to Health in Gosport

The scheme has been operating in Gosport since September 2002 as a collaborative effort between the Borough Council, PCT and voluntary sector.

The objectives of initiative are to:
Provide people with opportunities to walk in their local area
Encourage normally sedentary people to take exercise
Encourage the social aspect of walking
Enable those who do not feel safe walking alone to walk in a group
Target areas of high deprivation
Encourage the community to organise their own walks

The scheme currently delivers 3 walks per week of varying difficulty. These have been assessed for risk and health and safety. There are 10 voluntary walk leaders who have all undergone a training programme to support their role.
Each walk attracts approximately 20 people of varying age but are mainly older people.

The key benefits are improved physical capability. Some walkers have progressed from the easiest walks to the most difficult and are completing them in half the delegated time. Feedback from the walkers who participate have strongly advocated the social aspect of the walks and confidence in terms of feeling safe by walking as a group rather than alone.

Water is Cool in School Project

The initiative was prompted by reports from health professionals that large numbers of Children attending enuresis clinics locally did not drink at all during school time. Evidence suggests that good hydration improves health and educational performance.

The purpose of the project undertaken was to encourage schools in Fareham and Gosport to provide drinking water throughout the day for both pupils and staff. The project involved local school nurses, a health promotion specialist, a community dietician and an oral health educator.

The project was initiated through a questionnaire targeting all schools in the PCT area to establish what current facilities for drinking water existed and an offer of support to schools interested in improving the availability of water.

Activities to promote the imitative included;
newsletters citing the benefits of good hydration and examples of good practice
provision of sports water bottles for special schools
funding to support piped water systems in 10 local schools targeting special schools and those in the most deprived areas
Promotional opportunities to provide bottled water through local Children's disco event (800 Children) and local football teams (300 Children).

Follow up has been through questionnaire. Nearly three quarters of all schools in Fareham & Gosport ensure that water is available throughout the day to pupils and staff (approx 13,500 pupils benefiting). Schools involved in the initiative have commented that pupils appear less tired and more alert attentive with fewer headaches.

This project won a Strategic Health Authority Modernisation award for its contribution to reducing health inequalities in 2003.

2.20 Has the PCT undertaken any recent work to assess health needs of black and ethnic minority communities or disadvantaged groups (refugees, asylum seekers, travellers, addicts etc). Please describe and note the relevant changes to services that resulted.

Development/review of Health Improvement Programme for Haslar Removal Centre undertaken to inform delivery of Primary Care services and broader Health Improvement activity for the asylum seekers at the Centre. One key service change resulted in definition of Mental Health Service support to the Centre through identification of consultant/service input in Mental Health Service Level Agreement.

Strengths and weaknesses

2.21 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of health improvement initiatives.

Healthy Schools Programme

The National Healthy School Standard scheme is delivered in partnership locally primarily with local primary and secondary schools, Hampshire Local Education Authority, the PCT, local police, the youth service, local borough councils and voluntary agencies.

The initiative aims:

To promote the health of school Children by providing accessible information and equipping them with the skills and attitudes to make informed decisions about their health.
To enable schools to understand the importance of investing in health to assist in the process of raising levels of pupil achievement and improving standards.
To provide a physical and social environment that is conducive to learning.

The current phase (level 3) of the national programme is targeting work with schools that serve the most socially deprived communities identified by those with more than 20% free school meals.

The Hampshire Healthy Scheme offers schools a choice of areas to focus on including: drug education, sex and relationship education, emotional health and well being, physical activity, healthy eating, the environment, citizenship, PSHE and safety.

The scheme has promoted effective multi-agency partnerships around the Children's health improvement agenda.

63% of Fareham & Gosport Schools (45 total) are now working at level three of the Healthy Schools Standard. This includes 5 (50%) of schools that provide 20% free school meals.

Breathe Inn

The Breathe Inn project is a Hampshire wide scheme. Locally it involves the two local Borough Councils, the PCT and local business. The purpose of the project is to promote smoke free environments for customers who use local venues such as pubs, restaurants, health and fitness clubs and entertainment venues.

It is a voluntary scheme whereby participating establishments are assessed and awarded stars based on a range of criteria including the % of smoke free areas available within the venue.

All 'smoke free' establishments involved are published in a guide, which is distributed to places such as tourist offices, libraries, leisure centres and bed and breakfast.

A total of 11 establishments are involved with the scheme in Fareham & Gosport (6 in Fareham and 5 in Gosport).

2.22 Please identify the PCT's priority areas for developing health improvement initiatives in the next 12 months.

The Public Health Common data set established to support the forthcoming Annual Public Health Report has provided a tool to identify priority health improvement initiatives.

Analysis of local health needs has supported the development of a health a Health Improvement Partnership Plan focusing on the major causes of death and disease: CHD, Cancers and their risk factors. Priority objectives for health improvement are outlined below:

Promoting sustainable physical activity initiatives
Tackling obesity and promoting healthy eating
Smoking Cessation
Educational campaigns with a particular focus on sun awareness, beach safety and accident prevention

Prescribing And Medicines Management

Name and designation of person responsible for completing this section

Name: **Kathryn Rowles/Noreen Kickham**

Designation: **Joint Director of Public Health**

Name and position of the designated lead for prescribing and medicines management

Name: **Kathryn Rowles/Noreen Kickham**

Position: **Joint Director of Public Health**

Is this a PCT lead or board level lead? Board Lead

2.23 Please describe briefly the PCT's systems and processes for prescribing and medicines management by community health service staff, independent contractors and any specialist provider arms of the PCT. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The Executive Lead for Prescribing and the broader Medicines Management issues is the Director of Public Health. The PCT has a Medicines Committee and prescribing/medicines management issues are reported to the Board.

Planning and priority setting for Prescribing and Medicines Management has been reviewed since accountability for this area was assumed by the DPH in June 2003.

Utilisation of the NATPACT Medicines Management tool has facilitated a review of current and future priorities. A PCT Medicines Management Strategy is being developed. A Paper in Primary Care Prescribing was taken to the PCT Board in Jan 2004. This provided an overview of current and proposed action for Board sanction and approval.

The PCT was also successful in securing participation in the National Medicines Management Collaborative (commenced Nov 2003).

Monitoring of Medicines Management and Prescribing is undertaken through:

- Medicines Management Committee
- Performance Monitoring Committee
- Trust Board.

A framework for performance monitoring of Primary Care Prescribing is being developed and, the monitoring framework will supplement this for the wider Medicines Management Committee.

Audit Commission report on Prescribing was received by the PCT in December and further Internal Audit of Prescribing planned for March 2004. Recommendations/actions will be reflected in Medicines Management Strategy.

2.24 Please describe briefly either one or two examples of how the PCT has used prescribing and medicines management information to improve patient care across the PCT.

Patient Medication Reviews

The purpose of this initiative is to reduce drug wastage through over ordering and hoarding of potentially harmful medications in patients' homes.

Patient medication reviews have been undertaken by Practice Support Pharmacists working in local GP practices. The review has focused on patients aged 75 years and above who receive more than 4 repeat prescriptions.

As a result of the reviews undertaken by the practice pharmacists, the need for annual review and regular drug monitoring has been highlighted. Some practices have changed existing arrangements for ordering repeat prescriptions by the elderly to minimise over ordering by patients.

National Medicines Management Collaborative

The PCT commenced the 4th wave of the National Medicine's Management Collaborative in November 2003 and is currently working with 5 practices to achieve the a range of target, including repeat prescribing and medication reviews to improve prescribing practice and patient care.

Strengths and weaknesses

2.25 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of prescribing and medicines management.

Locality Nurse Prescribing Group

A Nurse Prescribing Group has been established within the PCT area to ensure that competencies of all nurse and supplementary prescribers are maintained, training issues are identified and issues arising from the monitoring of non-GP prescribing activity are addressed.

The membership of the Group includes district nurses, health visitors, nurse development manager, practice nurse trainer, service managers for Children's services and district nursing and the PCT's pharmaceutical adviser. The Group holds a minimum of three workshops a year.

A district nurse prescribing policy has been produced has a result of the establishment of the Group.

Clinical Pharmacist appointment Gosport War Memorial Hospital

This initiative was developed in response to the CHI investigation at Gosport War Memorial Hospital. The purpose was to improve prescriber support and prescription monitoring as well as to ensure pharmacy input to ward rounds and ongoing audit of prescribing.

The pharmacist has been in post since November 2003 and is based in Gosport War Memorial Hospital although provides a service to St Christopher's as well. A job plan has been developed and attendance on ward rounds is scheduled.

In addition monitoring of prescriptions and advice to prescribers takes place. Critical pathways are in place for concerns re prescribing and ward usage monitoring of specific medications has commenced.

2.26 Please identify the PCT's priority areas for developing prescribing and medicines management in the next 12 months.

Development of Medicines Management Strategy

Undertake review of resource support for prescribing and broader medicines management initiatives.

Dissemination/roll out of Medicines Management Service Collaborative to all practices across PCT

Sustained implementation of public awareness. "Drug Wastage " Campaign.

Improve Medicines Management action planning, monitoring and reporting.

Develop NICE monitoring sub group

Develop Clinical pharmacist role to include technician support.

3.0 Patient And Public Involvement

Name and designation of person responsible for completing this section

Name: **Kathryn Rowles/Noreen Kickham**

Designation: **Joint Director of Public Health**

Name and position of the designated lead for consultation and patient/service user involvement?

Name: **Kathryn Rowles/Noreen Kickham**

Position: **Joint Director of Public Health**

Is this a PCT lead or board level lead? Board Level

3.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to promote and support patient and/or carer involvement.

Patient and Public Involvement Strategic Framework and Action Plan approved by Board - Jan 2003. Resource implications approved.

Current allocations and staff time supporting patient and/or carer involvement (PPI) activity include:

Public Involvement and Communications Manager £38K, including on costs
PALS £48K
Non staff PPI costs £30K
Officer support provided to NSF LITs/DITs on Care Group basis e.g. Older Persons, Mental Health. This supports patient and carer involvement in planning process

Non-Executive leads and Executive leads identified (DPH) for PPI activity.

PPI Steering Group as a sub committee of the Board established involving Executive Directors/Senior Managers in PCT and participation from key partners (councils for Voluntary Service).

3.2 Please describe briefly the PCT's managed systems and processes for involving patients, users, carers and the public in the provision of community health services in accordance with Section 11 of the Health and Social Care Act 2001. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

Management Accountability for Patient and Public involvement (PPI) is with the Director of Public Health

A PPI Steering Group has been established as a Sub Committee of Board to oversee the strategic development and performance monitoring of the PPI agenda.

The PCT Board approved a PPI Strategic Framework and Action Plan in Jan 2003, including financial investment.

Priority setting is undertaken through PPI Steering Group.

The Public Involvement & Communications Manager undertakes day-to-day monitoring with feedback being reported back to PPI Steering Group.

Performance monitoring of outcomes is undertaken through the PPI Steering Group and up to Board.

At an operational level in Learning Disabilities Services, user reviews have been developed using accessible information and supporting processes to develop user involvement and true participation.

Learning Disabilities Local Implementation group has user and carer representatives. Also involvement from users and family carers on Learning Disabilities Partnership Boards.

3.3 Please describe briefly the PCT's managed systems and processes for involving patients, users, carers and the public in the provision of general practitioner services in accordance with Section 11 of the Health and Social Care Act 2001. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The PPI Steering Group (See 3.2) includes representation form the local Practice Manager forum.

The National Patient Survey undertaken April – May 2003 focused predominantly on GP Contractor Services. Results of Survey presented to PEC and Board.

Action planning to respond to the results of the survey have been agreed through the PPI Steering Group

Planning and priority setting identified in national survey and through new GMS Planning Groups within the PCT.

Ongoing monitoring is through the PPI Steering Group.

3.4 Please describe briefly either one or two examples of how the PCT has involved patients, carers, users and the public to improve the quality of services provided by community health services and, or independent contractors.

'Healthfit' (A Hampshire wide strategic planning process/initiative to develop models of future service provision/secured patient/carer involvement)

Four service areas - Older People, Children, Maternity and Emergency were explored to identify:

- Current Service provision
- Gaps
- Future models.

PCT reporting of Healthfit outcomes undertaken back to Strategic Health Authority.

Local Healthfit events involving key stakeholders undertaken (including patients/carers).

Outcome of local Healthfit Planning launched as part of Hants wide Strategic Healthfit Plan (Jan 2004)

Community Health Council Survey Gosport War Memorial Hospital

The Community Health Council (CHC) undertook a survey on behalf of the PCT. The survey was designed and conducted by the Community Health Council and focused on patient and relatives perception of staff communications with them.

The Community Health Council interviewed a number of patients and their relatives and produced a report, which went to the PCT Board in May 2003. A subsequent action plan has been completed and reviewed by the Board in January 2004.

The survey is being repeated at St Christopher's hospital. Advice for patients and their relatives on how to seek information and medical contact has been developed.

3.5 Please describe briefly either one or two examples of how the PCT supports staff and independent contractor who want to develop skills and, or initiatives for improving patient and public involvement (in accordance with Section 11 of the Health and Social Care Act 2001).

A collaborative training package,

This has been initiated by the PALS Service and local Complaints team and has been developed by the District Training and Development team. Its purpose is to:
- Raise awareness of PALS/Complaints processes
- Increase understanding of Customer Care.

Funding to roll out the training across the PCT has been secured from the Workforce Development Confederation. Dissemination (during 2004) will aim to establish a network of 'Champions' for PPI in its broadest sense.

3.6 Please describe briefly the PCT's managed systems and processes for enabling patients, carers, users and the public to raise issues of concern or to make complaints. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

Complaints/PALS

The PCT complies with the National complaints requirements.

Director of Nursing & Clinical Governance accountable for complaints function. A Complaints Manager and Assistant Complaints Manager provide 5-day access to the department.

Priorities are set via national guidance and driven by specific local focus. E.g. Complaints Manager working with Training & Development regarding training in complaints.

A PCT policy and information leaflet is available in all departments. Complaints awareness is a feature of induction.

Monitoring of patient feedback is achieved formally through complaints and concerns and informally through the letter of appreciation.

These are reported to the board quarterly.

Action plans arising from complaints are a feature of service quarterly reviews and remain in reviews till all actions are complete. Copies of action plans can be sent to complainants, where appropriate.

The PCT also has a PALS service hosted by East Hants PCT and reports are presented to F&G PCT Patient & Public Involvement Steering Group.

There are also a number of specific feedback mechanisms particular to individual services. Issues are also raised and discussed at Public Board meetings.

3.7 Please describe briefly either one or two examples of how the PCT specifically caters for the needs of individuals with a disability (e.g. physically disables, visually impaired etc).

Public Board Meetings

The Trust holds bi-monthly Public Board meetings to which all members of the public are invited to attend. Meetings are held in various venues across the Fareham and Gosport patch.

The Business Manager books the venues paying particular attention to disabled access and the availability of a hearing loop and personal address system.

When presentations are given at Public Board meetings using visual aids, attention is paid to font size to assist the visually impaired.

The meetings regularly attract disabled visitors who are appreciative of the effort we go to, to accommodate them.

By ensuring we always cater for disabled we are making the Trust accessible to all members of the community we serve.

Disability Discrimination Audits

Audits of all PCT premise have been completed for a number of our properties to ensure access for all groups.

The reports are reviewed by estates and a proposal to improve premise access presented to the operational management group. Funding is set aside in the Financial Programme to address DDA concerns.

Learning Disability – Makaton sign language

The learning disability service uses both Makaton and Pictorial symbols to enhance communications with clients.

The service has a communication group and works closely with the local implementation group and partnership board to ensure good practice is shared.

3.8 Please describe briefly either one or two examples of how the PCT specifically caters for the needs of individuals whose first language is not English.

Language Line

Language line is a telephone based interpreting service operating 24 hours a day, with unlimited and immediate access to professional, qualified interpreters in 100+ languages.

This service aims to offer support and an alternative interpretation service to that provided by PITA (Portsmouth Interpreting and Translation Agency) who provide face to face interpreters and will answer a need identified by patients, who are sometimes embarrassed to have intimate or personal questions answered by a third party and would feel more comfortable with telephone contact.

Portsmouth City PCT hosts Fareham and Gosport PCT's interpretation services.

This service was launched in Fareham and Gosport GP Practices in September 2003. An invitation was sent to all practices to attend training sessions on how to use the service, prior to this date in August 2003.

That activities did this initiative deliver? (outputs)
This telephone based interpreting service operates 24 hours a day, offering unlimited and immediate access to profession, qualified interpreters in 100+ languages.

What clinical governance improvements occurred? (outcomes)
Offering unlimited access to an interpreting service by telephone is a quick and easy system for GP practices to use.

It has been agreed with Portsmouth City PCT that a formal evaluation will be carried out every six months and the results analysed for quality and improved service delivery.

3.9 Please describe briefly the PCT's managed systems and processes for patient advocacy liaison services (PALS). [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The Executive Lead within Fareham & Gosport PCT is with the Director of Public Health (DPH).

A PALS Service is established and is hosted by East Hants PCT under a Service Level Agreement. Policies and protocols have been developed, and there is a PALS Service Information leaflet in PCT premise.

Portsmouth Hospitals Trust will assume responsibility for maintaining the administrative hub of the PALS from April 2004 via a further Service Level Agreement with the PCT. A

District wide Steering Group has been established to oversee the development and effective integration of the PALS across the local health economy.

Quarterly reporting of PALS activity within Fareham & Gosport is presented to the PCT's PPI Steering Group.

Monitoring of PALS activity is undertaken through the PPI lead within the PCT. Links with the Clinical Governance team are developing through joint protocol development between complaints and PALS.

Service/Clinical Governance improvements will be developed through the participation of the Director of Nursing/Clinical Governance in the PCT's PPI Steering Group and through DPH input to Clinical Governance Committee.

3.10 Please describe the PCTs systems and processes for patient choice and access and for responding to the needs of individual patients (e.g. appeals for unusual treatment)

Patient Choice

The PCT has Service Level Agreements with a range of providers for the provision of acute and community care for Fareham and Gosport residents. GPs can refer to these providers with no additional cost being occurred by the PCT. OATs can be made by GPs in line with the District-wide OATs guidance. OATs are normally made where patients cannot obtain effective and appropriate treatment from providers with which the PCT already holds Service Level Agreements. The PCT requests that GPs complete an OATs form as notification of an out of area referral.

The PCT has developed an implementation plan for Choice at 6 months). The implementation of the Plan is monitored by the District Choice Implementation Group. Reports are also made to the PCT's Professional Executive Committee.

Individual Patient

The PCT has an OATs/Treatments not normally Purchased Panel which meets to consider cases on an individual basis. The list of treatments not usually purchased has been agreed on a District-wide basis and has been developed after consideration of the evidence of the effectiveness of, and the potential health gain from, each of the procedures/treatments. The Panel consists of clinical, managerial and lay representatives.

Not Usually Purchased/Out of Area Treatment Committee

A Committee has been established to support a fair and transparent approach to decision making in relation to individual patient referrals received GPs/clinicians for treatments that the PCT would not normally purchase as part of the generic Service Level Agreement with acute hospital and other NHS providers.

The Director of Strategic Development is accountable for all services commissioned for local residents of Fareham & Gosport. The membership of the Committee includes, 2 GPs (PEC Chair and PEC Commissioning lead), the Director of Public Health, the Head of Commissioning, a Non Executive Director and the Assistant Service Planning Manager

Terms of Reference for the Committee have been agreed, including an appeals process. Criteria to assist decision-making have been developed along with a framework for recording the outcome of Committee meetings, which are formally held once a month.

The Assistant Service Planning Manager (ASPM) co-ordinates Committee meetings and is responsible for collating all relevant information to support decision-making and communicating this to members of the Committee. The ASPM provides quarterly monitoring data to the Committee detailing;

Number of referral requests received
Number of referral requests approved/not approved by treatment/ procedure type
Total cost of treatments/procedures approved
Comparative trend with previous quarter and year.

Commissioning issues are reported to the PCT PEC, as appropriate and are incorporated as part of the PEC Chairs report to the Board.

Strengths and weaknesses

3.11 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of patient/service user and carer involvement.

Internal Nursing reviews

Daedalus Ward at Gosport War Memorial Hospital has developed a system of internal nursing reviews. The purpose of a review is to ensure an objective view of treatment and care is provided to nursing staff, the patient and relatives. Staff wanted to identify concerns from patients and relatives early and take steps to address. All nursing staff have been involved as well as nurses from other wards who provide the input to the reviews.

Around 15 of these reviews have been conducted where the ward staff feel that a patient or their relatives are unhappy with any aspect of care.

The outcomes of these reviews is recorded and of those done there have been indications to make changes to practice which have improved the patient and/or relatives experience.

PCT Open Evening – 30th September 2003

A public open evening was organised as part of the Annual Public Meeting of the Board. The objectives were to:

- Launch the PCT's 5 year Strategic Direction
- Provide an opportunity for Public engagement with PCT.
- Provide an opportunity for Board and operational staff involvement

The event included a number of interactive stands, which promoted the work of the PCT. About 70 members of the public attended. As a result the PCT was able to create a model for future events, provide a profile for PCY Strategic Direction and increase the number of people engaged with the PCT.

3.12 Please identify the PCT's priority areas for improving patient, carer, user and public experience and involvement in the current financial year.

Key Priorities 2003/2004 PPI Action Plan

Expansion of PALS Service

Implementing National Patient Survey

Reviewing Carer /Patient involvement in Planning Structures (LITS/DITS)

Development of PCT website

Expansion of Expert Patient Programme

Sustain staff engagement/communication mechanisms (Publications: Briefing and Newsreach)

4.0 Clinical Audit

Name and designation of person responsible for completing this section

Name: **Fiona Cameron**

Designation: **Director of Nursing & Clinical Governance**

Name and position of the designated lead for clinical audit

Name: **Fiona Cameron**

Position: **Director of Nursing & Clinical Governance**

Is this a PCT lead or board level lead? Co-opted board member.

4.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to promote and support clinical audit.

The staffing resources and budget are included within Section 6.1 Clinical Effectiveness.

4.2 Please describe briefly the PCT's managed systems and processes for clinical audits by community health services, for example district nurses, health visitors, therapists, etc. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The PCT is in the process of developing a sub group of the Clinical Governance Group, responsible for the management of Clinical Audit. This group has met once to date and its terms of reference include:

- To develop a clinical audit strategy
- To identify PCT audit priorities
- To review current activity
- To monitor results and disseminate findings

Audit is also managed at service level through specific service led clinical groups. There are also a number of regular/annual audits e.g. infection control.
The CHI investigation at Gosport War Memorial Hospital also identified areas for audit and these have been pursued along with the resulting action plans.

Following this work a Clinical Pharmacist has been appointed based at Gosport War Memorial Hospital.

4.3 Please describe briefly the PCT's managed systems and processes for clinical audits by specialist provider services of the PCT, for example specialist services that are provider arms of the PCT such as community paediatrics, mental health, Child and adolescent psychiatry etc). [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

See 4.2.

Service level Agreements with providers would be the route by which the requirement for clinical audit would be specified. However, there maybe no identified audit given that the provider would be expected to comply with national requirements. Locally the District Clinical Governance Group meets to determine district wide priorities for audit and this group has representatives from all three PCTs and Portsmouth Hospitals Trust. In essence, the role of the group is to ensure national priorities are included in local programmes across all services provided within the locality. The District Clinical Governance Committee also has a role in informing commissioners across the PCTs and Portsmouth Hospitals regarding audit priorities.

4.4 Please describe briefly the PCT's managed systems and processes for supporting clinical audits by independent contractors, for example GPs, dentists, etc. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The PCT Quality function provides support to all independent contractors. A named clinical governance manager is linked to contractor services and works with the leads in dentistry, optometry, pharmacy and general practice. Independent contractors are all accountable for their own audit undertaking although supported by the PCT. The links established are designed to offer support and ensure consistency of approach.

Communication is managed by the district committees for each of these areas and in general practice a lead GP has been identified for each practice. In relation to pharmacy the PCT with its neighbouring PCT's fund a clinical governance support post.

Reporting and evaluation is through the district committees and locally thorough he PCT clinical governance committee.

4.5 Please describe briefly either one or two examples of how the PCT has involved NHS and partner organisations in clinical audits across the PCT (e.g. other NHS trusts and, or Social Services etc).

Resuscitation equipment audit

The purpose of the audit was to ensure adequate and timely checking of equipment in line with the PCT policy. All staff in the learning disability service participated and the audit showed 60% compliance with checking of basic life support equipment where it was available. However the audit also identified a lack of basic equipment in some areas and this was addressed as a result of the audit.

This audit will be picked up in future in the peer review process for policies.

4.6 Please describe briefly either one or two examples of PCT multidisciplinary clinical audits in the last 12 months that jointly involved at least two of the following three areas: community health service staff and independent contractors and specialist provider services.

Learning Disability Service - Breast Screening Audit

The purpose of the audit was to determine whether individual women over 50 years of age with a learning disability (in the learning disability service) had equal access to breast screening services. It was a joint audit between Portsmouth Hospitals Trust and Fareham

and Gosport PCT involving clinical staff from both organisations as well as learning disability clients and their GPs.

The audit involved a series of client questionnaires and a case note review in both the breast screening unit and learning disability houses with follow up to clients GP's. Results showed that :

- Breast screening service not always aware that a woman had a learning disability until she arrived for screening
- Staff within the breast screening unit felt ill equipped to deal with some learning disability clients and to meet their particular needs

The recommendations were:

- The development of a nurse in the breast screening unit with particular skills in the management of clients with a learning disability
- The learning disability service now regularly updates the register to ensure its' clients are identifiable to the breast screening unit
- The referral process was reviewed and altered to reflect the particular needs of this client group.

4.7 What national or regional multi centre audits does the PCT participate in?

The PCT has participated in the National Sentinal Audit – Stroke and will be repeating this application.

Strengths and weaknesses

4.8 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of clinical audit. Please also give details of arrangements in place to transfer these examples of good practice across the PCT.

Clinical Audit Network

The purpose of this group is to enable information sharing, networking and good practice dissemination. All three local PCTs and Portsmouth Hospital Trust are members of the group, and have been instrumental in developing and supporting audit locally. A particular success has been the development of a district wide clinical audit programme.

District Clinical Governance Committee (DCGC)

The role of this group is to ensure that national priorities are included in local programmes to inform commissioners of services regarding audit priorities and to manage 30% of the Portsmouth Hospital Trust audit budget to ensure coherence of audit priorities across the district. The group is lead predominately by the National Service Frameworks and has representation from all three PCTs and Portsmouth Hospital Trust.

4.9 Please identify PCT's priority areas for improving clinical audit in the next 12 months.

- Development of a clinical audit strategy
- Development of a clinical audit programme
- Establish research and effectiveness groups
- Develop a mechanism for sharing audit results.

5.0 Risk Management

Name and designation of person responsible for completing this section

Name: **Caroline Harrington**

Designation: **Risk & Litigation Manager**

Name and position of the designated lead for risk management

Name: **Alan Pickering**

Position: **Director of Finance/Deputy Chief Executive**

Is this a PCT lead or board level lead? Board Level Lead

Name and position of the designated lead for clinical risk management

Name: **Fiona Cameron**

Position: **Director of Nursing & Clinical Governance**

Is this a PCT lead or board level lead? Board Level Lead

5.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to promote and support clinical risk management.

Whole Time Equivalents

0.5 Wte	Risk and litigation Managers
0.3 Wte	Director of Nursing & Clinical Governance
1.0 Wte	Clinical Governance Managers
0.4 Wte	Quality Information Manager
0.2 Wte	Director of Finance
0.5 Wte	Secretarial Services
2.9 Wte	Total

Budget	**£**
Salary Costs	117,094
Non Pay Costs	8,575
Total Budget	125,669

Training and Development costs are included in the Clinical Governance Managers Costs

5.2 Please describe briefly the PCT's managed systems and processes for clinical risk management. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The **Director of Finance** is the Executive Lead for Risk Management, Controls Assurance and the Assurance Framework (Statement of Internal Control).

The **Director of Nursing and Clinical Governance** has an executive role in relation implementing Clinical Governance processes throughout the PCT. There is also a PEC lead for clinical governance.

The **Operational Director, Learning Disabilities & Community Services** is responsible for the operational management of all of the PCT's provider services.

The **Risk and Litigation Manager** is responsible for implementing and monitoring PCT-wide risk management systems, and takes responsibility for co-ordinating the PCT's controls assurance assessment.

The **Risk and Litigation Manager** is also responsible for identifying risk issues arising from compensation claims made against the PCT. These issues are reported to the Risk Management Committee so that action to reduce the likelihood of the risks reoccurring can be monitored.

The **Clinical Governance Manager (Community Services)** is responsible for implementing Clinical Governance systems throughout directly managed Services across the PCT and monitoring the clinical element of risk management systems, training and action arising from action plans.

The **Clinical Governance Manager (Primary Care)** is responsible for implementing Clinical Governance systems throughout Primary Care and Independent Contractors providing Services commissioned by the PCT and monitoring the clinical element of risk management systems, training and action arising from action plans.

The **Complaints Manager** is responsible for identifying risk issues arising from complaints made against the PCT, both for services directly managed by the PCT and for Primary Care across the district. These issues are reported to the appropriate PCT Risk Adviser and to the Risk Management Committee so that action to reduce the likelihood of the risks reoccurring can be agreed.

All staff are responsible for attending mandatory and statutory training as advised by their Manager. Individuals are also responsible for ensuring that they know who the Policy holder is and where the Policy folder (Clinical, Operational, Personnel and Occupational Health) are stored in their department/ward.

All staff are responsible for identifying and responding positively to any risks they encounter or observe, or foresee during the course of their work by following the risk management systems outlined in this document, and through associated policies and procedures which set out in more detail the process for managing risks. For example, Health and Safety Policy, Recording and Reviewing Risk Events, Risk Assessment Guidance.

The **Risk Management Committee** is the over-arching Board sub-committee responsible for risk management. It is responsible for the development and implementation of the Risk Management Strategy, and the Controls Assurance programme. It also provides a forum for evaluating and prioritising risks, as well as monitoring the effectiveness of action taken to manage risks. Components feeding into the Risk Management Committee are set out

in Appendix 3 (Risk Management Strategy), and the specific responsibilities of the Risk Management Committee are set out in the Terms of Reference Appendix 4 (Risk Management Strategy).

The **Risk Management Committee** is chaired by the **Director of Finance**, and membership of the Committee includes representation from directly managed services, Non-Executive Director and Primary Care.

The **Risk Management Committee** is accountable to the PCT Board and links with the Clinical Governance Committee, Health and Safety Committee, Fareham and Gosport Audit Committee and Internal Audit via shared membership and shared minutes of meetings. The minutes are also shared with the Strategic Health Authority and neighbouring PCTs.

The **Audit and Assurance Committee** is also a sub-committee of the Board, which is responsible for overseeing the governance and assurance processes of the PCT and to assist in discharging the responsibility of members for its financial performance and stewardship of public funds. The Committee's responsibilities encompasses all activities of the PCT. The Audit and Assurance Committee's Terms of Reference are in Appendix 3.

The **Health & Safety Committee** provides a framework for dealing with all aspects of health and safety at work. This Committee is chaired on a 6 monthly rotational basis by Service Managers representing Community Services and the Learning Disability Service. Membership includes Health & Safety representatives from the Royal College of Nursing and UNISON.

The specific responsibilities of the **Health and Safety Committee** are set out in the Terms of Reference, which can be found in the PCT's Health and Safety Policy.

Pan-PCT groups, which focus on specific risk issues, include COSHH, Moving and Handling, Infection control, medical devices, and emergency planning. Each group feeds issues into the relevant Committee, be it Health and Safety, Clinical Governance, or Risk Management.

Risk Management priorities are set through action planning resulting from various internal and external assessments, e.g. Internal Risk Assessments, Incidents, Controls Assurance, Risk Pooling Scheme for Trusts, CHI Clinical Governance Review, CHI Investigation, HSE Improvement Notice, Assurance Framework.

Priorities and plans are communicated with staff via Service Manager cascade and the formalised quarterly review process.

Monitoring of risk management priorities is mainly through the Clinical Governance Committee and/or Risk Management Committee. Occasionally a separate 'Steering/Implementation' Group is set up to oversee the completion of actions, e.g. CHI Investigation, HSE Improvement Notice, Critical/Serious Untoward Incident.

Evaluation occurs through achieving targets (national and local), meeting objectives, through audit, patient feedback (e.g. complaints and claims), all of which are Quality Performance Indicators, which are, reported quarterly to the Trust Board.

Risk Management priorities and plans are communicated from the Risk Management Committee and Clinical Governance Committee through minutes being submitted to the Trust Board, through quarterly Review cascade to all staff, and via Health & Safety Committee representatives.

5.3 Please describe briefly the most important clinical risk assessment undertaken by the PCT in the last 12 months. Please also describe briefly the managed changes in the PCT that directly resulted from undertaking the clinical risk assessments.

Controls Assurance is designed to provide evidence to the NHS Executive that NHS organisations are doing their reasonable best to manage themselves, meet their objectives and protect patients, staff, the public and other stakeholders from risks of all kinds.

HSC 1999/123 sets out the Controls Assurance process and requires Trusts to assess their risk and organisational management arrangements against a set of 22 Standards which cover significant risk areas and summarise relevant laws and Department of Health guidance. The standards are designed to ensure quality can be met within the right environment of care.

NHS organisations are required to annually self-assess against the Standards and to provide an assurance statement based on the results in their Annual Report.

Trust's are expected to demonstrate year-by-year improvement in all 22 Standards, however, during a Trust's first year this is not possible.

Targets for attaining Milestones based on the Control and Risk Maturity Matrix, are set out in Appendix 2 of the Controls Assurance Board Report (April 2003). The Milestones relate to establishing organisational frameworks and structures for managing risk, keeping the Board informed of significant issues and of progress in implementing Controls Assurance.

Internal Audit are required to assure PCT Boards there is an effective and consistent system in place for implementing Controls Assurance and that the process has been completed in accordance with national guidelines.

The PCT's first Controls Assurance assessment (2002-03) produced a variety of results, the 3 Core Standards (Risk Management, Finance, Governance) were achieved with a score of 75% or more. The completed scores and action plans for each of the Standards were discussed at Risk Management Committee, where 2003-04 priorities were agreed. The 6 monthly update has shown excellent progress against the majority of Standards, particularly the priority areas.

Benchmarking both locally and nationally has shown that the PCT is performing similarly to other Trusts and PCTs – documentation available e.g. Controls Assurance Board Report 2002-03 and South & West Risk Management Consortium Benchmarking document.

5.4 Please describe briefly the clinical incident report systems used by the PCT's community health services, for example district nurses, health visitors, therapists, etc. [In particular the system of reporting serious untoward incidents (SUIs).]

The PCT's has a standard paper form Incident Reporting System which is applied to all clinical and non-clinical incidents throughout the PCT. One Risk Event Form captures all

of the information relating to the incident, and this information is held centrally both in paper form and in electronic format on the PCT's Risk Management database. Continuations sheets are available for particularly complex incidents, and for reporting the outcome of the incident.

The Incident Reporting System is supported by the 'Recording & Reviewing Risk Events Policy' (Board approved March 2003), and by the Risk Management Strategy (Board approved March 2003 and updated Strategy Board approved January 2004).

All Risk Event Reports are to be received at PCT Headquarters for entry onto the database within 5 days of the incident. However, Critical Incidents and Serious Untoward Incidents (SUIs) must be faxed immediately to the PCT Headquarters, and a rapid reporting and response process has been appended to the existing Recording & Reviewing Risk Events Policy.

A new Adverse Event Form is currently being developed, which reflect NPSA reporting requirements. This form encompasses Independent Contractors as well as Provider Services.

5.5 Please describe briefly the clinical incident report systems used by the PCT's specialist provider services, for example community paediatrics, mental health etc. [In particular the system of reporting serious untoward incidents (SUIs).]

Please see 5.4 – the same Incident Reporting System is used by all PCT staff.

5.6 Please describe briefly the clinical incident report systems used by the PCT's GPs. Please also describe briefly how the PCT supports incident reporting within general practices.

A new Adverse Event Form is currently being developed, which reflects NPSA reporting requirements. This form encompasses Independent Contractors as well as Provider Services and will be launched in March 2004. GPs Practice Managers and Practice Nurses have unlimited access to the PCT Risk and Clinical Governance Managers for support.

5.7 Please describe briefly the format and frequency of reporting the following matters to the PCT's board and the professional executive committee?

GPS and Practice Managers have access to the PCT Risk Manager for support.

a) **complaints**: A quarterly report on complaints received and target response dates are produced. The complaints manager generates an annual report which also goes to the board.

b) **critical incidents**: Critical Incident Reviews (CIR) are submitted to the PCT's Risk Management Committee, Clinical Governance Committee (if clinical) and Board. There is a standard CIR Report format setting out events leading up to the incident and a standard action layout indicating actions, deadlines and individual responsibilities for ensuring actions are completed.

c) **litigation cases in process**: The Risk Management Committee, Clinical Governance Committee and Board receive a quarterly update of all claims

received during the last quarter, a status report for each on-going claim, and a brief update on claims closed during the last quarter. All information is anonymised, and costs are aggregated to prevent individual claims costs being identified.

d) **litigation cases pending**: Potential Claims are included in the Board Report, but less detail is provided.

5.8 Please describe briefly how the PCT shares following policies, protocol or guidelines with respect to:

a) Child Protection

- PCT Child Protection Management Team established. This acts as the conduit for policies, protocols and guidelines to be disseminated from:
- Hampshire wide Area Child Protection Committee
- District Child Protection Liaison Group (health Care organisations only)
- Designated doctor and nurse provide training and supervision (under Service Level Agreement with Portsmouth City PCT) to ensure dissemination and compliance of policies.
- Comprehensive Action Plan has been developed for Child Protection in Fareham & Gosport PCT. This reflects national recommendations and priorities (CHI Audit and Lord Laming Report recommendations).

b) Mental Health

The objective of the referral guidelines is to provide a clear outline of the options available to Primary Care clinicians in managing or referring to secondary care, a range of mental health conditions.

The objective of the transition protocols is to provide a clear outline to clinicians of the criteria and process of transferring patients across service boundaries.

The guidelines were developed to incorporate service eligibility criteria in line with the National Service Framework for Mental Health.

Referral guidelines were originally developed within a district wide steering group of mental health practitioners followed by a process of consultation with Primary Care practitioners and other stakeholders. Within Fareham and Gosport PCT, updating guidelines, the development of new guidelines and the dissemination of guidelines are co-ordinated through the Primary Care Sub-group of the Mental Health Locality Implementation Team (LIT).

The implementation of guidelines and transition protocols enables a consistency of referral practice, therefore increasing the number of appropriate referrals into secondary care and providing a smoother transition between services. The guidelines are evidence based and therefore improve the standard and equity of service provision.

It is planned to include the monitoring of referral guidelines within the PCT audit programme for 2004/05.

c) Health Promotion

National Service Frameworks – Sharing of prevention standards and policies, protocols and guidelines relating to this are shared through the NSF Planning Structures e.g. Mental Health Local Implementation team (LIT), Older Persons LIT (falls group). Multi-agency representation on LITs to ensure dissemination and cascade of relevant prevention standards and guidelines/action plans.

Public health programmes/national Guidelines – Planning structures are established for specific programmes e.g. smoking cessation - Service Level Agreement with Portsmouth City PCT for delivery of smoking cessation service, including training and dissemination of guidelines to relevant staff within the PCT and primary care contractors.

Teenage pregnancy – Local Implementation team established for the PCT including multi-agency representation. Dissemination of local policy from Hampshire County Council Teenage Pregnancy Strategic Group for local interpretation, dissemination and delivery.

d) Older People

A number of existing guidelines for referral relate to older people, in particular podiatry referral and stroke guidelines. These are routinely shared with general practitioners and community services staff. More recently the PCT has worked with Hampshire County Council in relation to its Adult Protection Policy and the need to link that with the PCT. There is a clear structure within the PCT for policy development and where those policies are clinical the route for ratification and monitoring is via the Clinical Governance Committee. Similarly, patients group directions and guidelines developed by other professions would be ratified by the Clinical Governance Committee.

In terms of distribution of the latter two they would usually be distributed to all of the professional groups concerned with their use. Policies are freely available in all provider areas and access is available to all GPs.

e) Learning Difficulties And Vulnerable Adults

- Shared Adult Protection Policy with Social Services and Health
- Awareness training delivered to some staff – need to expand training across all areas within the Trust
- Joint Multi Agency Management Committee
- Adult Protection which links into the Trusts Clinical Governance Structure

5.9 Please describe briefly either one or two examples of how the PCT promotes and supports an open and just culture as a basis for encouraging staff to report clinical errors.

The PCT encourages an open and just culture for reporting incidents, which is underpinned by the Risk Management Strategy, Recording & Reviewing Risk Events Policy and Health & Safety Policy. The Whistle Blowing Policy provides an alternative method of raising concerns.

Staff at all levels are provided with quarterly feedback on Risk Event trends. RCN and Unison representatives attend the PCT's Health & Safety Committee, where quarterly Risk Event statistics are discussed in depth.

RCN & UNISON representation on Health & Safety Committee
Multi-agency Critical Incident Review (Bomb Scare, Gosport War Memorial Hospital 4/10/02)
Whistle blowing policy
Employee partnership forum
Recently reviewed emphasis on whistle blowing all staff received leaflet on payslips.

5.10 Does the PCT have any improvement notices, prohibition or enforcement orders from the health and safety executive either pending or current? If yes, please give details.

Health and Safety Executive Improvement Notice served on all three PCTs in June 2003 relating to the provision of Manual Handling Training. A comprehensive Action Plan was submitted to the HSE in July 2003 and it was been confirmed by the HSE Inspector that the Action Plan meets the requirements of the Improvement Notice.

5.11 Have you had any case reviews conducted in accordance with chapter 8 (enquiries into Child abuse) that have reported in the last three years? If yes, what changes have you made as a result.

No

5.12 Are there any services, including those provided on one of your hospital sites but managed by another organisation where health professionals also work for your PCT or closely with your PCT staff, where quality of care has caused concern or been subject to investigation (in the last three years)? Please give details.

Report of an Independent Enquiry (RS)

This enquiry was established in March 2003 by the Hampshire and Isle of Wight Health Authority pursuant to Health service Guidance 94/27: The Discharge of Mentally Disordered People and their Continuing Care in the Community following an incident in February 2000.

The panel concluded their investigation and a report was presented to stakeholders in November 2003. This has subsequently been presented to the Strategic Health Authority (SHA) Board and work is progressing to finalise an action plan between the SHA, West Hampshire Mental Health Trust and the PCT. The action plan will be monitored by Fareham and Gosport PCT.

Lorazepam Review in Collingwood and Mulberry ArkRoyal EMH Wards GWMH

The EMH Wards at GWMH are managed by East Hampshire PCT.
As a result of allegations made by a member of staff, in 2002, that sedative medication was being given when not prescribed, an external investigation was commissioned by East Hants PCT. The findings of the investigation were that the allegations were not substantiated. A series of audits were undertaken as part of the review on usage of Lorazepam and olanzapine on wards at both Gosprt and St James' Hosptals.

The investigation did reveal systems and service failures in the control and management of medication records between pharmacy and wards. Detailed action plans have been developed and are being implemented in collaboration with PHT hosted Pharmacy Services .

Strengths And Weaknesses

5.13 Please describe briefly one or two examples of what the PCT considers to be best practice in respect of clinical risk management. Please also describe briefly what arrangements are in place to transfer these examples of good practice across the PCT.

Risk Assessment Process (Clinical & non-clinical)

The purpose of completing Risk Assessments (apart from the legal requirement under Health & Safety Law) is to allow managers and staff to identify and manage risks relating to their work and the people who use local PCT health services.

The completion of a Risk Assessment is at the heart of the Management of Health and Safety at Work Act Regulations 1992 and 1999. It underpins all Health & Safety legislation covered in the 1992 Regulations.

In Fareham & Gosport PCT Risk Assessments are carried out by trained Risk Assessors in each area (Ward, Community Home, non-clinical areas) annually for general risks, and on an ad hoc basis when necessary, for example, for a specific patient or a specific issue where a risk has been identified.

The PCT has developed detailed guidance (in conjunction with East Hampshire & Portsmouth City PCTs) which outlines the process for carrying out Risk Assessments, and provides a standard format for recording the findings, the action recommended, and ensuring action is taken. It is designed to help managers focus on high risk areas, without losing sight of less urgent issues.

What Is A Risk Assessment?

It is a way of:

* identifying hazards and threats;

* assessing these in terms of the likelihood that they will occur, and the severity of the consequences if they do occur;

* prioritising action required to reduce the potential for harm/damage, based on this assessment.

Risk Assessments are carried out by nominated trained Assessors. Nominations are agreed by Line Managers and details forwarded to the PCT Risk Adviser who maintains a central Assessers register. Training provided for Risk Assessors and only those people who have attended should complete a risk assessment.

All risks allocated a score of 7 or higher are collated onto either the Learning Disabilities Health & Safety Action Plan or the Community Services Action Plan and are discussed at Health & Safety Committee. Individual risks are then managed through Service review, and if necessary (not able to be managed within Service review), are presented at Risk Management Committee for high level consideration.

Incident monitoring Group (including medication errors)

This group is only recently established and has met on two occasions. Its terms of reference are to:

- Review all high-risk incidents and all medication errors.
- Monitor trends
- Provide feedback to services
- Ensure action taken

The group is chaired by the Director of Nursing and Clinical Governance with representatives from community services, learning disabilities, a pharmacy advisor, risk manager and clinical governance manager.

Reports are produced quarterly and individual incidents/errors are reviewed and a record kept of the outcome. Eventually the group will be able to evidence trends/patterns and seek advice from clinicians as to appropriate action.

The group reports to the Clinical Governance Committee.

5.14 Please identify PCT's priority areas for developing clinical risk management in the next 12 months.

Launch the new Adverse Event Form throughout the PCT's provider Services

Develop Risk Management systems & processes in Primary Care – roll out the new Adverse Event Form to all Independent Contractors

Engage with the National Patient Safety Agency and National Reporting and Learning System.

Improve Controls Assurance scores from last assessment (2002-03)

Achieve Level 1A Risk Pooling Scheme for Trust Assessment

Further develop incident monitoring to ensure appropriate and timely feedback.

6.0 Clinical Effectiveness Programmes

Name and designation of person responsible for completing this section

Name: **Fiona Cameron**

Designation: **Director of Nursing & Clinical Governance**

Name and position of the designated lead for clinical effectiveness

Name: **Fiona Cameron**

Position: **Director of Nursing & Clinical Governance**

Is this a PCT lead or board level lead? Co-opted Board member

6.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to promote and support clinical effectiveness.

Whole Time Equivalents

0.2 Wte	Risk and litigation Managers
0.2 Wte	Director of Nursing & Clinical Governance
1.0 Wte	Clinical Governance Managers
0.4 Wte	Quality Information Manager
0.3 Wte	Secretarial Services
0.3 Wte	Complaints Manager
0.5 Wte	PRIMIS Facilitator
0.3 Wte	Director of Public Health
3.2 Wte	Total

Budget	**£**
Salary Costs	118,844
Non Pay Costs	13,251
Legal Fees	46,800
Total Budget	178,895

Training and Development costs are included in the Clinical Governance Managers Costs

6.2 Please describe briefly the PCT's managed processes and systems for developing and supporting initiatives on clinical effectiveness across the PCT. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

All new developments are discussed and ratified at the Clinical Governance Committee. If these are approved, they are reported to the Professional Executive Committee (PEC) for approval.

The Clinical Governance Committee is responsible for planning and priority setting. This is done through reporting from the Local Implementation Teams and the other groups that report into the Clinical Governance Committee (please see Terms of reference).

The PCT Clinical governance lead and the Director of Nursing and Clinical Governance are responsible for communicating priorities and plans. The minutes from the Clinical Governance Committee are reported to the Trust Board.

The Clinical Audit, Research and Effectiveness (CARE) Group is responsible for monitoring processes and activities. This is carried out in conjunction with the LITs and the minutes fed back to the Clinical Governance Committee.

The CARE group is responsible for evaluating outcomes. Any actions identified from evaluation are fed back to the LIT or group responsible for progressing the particular area of work.

Minutes from the Clinical Governance Committee are reported to the Trust Board.

A NICE sub group reports to the CARE group and monitors the implementation of clinical effectiveness guidance. This group is only recently established.

6.3 Please describe briefly either one or two examples of initiatives on clinical effectiveness in the current financial year.

Clinical Audit Database

The objective was to provide a system to capture and report on Clinical Audit projects conducted within the tri-PCT district of Fareham & Gosport, Portsmouth City and East Hants. Once tested and the infrastructure is in place, it is intended that one central database will serve all three PCTs and that multiple users will be granted varying levels of access, predominantly to interrogate the database only (read-only access).

The requirements specification and system testing involved Clinical Governance managers from Fareham & Gosport and Portsmouth City PCTs. The PRIMIS Information Facilitator at Fareham & Gosport PCT completed the database design and development.

Consistent capture of clinical audit project information, using standard lists of Departments, Authorities, Sites, Services, people etc. is the desired outcome.
Progress monitoring and reporting of Clinical Audit initiatives will be managed in this way.

6.4 Has the PCT developed or adopted:

a) evidence based co management protocols (e.g. screening diabetic retinopathy)?

DRIVE (Diabetes Risk Factor Intervention to Reduce Vascular Events) guidelines.

The objective of this initiative was to disseminate and implement District-Wide guidelines on the care of patients with diabetes. This was done with the aim of improving the quality of care provided to diabetic patients and ensuring uniformity of care in line with the National Service Framework and the NICE guidelines. These standards and guidelines form the basis of a 3-year rolling audit programme for diabetes care.

The guidelines were developed by a multi-disciplinary group with representatives from primary and secondary care. Diabetes Specialist Nurses from the acute Trust were responsible for helping to implement the guidelines in primary care by visiting practices. The programme has helped to deliver diabetic disease registers in primary care, thus ensuring patients are reviewed regularly and are receiving up-to-date treatment based on clinical evidence. This project has also strengthened links between primary care; community care and secondary care services.

As above. This initiative has also provided a platform for the first F&G PCT TARGET meeting. This involved all the general practices in F&G closing for an afternoon and attending an educational event about diabetes.

b) A local formulary – a district prescribing formulary is in use by primary and secondary cure providers.

c) Disease management guidelines or integrated Care Pathways across primary and secondary care.

The Personnel Director is accountable for the development of the overall framework for the managed systems and processes. The strategic approach to training and development is outlined in the HR Strategy. A key priority for the PCT is the production of a written training and education strategy.
Each Executive Director is accountable for the organisation and delivery of training and education within their own directorate. In addition each Director has an identified lead responsibility, i.e. Clinical Governance, Communications, for which they are responsible for identifying priorities and coordinating training and development across the PCT.
The system and process for the planning and delivery of training and development is part of the PCT Business Planning cycle, as outlined in the HR Strategy and Appraisal and Personal Development Policy.
A PCT Training and Development Group was established in 2002, chaired by the Nursing and Clinical Governance Director, membership includes service mangers, TDSS representatives and Personnel (terms of reference attached). The PCT Training and Development group reports to the Personnel Panel, a sub panel of the Board. The Personnel Panel is the committee accountable for scrutinising the managed systems and processes.

Executive Directors are responsible for determining priorities and planning activities for the areas for which they have an identified lead. There are a number of mechanisms for supporting this, for example the Clinical Governance Committee.
Training needs and priorities are determined in a number of ways e.g., personal development plans, team away days, mandatory training requirements, service specific developments (as outlined in the business plan) and training identified in the annual clinical governance, HR and communication plans. To support this process a number of services have training and development groups/forums, for example Children's Services and Learning Disability Services. The majority of services have annual training plans examples include Physiotherapy and Learning Disabilities.
The PCT has identified the need to develop a framework that coordinates this process into the production of an annual training plan.

Executive Directors are responsible for communicating priorities and plans across the PCT, Service Managers within their services. This is communicated via a number of

mechanisms for example the PCT and service specific Training and Development Groups, Team Meetings, Executive Team Meetings, monthly Briefings.

The Personnel Director is responsible for the overall monitoring of processes and activities. This is conducted in a variety of ways: -
The TDSS Service Level Agreement is monitored quarterly at a Pan PCT meeting which is chaired by the Chief Executive of the PCT. In addition TDSS provides an annual report (copy attached).
TDSS provides quarterly monitoring data as outlined in the Service Level Agreement.
The PCT has an annual partnership agreement with the WDC; this is monitored by the WDC on a quarterly basis via the provision of monitoring data, which is discussed at a meeting with representatives of the PCT and WDC.
The PCT is represented at a Pan PCT group, which monitors the provision of the Southampton University post qualification courses.
Personnel record mandatory training on the Integrated Personnel Computerised system (IPS), both the recording and monitoring of this system is currently being reviewed.

The outcome of the above monitoring is a regular agenda item for the Training and Education Group.

Internal audit have devised a plan of internal audits that audit systems and process including Training and development. In 2002 an audit was undertaken of training and development, this resulted in an action plan, progress of which was reported to the PCT audit committee.

Evaluation occurs on a number of levels as follows: -

Each training activity should generate a T1 form, the prime function of which is to facilitate an evaluation of outcomes of the learning activity, of which the Line Manager is responsible for undertaking in conjunction with the individual. There is currently no mechanism for monitoring whether this evaluation occurs, however, during the review of the Appraisal and PDP policy members of the training and development group identified the T1 system as a valuable tool to aid evaluation.

Post course evaluations are completed by all participants attending TDSS courses at the time of course completion. These are reviewed on a course by course basis and feedback incorporated into future course structure where appropriate. An earlier manual system was replaced (w.e.f. 1 November 2003) to permit easier access to this data through the use of a dedicated database. Three months after the completion date, a questionnaire is sent to the participant and her/his Line Manager requesting feedback on the effects of the training course. This information is currently reviewed manually and feedback incorporated into future course structure where appropriate.

The Training and Education Group receives regular reports on the range of activities, including the TDDS annual training report. Copies of the notes are forwarded to the Personnel Panel, which is a sub panel of the Board. The Trust Board does not receive regular training reports. However, details on training activities will be contained within various reports, for example the training activity associated with the Gosport War Memorial Hospital action plan.

6.5 please describe briefly the PCT's managed systems and processes for implementing, monitoring and reviewing the adoption of NICE guidelines, NSFs, and other national guidance (e.g. Victoria Clumbie, Bristol etc). [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

a) NICE Guidance

A sub group of the clinical audit, research and effectiveness group (CARE) has been established to monitor implementation of NICE guidance.

The group's terms of reference are to review all NICE guidance, distribute as appropriate across primary and community services, including independent contractors and monitor compliance.

The Group comprises representation from commissioning, public health, pharmacy and clinical governance and will be chaired by a public health specialist.

A system is being developed to review the NICE web site weekly and pull off all guidance for distribution to the sub group which will meet monthly.

b) National Service Frameworks (NSF)

The PCT has local implementation teams (LITs) for each National Service Framework. Membership of the LITs includes clinicians, lay individuals, statutory and voluntary agencies and non-executive directors.

Each LIT is responsible for ensuring NSF targets are met and included in the PCT business and local delivery plans.

The Professional Executive Committee also has an identified clinical and managerial lead for each NSF.

c) Child Protection (Victoria Climbie)

PCT Child Protection Management Team established. Director of Public Health is the Executive and Board lead for Child Protection.

A PCT Action Plan has been developed reflecting CHI Audit and Lord Laming recommendations.

Implementation, monitoring and review undertaken through the Child Protection Management team. This team reports to the Clinical Governance Committee and provides an Annual Report to the PCT Board.

6.6 Please describe briefly any examples in the last 12 months year where the PCT has withdrawn a treatment that has been shown to be ineffective?

The PCT has not withdrawn complete access to any treatment over the last 12 months. The PCT does have a list of treatments that it does not routinely purchase. This list has been developed based on evidence of clinical reviews regarding the clinical effectiveness of procedures or treatments. The PCT has an established process through which GPs can

request that a patient's case is reviewed to take into account individual circumstances. This is undertaken through the PCT's OATs/Treatments not Normally Purchased Panel, whose membership includes the PCT Directors of Public Health, NED, G.P, Head of Commissioning and Service Planning Managers.

6.7 What support does the PCT provide for training on evidence based practice and critical appraisal skills?

All qualified staff can access the Southampton University module "Evidence for Practice" via the WDC funded Post Qualifying course provision. Full details of the course can be found in the Southampton Prospectus.

A team development facilitator has recently been appointed to the quality team whose role is to work with teams developing evidence practice and supporting the management of change.

Strengths and weaknesses

6.8 Please describe briefly one or two examples of what the PCT considers to be best practice in respect of clinical effectiveness initiatives in your PCT.

Serious Mental Illness Registers – working to standardise the definition of Mental Health and Serious Mental Illness registers in the tri-PCT district. This work has involved Service Commissioning staff, a GP, the PRIMIS facilitator and two drug representatives. All practices in the F&G patch have been requested to conduct some simple searches on their clinical data systems, based on a list of standard diagnosis Read Codes. The patient records identified will be reviewed and coded with the appropriate MH or SMI Register codes (9H6 and 9H8). PRIMIS style queries will then be run to identify patients without diagnosis Read Codes but who do have associated Read Codes (e.g. medication codes), patients being added to the registers as appropriate.

Infection Control Guidelines for Primary Care have recently been developed. These are intended for all practice staff and provide reference to important aspects of infection control to ensure protection for patients and staff. They were developed not only as guidelines for the practice of good infection control but also to highlight those areas that are considered obligatory by law.

The guidelines were developed locally by the Health Protection Agencies with input from F&G PCT, East Hants PCT and Portsmouth City PCT. These guidelines were launched at a series of lunchtime and evening meetings, specifically aimed at Practice Nurses. Two Health Protection Nurses were on hand to discuss the guidelines and answer any queries that practice staff had.

Every General Practice across Fareham and Gosport now has a copy of the Infection Control Guidelines. The guidelines came complete with an infection control audit for general practice to enable staff to audit their practice. To date, the Health Protection Nurses have also visited many of the General Practices to audit practice against these guidelines and compile action plans for areas of practice that are sub-optimal.

6.9 Please identify PCT's priority areas for developing clinical effectiveness in the next 12 months.

- Robust evaluation of the implementation of guidelines including NICE
- Establishing the link between audit research and clinical effectiveness
- Develop the role of the Team Development Facilitator
- Develop a Clinical Effectiveness Plan as a part of Clinical Governance Strategy.
- Review of Clinical Governance structure and processes to take account of progress in year and to identify the need for sub groups on specific core elements/pillars of clinical governance e.g. effectiveness evidence, research, and audit.
- Develop a Clinical Effectiveness Plan as a part of Clinical Governance Strategy
- Review of Clinical Governance structure and processes to take account of progress in year and to identify the need for sub groups on specific core elements/pillars of clinical governance e.g. effectiveness evidence, research, and audit.

7.0 Staffing And Staff Management

Name and designation of person responsible for completing this section

Name: **Jane Parvin**

Designation: **Personnel Director**

Name and position of the designated lead for staffing and staff management

Name: **Jane Parvin**

Position: **Personnel Director**

Is this a PCT lead or board level lead? Co-opted Board Member

7.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to staffing and staff management.

Whole Time Equivalents	
Human Resources	9.67
Hosted Services	4.20
Total	13.87

Budget	**£**	**£**
Human Resources		
Staffing Costs	286,767	
Non Pay Costs	45,898	332,665
Hosted Services		
Staffing Costs	124,067	
Non Pay Costs	56,800	
Recharged Out	(136,684)	44,183
Occupational Health		
Hosted by Portsmouth Hospitals	110,041	110,041
Total		486,889

7.2 Please describe briefly the PCT's managed systems and processes for staff management, including monitoring and reporting on vacancy rates, sickness rates, and staff turnover rates. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The Personnel Director is accountable for the overall systems and processes. Executive Directors are accountable for the effective management of staff within their directorate.
The PCT has established a Personnel Panel as a sub group reporting directly to the Board and is chaired by Non Executive Director. A detailed description of the Panel and its supporting committees is described in the HR Strategy.

The HR Strategy identifies the key HR priorities for the next three years. Priorities and action plans developed by the Senior Management Team/Personnel Panel e.g. in response to absence levels. In addition to this, further priorities are identified in the PCT's Improvement Plan, annual Business Plan and Local Delivery Plan. These are communicated via the Personnel Panel to the sub groups e.g. Equality and Diversity Steering Group, IWL which are responsible for planning and prioritising the HR activities within the remit of the group. The key activities are incorporated into the PCT annual Business plan.

Team and individual objectives and priorities are linked into an annual cycle cascading from the Chief Executive down through the organisation.

The HR Director is responsible for the communication of the priorities and plans, which are incorporated into the PCT annual business plan. There are a number of mechanisms for achieving this e.g. monthly briefings, team meetings, executive team meetings, reports to the Board, IWL monthly briefings and a regular PCT magazine, 'News Reach'.

The HR Performance Indicators are communicated, along with other service specific information, at quarterly Service Review meetings that are attended by Service Managers, the Executive Director and the Chief Executive. A quarterly Board report that includes the HR Indicators is produced for the whole PCT. Data is provided to Service Managers at a local level.

The Personnel Director is responsible for the overall monitoring of the PCT's managed systems and processes for staff Management and related topics. The HR Performance Indicators are used to provide information to a number of agencies that require the information for a variety of purposes including the WDC, IWL assessments and CHI.

The principal process for the monitoring of HR activity is via the production of quarterly HR activity reports. An overall report is provided for the Trust board. In addition to this a HR activity reports are provided for the Community Services and Learning disability services. These are monitored at the quarterly service reviews. Comparisons are made to national figures to demonstrate how the PCT is performing in relation to other NHS organisations. Exceptions are reported to highlight where there are successes or concerns.

The Personnel Panel is responsible for monitoring the activity of the Sub groups.
In addition to the above Key HR monitoring data is scrutinised by the PCT Performance Committee.

A key activity that provides monitoring data is the annual staff survey. The data is analysed and communicated widely within the PCT, all staff are encouraged to participate in the

production of an action plan, which is published and monitored by the Personnel Panel. The PCT's response rate in October 2003 was 71%.

In 2002 an audit was undertaken of employment systems, inc manpower planning, recruitment, training and development and staff welfare. This resulted in an action plan, progress of which is reported to the PCT Audit and Assurance committee.

The Personnel Panel is responsible for evaluating outcomes across a wide range of activities within the PCT.

The Executive Directors and Chief Executive are responsible for evaluating the HR Performance Indicators and ensuring that appropriate action is undertaken to resolve any management issues. The Service Review meeting gives the Executive members of the organisation the opportunity to discuss and resolve staff management issues as they arise.

Three recruitment groups operating within the PCT, covering both Learning Disabilities and Community Services, monitor a wide range of operational and strategic issues e.g. recruitment and retention issues, vacancy management and the results of targeted recruitment campaigns and job fairs.

The main mechanism for reporting activities and outcomes is through the HR activity reports. In addition specific HR reports are provided to the Board as appropriate, examples include reports on Improving Working Lives and the Staff survey.

The PCT has a well-defined process of progressing staff management information up through the organisation from first level management, through Services Managers to the Directorate Service Review meeting, and then for the whole PCT, to the Board.

7.3 Please describe briefly any areas in your PCT that:

Are particularly difficult to staff:

The PCT currently have difficulty recruiting to some areas of Learning Disabilities, in particular Health Care Support Workers. In Community Services there has been a long-term problem with recruitment to trained Nursing posts in Community Hospitals. These difficulties reflect problems being experienced nationally. There is also a problem particularly in Gosport recruiting health visitors.

Particularly attract staff:

Conversely, the PCT has had no difficulty recruiting Health Care Support Workers to the Community Hospitals in Fareham and Gosport. Any advertising results in acceptable levels of response from candidates, reflecting the excellent reputation of both hospitals within the local community. The locality OT service has also had extremely good recruitment results.

7.4 Please describe briefly either one or two examples of joint planning and recruitment of staff with other local PCTs, social services or other organisations.

Workforce Development Confederation

The PCT works closely with the recruitment lead for the Hampshire and Isle of Wight Workforce Development Confederation who is co-ordinating recruitment projects in the area. As part of this activity the PCT took part in a national 'Jobshop' campaign with other local PCTs and Trusts and have worked on cross-county, joint advertising campaigns to raise awareness of job opportunities within the NHS. The PCT has appointed the first member of staff recruited through the 'Jobshop' campaign. Personnel team members are involved in a countywide recruitment network. The PCT is a member of the Local Workforce Reference Group, whose role is to ensure the collaboration of local NHS PCTs and Trusts. This group has a key objective to develop joint workforce planning across the local health economy

Partnership Manager

The PCT jointly with Hampshire County Council and East Hants PCT has recruited a Partnership Manager. The role is to facilitate effective joint working between the PCTs and Hampshire County Council.

The Partnership Manager is a member of PEC and has an open invitation to Executive Team and PCT Board meetings. From April 2004 the PCTs and Hampshire County Council anticipate employing a second partnership post.

7.5 Please describe briefly either one or two examples of workforce planning by the PCT.

Workforce trajectories were recently produced as part of the Fareham and Gosport Local Delivery Plan. The PCT has a number of Recruitment groups that focus on workforce planning, identifying recruitment gaps and finding a means to fill the gap.

Workforce projections are produced on a monthly basis for Community Hospitals (example attached). These were established as a result of difficulties in recruiting staff for community hospitals, and the need to plan the recruitment cycle particularly that of overseas nurses. The projections are sent as a monthly report to Service Managers, and have also been reviewed and discussed at a monthly recruitment and retention group. This is now disbanded and will be picked up at quarterly service reviews.

The PCT liases with the WDC to maximise any involvement in cross-county recruitment initiatives and has taken advantage of widespread advertising campaigns on behalf of the H&IOW health economy. The underlying principle is that anyone who expresses an interest in working for the NHS is routed to an organisation that has the type of role the individual is seeking.

7.6 Please describe briefly the PCT managed systems and processes for staff appraisals, including how appraisals are linked to the PCT's clinical governance objectives. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The Personnel Director is accountable for the development of the PCT managed systems for staff appraisals, whilst Executive Directors are accountable for the delivery of appraisals and Personal Development Plans within their own directorate. The Personnel Panel is the PCT's accountable committee.

The Appraisal and Personal Development Policy was reviewed in October 2003; this sets out the process for the delivery of effective appraisals and PDP's.

Appraisals and PDP's for all staff is identified in "Working Together for our Future Health" as a key priority for the PCT. Appraisals and PDP's are part of the business planning process as detailed in the PCT's Business Planning Cycle.

The Executive Team identifies the Business Plan. Teams in each Directorate identify their priorities and objectives from the Plan and translate into Team objectives and priorities at Team away days. Individual objectives and priorities are established though individual appraisal meetings and are monitored through regular supervision meetings.

A recent initiative has been the creation of Personal Development Portfolios for all staff. A copy of the appraisal policy and the planning cycle for appraisals and personal development plans is included in the portfolio. The portfolio also provides a means for staff to keep their training, professional development and appraisal documents together for reference. The launch of the portfolios has been communicated through the Team Briefing process that cascades information from the Executive Team down through the management structure of the organisation.

The overall responsibility for monitoring appraisals lies with the Personnel Director. Each Director is responsible for the delivery of objectives and priorities within appraisals. Managers are responsible for recording the outcome of the appraisals that have been completed within the PCT. The Personnel team is formulating a managed system that will allow the PCT to review the appraisal process and undertake PCT-wide reporting. The recent NHS staff survey showed that 77% of staff had received an appraisal in the last year.

The mechanism for monitoring appraisals include team meetings, regular supervision and a culture within the PCT that encourages all teams to have time out to plan their objective and priority setting.

Line mangers are responsible for evaluating the outcomes of team meetings and supervision. The results are fed back through the management reporting system and where appropriate action takes through the Policy and Procedure for Managing Poor Performance.

The reporting process for appraisals will be through the Quarterly Service Review process. As the PCT has not yet been through a full cycle since the launch of the Appraisal and PDP Policy there is no opportunity to present the outcomes at Service Reviews but it is envisage that it will provide a valuable mechanism for Directors to focus on the outcomes of the appraisal process.

IPR's and Supervisions in many areas are well developed
Training and Development plans linked to clinical governance service objectives

7.7 Please describe briefly the PCT managed systems and processes for supporting personal development plans (PDPs), annual appraisal and revalidation for GPs, including how appraisals are linked to the PCT's clinical governance objectives. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The Head of Primary Care is responsible for the above. She is supported by a Clinical Governance Manager who coordinates General Practitioners' Appraisals, whilst the PCT Clinical Governance Lead receives the Form 4s and Personal Development Plans that are produced from these appraisals. The PDPs are fed into the PCT educational process via the GP patch tutor. Updates from the appraisal process are reported to the Clinical Governance Committee. The appraisal process will form part of GP's revalidation and this is being highlighted to them in their appraisal correspondence.

All Principal GPs were expected to, and have been, appraised during 2003/04. Non-principal GPs are being included from 2004/05.

PDPs and form 4s are sent to the Clinical Governance Lead GP for the PCT. These are read and the anonymised PDP sent to the GP patch tutor for F&G. The PDP areas are themed, prioritised and fed into the educational process of the PCT. GPs are responsible for ensuring they are revalidated with the General Medical Council (GMC), therefore the PCT is only responsible to put in place processes and systems to ensure that revalidation is achieved.

The GP Clinical Governance lead is responsible for ensuring that this process is robust and that all GPs are appraised throughout Fareham and Gosport. An update is provided to him at regular intervals regarding this progress.

The GP Clinical Governance lead is responsible for ensuring that the content of form 4s and PDPs is sufficient to inform the educational and revalidation process. He is in regular contact with all the F&G appraisers to ensure that they are confident in their abilities to appraise and support the GPs who are being appraised.

Updates from the appraisal process are given at the Clinical Governance Committee whose minutes are reported to the Board. Each General Practice has a Clinical Governance Lead GP. These GPs have been involved in discussions regarding how to implement the appraisal process and are attending a workshop in March to review the first year of appraisals and consider how to build on its successes in the second year.

7.8 Please describe briefly the PCT's arrangements for dealing with poor performance among community health service staff (e.g. district nurses, therapists etc). In particular what arrangements has the PCT for remedial education, support and monitoring for poorly performing professionals.

The PCT employs a number of mechanisms for dealing with poor performance. For minor performance issues managers will informally discuss these with staff during their regular supervision or one to one sessions. This would usually be the first stage in dealing with a member of staff whose is under performing in an aspect of their work.

If, after initial discussion, there has been no improvement the line and personnel manager will arrange for a performance management meeting with the individual. The purpose of this meeting will be to identify the area/s of poor performance, discuss the reasons for this and produce a performance plan to support the member of staff to improve. The performance plan will include targets and details of support required to enable the individual to improve performance, this may be on the job training or more formal training or updating sessions as appropriate. Progress will be monitored regularly to identify improvement. If after this process performance has still not improved, action may be taken under the disciplinary policy.

The PCT has recently developed a Performance Policy that is going through a process of ratification. It will shortly be distributed to all policy folder and communications made to staff.

The above is in conjunction with individual supervision and appraisal.

7.9 Please describe briefly the PCT's arrangements for dealing with poor performance among independent contractors (e.g. GPs, dentists etc). In particular what arrangements has the PCT for remedial education, support and monitoring for poorly performing professionals.

There is a policy in relation to poorly performing doctors, which is supported by the local PCTs and the Local Medical Committee.

At a less formal level the appraisal process is seen as the main mechanism for dealing with poor performance.

In relation to remedial education support and monitoring the GP tutor, Clinical Governance lead PEC Chair and LMC might all be involved. GP appraisal is well advanced with all principals having undertaken the process, and currently work is underway to develop the themes arising from these appraisals into a Training Plan for the coming year.

The PCT employs the GP tutor for two sessions and this role can be made available to doctors requiring support. The Clinical Governance lead for the PCT would also anticipate being informed where poor performance was picked up. The other ways in which poor performance might be identified are through complaints or concerns being raised by a GP's colleague.

7.10 Please describe briefly any cases of staff or independent contractors who are currently suspended or subject to investigation. (Please do not identify individuals by name).

The PCT has no current internal investigations or staff who are suspended. However a police investigation is underway at Gosport War Memorial Hospital including staff from both nursing and medicine.

7.11 Please describe briefly the induction arrangements for new members of staff (employed and independent contractors).

Induction arrangements are clearly described in the PCT induction policy. It is the manager's responsibility to devise an individual induction plan for all staff. Key elements of

an induction are identified in an induction checklist that is returned to personnel with the signature of the manager and employee.

A new starter pack is provided to all new employees, this pack is explored with the new member of staff on day one and may take up to a month to complete, this pack includes:

Staff handbook
Contract of employment
P46
Occupational Health information including the PCT Employee Assistance Programme
Information on staff discount scheme and lottery
Bullying and harassment at work guidance
Local Induction checklist

The PCT has 2 induction programmes.

The 2-day induction for community and headquarters staff includes:
Introduction to the PCT
Training and development
Personnel policies and procedures
Occupational Health
Health and safety
Risk management
Food hygiene
Basic life support
Control of infection
Equality and diversity
Data protection
Complaints, fire regulations, IWL, unions and fraud awareness.

The Learning Disability Service has a 3-stage induction process.

1) The Trust induction checklist (as above)

2) Local Induction - each house/team with the Learning Disability Service has a 'local' induction pack that they will use with all new members of staff, this will include all of the information/details that the staff require to work in that area.

3) Learning Disability Service Induction (one-week duration) - a summary of the content of the course is as follows:

Introduction

Training and Development Portfolios
Introduction to the service
Philosophy and what is a Learning Disability
Sensory Disabilities
Autism
Roles and Responsibilities
Health and Safety, and Employment awareness
Occupational Health
General Fire Safety

Data Protection
Basic Food Hygiene
Epilepsy
Abuse Awareness
Communication
Food and Nutrition
Moving and Handling Unit 1 and Unit 2
Basic Life Support
SCIP training

Independent contractors have their own induction arrangements but Practitioner Patient Services Agency Winchester have all initial contacts providing all necessary information. Dental Practitioners also are provided through Post Graduate Education a course on General Dental Services (GDS) organised through the Southampton Assistant Post Graduate Dean. (MS)

7.12 Please describe briefly the PCT's arrangement for providing staff and independent contractors with access to occupational health services. Please clarify whether this service includes independent contractors and their practice staff.

All staff have access to an Occupational Health Department, provided by a local NHS Trust, under the terms of a Service Level Agreement. Personnel leads and Service Managers are responsible for monitoring the Service Level Agreement through a Pan PCT group. This service also includes the use of a comprehensive Employee Assistance Programme that extends to family members.

The EAP recently underwent a tendering review process to ensure that it met the needs of staff and represented good value for the organisation. The PCT renewed the contract with an independent provider (Wright Corecare) for the provision of this comprehensive counselling and support service that also includes a critical incident support service and decided through and evaluation process that the existing provider demonstrated an excellent service compared to other organisations.

General Medical Practitioners are provided with a limited range of occupational services through the occupational health service. It is a service for employment and long-term sickness. CoreCare a telephone help service, provided for all Trust staff is also provided for General medical Practitioners in Gosport. This is a confidential service and the activity is only provided in usage. Clinical Governance improvement expected is a less stressed GP workforce.

7.13 Please describe briefly the PCT's arrangements for checking the registration and qualifications of all clinical staff in both community health services, specialist provider services and among GPs and dentists (e.g. bank/agency staff, locums etc).

Registration and qualification checks are part of the PCTs pre-employment checks. The Computerised Personnel Information system used by the PCT allows a notification to be raised that a member of staff is approaching the expiry date of their professional registration. This flag generates a letter that will be sent out to the person concerned and their manager will also be notified of the event. The Personnel have produced a desktop procedure as a result of an internal audit and will be incorporating the procedure into the next review of the PCT's Recruitment and Selection Policy and Procedure.

An integral part of our Service Level Agreement with Nursing Agencies who provide staff is that they will carry out these checks on our behalf. The development of NHS Professionals as a provider of bank nursing staff has incorporated the need to have the same level of screening and monitoring.

The PCT currently manages the Health Professional Alert Letters distributed by the Department of Health on behalf of GP, Nursing Homes, Dentists and Opticians within the catchment area of the PCT.

The objective is to ensure registration with the registering body. The Patient Practitioner Services Agency Winchester organise the process. There is assurance that no single contractor is able to have access to an entry on the Fareham & Gosport list of independent contractors. All independent contractors provide original registration forms and these are checked against the relevant national registering body list. (MS)

7.14 Please describe briefly how the PCT communicates and monitors compliance by staff and independent contractors with its human resources policies, including equal opportunities, race relations and human rights.

A list of Personnel policies is given to new staff at the induction, and a Personnel Manager briefly explains the list and what is available in the staff handbook. A number of revised policies, including Whistle Blowing and Appraisal and Development have recently been relaunched. Pamphlets giving an overview of these relaunched policies have been issued to all staff by attaching them to payslips. Policies are reviewed through a Pan PCT Policy Group. During 2003 the majority of policies within the PCT underwent a full review. The Policies were relaunched in new files to ensure that all staff was aware of them. There is a robust system in place with numbered files being issued to specific members of staff who have responsibility for maintaining them.

In addition, there is routine monitoring of sickness absence and disciplinarians in progress which goes to the Trust Board. Staff surveys also give an indication of understanding of policies.

Strengths and weaknesses

7.15 Please describe briefly one or two examples of what the PCT considers to be best practice in respect of staffing and staff management. Please also describe briefly what arrangements are in place to spread these examples of good practice across the PCT.

Staff Survey

The first staff survey undertaken by the PCT at the beginning of 2003 indicated that there was a small group of employees within the PCT who considered that they were being bullied or harassed within the workplace. As a result the PCT instigated a series of training events to raise awareness of how to manage and deal with this type of behaviour. The initiative resulted in the provision of a regular course being delivered through the Training and Development Shared Services department and Personnel Managers providing training for teams when the need was identified. The result of the training has been to reinforce the positive culture of the organisation, provide a healthy working environment for employees and thereby improve the care given to patients/clients. The benefits of running the course

have proved invaluable to managers and staff alike and the success has encourage others throughout the PCT to improve the effectiveness of their teams by utilising the course.

Personal Development Portfolios

The production of a PCT Personal Development Portfolio came about as a result of the development of a new Appraisal and Personal Development Planning Policy. The portfolios were seen as a means of demonstrating the organisation's commitment to the Appraisal and PDP process and were fully supported by the Chief Executive. The initiative was linked into the PCT's 5 year strategic plan, set out in 'Working together for our future health', which identified eight priorities for the organisation. Priority three aims to ensure that the PCT will be 'a valued employer and contractor with staff who are trained and supported to provide patient focussed care in new ways and settings...'. The Portfolio was devised by the Personnel team and will be issued to existing staff as well as newcomers to the organisation. It is anticipated that this tool will prove useful to employees to record elements of their employment and development activity, their personal learning activities and their achievements as well as being a receptacle for important information and documents. The release of the portfolios was publicised through management teams and then distributed across the PCT.

Annual Award for Excellence

The PCT introduced an "Annual Award for Excellence " awarded to individuals and teams in four categories. They are Partnership working/ collaboration, Improving services for patients, Improving working lives for staff and Clinical excellence/ innovation. It is intended that this initiative will continue each year and will provide an incentive for all employees in the organisation to seek out excellence and improve the patient experience. Individuals and staff groups are nominated by their managers and each nomination evaluated by a panel comprising Senior Mangers and Board members. It is hoped that by recognising the good work undertaken by employees during the year the awards will encourage all other employees to emulate the good practice and strive to improve their own work activities. The results of the award were celebrated by a dinner for the nominated employees where almost one hundred attended. The event and the winners were highlighted in the PCT's magazine 'NewsReach'.

7.16 Please identify the PCT's priority areas for developing staffing and staff management in the next 12 months.

- Sickness management – the PCT is running workshops, including staff side representation, to develop an action plan to reduce levels of sickness.
- Implementation of Agenda for Change/New Consultant Contract/new GMS contract
- Developing a workforce plan.
- Implementation of NHS Professionals.
- Implantation of IWL Action Plan.
- Developing an Equal Opportunities Strategy and implementing the action plan.
- Developing a stress Management Policy.
- Review the quality and provision of HR Performance Indicators.

8.0 Education, training and continuing personal and professional development

Name and designation of person responsible for completing this section

Name: **Jane Parvin**

Designation: **Personnel Director**

Name and position of the designated lead for education, training and continuing personal and professional development

Name: **Jane Parvin**

Position: **Personnel Director**

Is this a PCT lead or board level lead? Co-opted Board Member

8.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to training, education and continuing professional development.

Training and Development Services (TDSS) are provided by a central team based at St James Hospital. The department is a shared service with East Hampshire and Portsmouth City PCT's and is hosted by Fareham & Gosport PCT. The total budget is £180,992, of which the Fareham and Gosport element is £56,100. In addition to this TDSS hosts, on behalf of the three PCT's, two Hampshire & Isle of Wight Workforce Confederation (WDC) funded posts; a Practice Development Facilitator and Life Long Learning Facilitator, funded at £60000. A key function of the department is the provision of a range of internal courses as outlined in the TDSS annual activity report.

The WDC fund annually a number of schemes that support professional development, continuing education and training as follows: -

Salary support for Pre-reg training, Public Health BSc,	
Enrolled Nurse Conversion	£85,364
Foundation Degrees	£3,560
National Vocational Qualifications	£33,220
Individual Learning Accounts	£14,980
Training & Development Programme	£115,500
Post Qualification AHP programme	£4,400
Post Qualification Nursing training	£70,000
The majority of services have training budgets totalling	£90,000
Total Costs for the ICON Centre 2002/03	£47,398

Funding for IT training courses through an Service Level Agreement 2002/03 £21,000
2003/04 £28,000

8.2 What other resources does the PCT make available for professional development and continuing education and training (e.g. libraries, learning materials etc)?

Library Services, provided by Portsmouth Hospitals NHS Trust. Local bench libraries based at St Christopher's and Gosport War Memorial Hospital.
Learn Direct Centre based at central training and development department (TDSS), St James Hospital.
ICON Learning Centre based at Gosport War Memorial Hospital (see 8.14)
TARGET programme for Primary Care
Personnel Department have a range of learning materials for providing education and training on Personnel Policies e.g. Harassment & Bullying, Appraisal and Personal Development Planning.
The ICT Department provide a programme of training activities, (a break down of activity is provided in the training activity report).

All staff have access to a Life Long Learning Advisor (a joint post managed under the TDSS Service Level Agreement), who provides support and advice on the range of training and education opportunities from mandatory and core skills training to continuing professional development.

Staff who do not have a professional qualification have access to an Individual Learning Account.

8.3 Please describe briefly the PCT's managed systems and processes for supporting education, training and continuing professional development among community health service staff for example district nurses, therapists, etc. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The Personnel Director is accountable for the development of the overall framework for the managed systems and processes. The strategic approach to training and development is outlined in the HR Strategy. A key priority for the PCT is the production of a written training and education strategy.

Each Executive Director is accountable for the organisation and delivery of training and education within their own directorate. In addition each Director has an identified lead responsibility, i.e. Clinical Governance, Communications, for which they are responsible for identifying priorities and coordinating training and development across the PCT.
The system and process for the planning and delivery of training and development is part of the PCT Business Planning cycle, as outlined in the HR Strategy and Appraisal and Personal Development Policy.

A PCT Training and Development Group was established in 2002, chaired by the Nursing and Clinical Governance Director, membership includes service mangers, TDSS representatives and Personnel (terms of reference attached). The PCT Training and Development group reports to the Personnel Panel, a sub panel of the Board. The Personnel Panel is the committee accountable for scrutinising the managed systems and processes.

Training needs and priorities are determined in a number of ways e.g., personal development plans, team away days, mandatory training requirements, service specific developments (as outlined in the business plan) and training identified in the annual

clinical governance, HR and communication plans. To support this process a number of services have training and development groups/forums, for example Children's Services and Learning Disability Services. The majority of services have annual training plans examples include Physiotherapy and Learning Disabilities.
The PCT has identified the need to develop a framework that coordinates this process into the production of an annual training plan.

Executive Directors are responsible for communicating priorities and plans across the PCT, Service Managers within their services. This is communicated via a number of mechanisms for example the PCT and service specific Training and Development Groups, Team Meetings, Executive Team Meetings, monthly Briefings.

The Personnel Director is responsible for the overall monitoring of processes and activities. This is conducted in a variety of ways: -
The TDSS Service Level Agreement is monitored quarterly at a Pan PCT meeting which is chaired by the Chief Executive of the PCT. In addition TDSS provides an annual report.
TDSS provides quarterly monitoring data as outlined in the Service Level Agreement.
The PCT has an annual partnership agreement with the WDC; this is monitored by the WDC on a quarterly basis via the provision of monitoring data, which is discussed at a meeting with representatives of the PCT and WDC.
The PCT is represented at a Pan PCT group, which monitors the provision of the Southampton University post qualification courses.
Personnel record mandatory training on the Integrated Personnel Computerised system (IPS), both the recording and monitoring of this system is currently being reviewed.

The outcome of the above monitoring is a regular agenda item for the Training and Education Group.

Internal audit have devised a plan of internal audits that audit systems and process including Training and development. In 2002 an audit was undertaken of training and development, this resulted in an action plan, progress of which was reported to the PCT audit committee.

Evaluation occurs on a number of levels as follows: -

Each training activity should generate a T1 form, the prime function of which is to facilitate an evaluation of outcomes of the learning activity, of which the Line Manager is responsible for undertaking in conjunction with the individual. There is currently no mechanism for monitoring whether this evaluation occurs, however, during the review of the Appraisal and PDP policy members of the training and development group identified the T1 system as a valuable tool to aid evaluation.

Post course evaluations are completed by all participants attending TDSS courses at the time of course completion. These are reviewed on a course by course basis and feedback incorporated into future course structure where appropriate. An earlier manual system was replaced (w.e.f. 1 November 2003) to permit easier access to this data through the use of a dedicated database. Three months after the completion date, a questionnaire is sent to the participant and her/his Line Manager requesting feedback on the effects of the training course. This information is currently reviewed manually and feedback incorporated into future course structure where appropriate.

The Training and Education Group receives regular reports on the range of activities, including the TDDS annual training report. Copies of the notes are forwarded to the Personnel Panel, which is a sub panel of the Board. The Trust Board does not receive regular training reports. However, details on training activities will be contained within various reports, for example the training activity associated with the Gosport War Memorial Hospital action plan.

8.4 Please describe briefly the PCT's managed systems and processes for supporting education, training and continuing professional development among independent contractors e.g. GPs, dentists, etc. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The post of Training Adviser for General Practice (hosted by Fareham and Gosport PCT) acts as a central co-ordinator for education, training and CPD for nurses, managers and admin staff employed in general practice in Fareham and Gosport, East Hants and Portsmouth City PCT's.

The post holder devises a training programme every quarter based on demand (knowledge of which is gained from questionnaires sent to managers); priorities from the PCT's; priorities from central government (for example from the new contract). The program is entirely flexible, in that if a need arises mid-quarter, training is commissioned to meet that need.

The quarterly training calendar is then sent in hard copy to every practice, Practice Nurse Trainers, and Education Leads within the individual PCT's. Copies are also available electronically. We are currently moving towards being able to publish the calendar on the Internet. Any updates or amendments are then sent electronically to all parties.
Bi-monthly meetings with Practice Manager representatives, Primary Care heads in the PCT's, and the Training Manager and Adviser are held to discuss the training programme and priorities, and to resolve any issues that have arisen. The PCT is kept up to date by email and telephone on any themes that emerge.

At the end of every quarter, a report is sent to each of the PCT's detailing attendance on training by course and practice, as well as a breakdown of reimbursement for the quarter.
Each delegate on a course commissioned or run by TDSS has an evaluation form at the end of the course, as well as a post course evaluation (which is sent to the delegate and the manager three months after the course has ended). The feedback from the evaluations is then analysed internally, changes are made as necessary to the content and delivery of the training, and the data is then made available to the PCT's.

A proportion of practice nurse training is funded by the WDC. An induction programme, with a self-assessment competency framework, is available to all practice nurses, which again will identify any training needs.

A GP tutor has been appointed and links to the Deanery.

TARGET's protected training time is established in Portsmouth City PCT, and is currently being implemented in Fareham and Gosport PCT.

8.5 Please describe briefly arrangements for working with NHS, non-NHS, and academic partner organisations to support education and training initiatives.

NHS Partners

East Hampshire and Portsmouth City PCTs

There is close liaison and cooperation with these PCT's; this is facilitated by a Pan PCT Training Group.

Portsmouth Hospital Trust

Co-operation between Portsmouth Hospitals Trust and TDSS is established and continues to be embedded more strongly. TDSS represents the PCT's on the PHT Nursing & Medical Education Committee and there is close co-operation in regard to contacts with the Universities at Bournemouth, Southampton and Portsmouth and the Open University in regard to pre-registration training, post qualification courses, Foundation degree and sponsored training.
This includes joint induction and information sessions for pre-registration nursing students.
Co-operation through the Life Long Learning Advisers and Clinical Placement Liaison Officers is also well established.
Joint e-learning initiatives have also been undertaken.

Workforce Development Confederation

- The PCT agrees an annual partnership agreement with the WDC, which is monitored on a quarterly basis.
  Links are also maintained through the Southampton Post Qualification Operational Group with NHS organisations throughout H & IoW through the WDC.
  The posts of Life Long Learning Adviser and Clinical Placement Liaison Officer are placed within TDSS on behalf of the three PCT's and TDSS has membership of the relevant WDC committees.

- The PCT has worked with the WDC to support the development of a School Of Health Professionals Complimentary To Dentistry. This should enable the local area to benefit from well-trained dental nurses, at a higher level than currently and promote the role of therapists in general dental practice and the community dental service.

NHS Direct

Links are established which have resulted in the sharing of experience and the exchange of training programmes e.g. handling difficulty situations.

Non-NHS Partners

In Fareham & Gosport, links are established with the Gosport ICT UK Online Group with the PCT established as member through the development of the ICON Centre.

The support of UNISON and other trade union partners is actively sought and the partnership with UNISON Lifelong Learning Advisers continues to develop. Linked to both UNISON and the WDC, partnership working with the WEA also continues to develop.

Academic Partners

Southampton University Health Care Innovations Unit – Joint appointment of Team Development Facilitator.

In addition to the links with the Southampton and Bournemouth Universities, which are predominantly concerned with the management and operation of WDC contracts, a strong link exists with PIMHS at Portsmouth University. This is evidenced through both the Foundation degree programmes and the Continuing Education Contract.

Further Education

Links are established through NVQ programmes and others with the following local Colleges of Further Education:
Basingstoke College
Fareham College
Highbury College
Portsmouth College
South Downs College
St. Vincent's College

8.6 Please describe briefly how the PCT monitors and reports on staff attendance at internal and external training courses.

Departmental managers keep an individual staff record of training and development activities. The TDSS department provides a quarterly list of attendees of all courses it provides/organises.

Any DNA's are monitored by TDSS; this generates a letter to the manager of the person requesting a reason for the non-attendance. The non-attendance is also recorded against the individual REGISTRAR record.
The collated information is provided to each PCT as apart of the quarterly reports.

8.7 Please describe briefly what action the PCT takes if a member of staff persistently fails to attend arranged training sessions.

Managers are informed by training and development if a member of staff fails to attend a training session. Repeated non-attendance may be dealt with under the Disciplinary procedure.

8.8 Please describe briefly how the PCT ensures cover for frontline staff to enable them to attend professional training and education events.

Cover for frontline staff attending training and development activities rests with departmental managers. This may involve the use of bank agency cover or use of excess hours from part time staff.

There is some allowance for training built in to establishments.

8.9 Please describe briefly any training initiatives in managing equality and diversity within the PCT, including that received by the PCT board.

A Diversity awareness-training course is currently provided by the Training and Development Service. The Equality and Diversity focus group are currently planning a series of further training sessions, including a training event for the board in February.

8.10 Does the PCT have access to NHS library services? If so at which NHS trust, and what is its latest Helicon accreditation rating?

All PCT staff has access to a comprehensive range of library and information services provided by Portsmouth NHS Library Service. Portsmouth NHS Library Service is hosted by Portsmouth Hospitals NHS Trust and access for PCT staff is formalised in a Service level Agreement. The Library Services is to be accredited in February 2004 and we anticipate a level 2 or level 3 rating.

8.11 Did the NHS library Helicon accreditation find that the libraries resources in terms of budget, staffing and IT access to be adequate?

We await the results of the Helicon accreditation but do not anticipate problems in these areas.

8.12 Which PCT staff groups have access to library services?

All PCT staff groups have access to library services.

8.13 Did the Helicon accreditation find that library users had access to electronic resources, document delivery services, reference and enquiry services, and stock lending, reservation and renewal?

We await the results of the Helicon accreditation but under the terms of our Library Service Agreement, library users have access to all the above.

Strengths and weaknesses

8.14 Please describe briefly one or two examples of what the PCT considers to be best practice in respect of education, training and CPD. Please also describe briefly what arrangements are in place to transfer these examples of good practice across the PCT.

Lifelong Learning Advisor

A Lifelong Learning Advisor has recently been appointed to the PCT. An Information Technology Access Centre was recently opened at Gosport War Memorial Hospital.
Nurse in community hospitals undertook the erotological-nursing programme.
Clinical supervision structures are developing in most service areas.

The object was to increase the amount of training available to staff in the F&GPCT area by providing them with the facilities to study and an advisor to access information concerning learning and development.

All staff within the F&GPCT area has had access to the Learning Advisor as well as the Icon Centre, including Health Centre Staff, local GP practices and three hospitals, Gosport War Memorial Hospital, Haslar Hospital and St Christophers. Also staff located within the learning disabilities locations within F&GPCT. The project is aimed at all staff from the GP's, Support staff, Catering, Estates Management and the contracted Cleaners and Porters. Nursing staff, including Midwives and Health Visitors are also included in the meetings as well as Dental Nurses within the F&GPCT area, OT's and Physios.

IT Facilities

Access to IT facilities have allowed ECDL courses to run as well as Getting Started and Introduction to Word and the Internet. It has also allowed access to the courses offered by the local further education providers, St Vincent's College, Fareham College, South Downs College, Chichester College, Highbury College and Portsmouth College as well as Portsmouth University and Southampton University. We have also provided funding for staff to participate in further education by offering the Individual Learning Account, which is £150.00 per year for staff who either do not have a professional qualification or who are not using one. This has led to a very positive take up of ECDL courses, as well as the Individual Learning Accounts, which means that a lot F&GPCT staff have been able to take up the further education courses offered by the above locations.

An increase in the amount of IT skills acquired is one of the many positives outcomes of the Icon Centre, as well as an increase in staff morale due to having the funding in place to study a course that is of a personal interest to them, such as a hobby or learning a new skill or language. A better-developed workforce should lead to improved patient experience.

8.15 Please identify the PCT's priority areas for developing education, training and CPD in the next 12 months.

Monitoring and recording of mandatory training
Production of a PCT annual training plan, which links training and development to the Local Delivery Plan/Business Plan/Improvement Plan. Training and Education strategy.
Manual Handling Training Review

9.0 Use of information

Name and designation of person responsible for completing this section

Name: **Chris Tite/Fiona Cameron / Mike Wagg**

Designation: **Director of Nursing & Clinical Governance**

Name and position of the designated lead for clinical information management

Name: **Alan Pickering**

Position: **Director of Finance**

Is this a PCT lead or board level lead? Board

9.1 Please describe briefly both the financial (budget) and staffing resources that the PCT allocates to information technology (IT).

a) IT:

Salaries		
0.80 Wte	PRIMIS Facilitator	£26,384
0.80 Wte	Public Health Analyst	£17,912
0.50 Wte	Information Analyst	£12,583
2.1 Wte	Total	£56,879

b) Information analysis:

Information and IT non pay costs

Normal Roll Over Budget	£112,311
2003/04 Development Costs	£ 84,557
Extra PC's 2003/04	£ 15,647
	£212,515

9.2 Please describe briefly the PCT's managed systems and processes for information communication and technology (ICT). [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The Director of Finance is accountable for the managed systems and processes associated with information, communication and technology.

An SLA is in place with Portsmouth Hospitals Trust and a named lead individual links to the PCT.

The service reports quarterly to a district group with representatives from the PCTs and monitoring takes place in this forum in relation to the SLA.

At PCT level reporting is through the Operational Management Team and the named link.

A revised Information Communication Technology strategy is being presented to the PCT Board in March 2004.

9.3 Please describe briefly one or two examples of how the PCT is developing the use of clinical information in order to improve services in community health services (e.g. district nurses, therapists etc).

The PCT has routinely provided Korner data to clinicians many of whom use 'light pen' data collectors.

The data is not viewed favourably by staff.

As a consequence the information team is commencing a piece of work with all community service managers to improve both data collected and produced.

9.4 Please describe briefly one or two examples of how the PCT is developing the use of clinical information in order to improve specialist clinical services provided by the PCT (e.g. community paediatrics, mental health etc).

CAMHS Identifying Priorities to support the commissioning of CAMHS.

The purpose is to use a priority-setting framework developed in the PCT to support the development of a more robust model of service for the commissioning of CAMHS. This initiative involves PCT commissioning team. Public health and the CAMHS consultant lead and team.

This work is currently underway and includes the following:

- Analysis of current activity
- Rapid review of effectiveness evidence
- Identification of clinical decision-making and diagnosis models

The outcome will be the development of a more robust service specification by the PCT to facilitate more effective management of service demand.

9.5 Please describe briefly one or two examples of how the PCT is developing the use of clinical information in order to improve services among independent contractors (e.g. GPs, dentists etc).

GPs – Anonymised Practice data, extracted from clinical systems for the purposes of PRIMIS, is used, with the signed agreement of all Partners, to determine disease prevalence figures locally, to assist in justifying or challenging drug usage figures, and to investigate unexpected variations. Data is passed to clinical specialist groups, such as the CHD Collaborative to assist in their work.

9.6 Please describe briefly either one or two examples of how the PCT involves different types of clinical staff in improving the quality and use of clinical information in order to improve services.

Use Of Clinical Information.

The PCT has routinely provided community contacts data to clinicians many of whom use 'light pen' data collectors.

The data is not viewed favourably by staff, as it does not reflect the quality and totality of their work.

As a consequence the information team is commencing a piece of work with all community service managers to improve both data collected and produced.

9.7 Please describe briefly either one or two examples of how the quality of patient care has improved as a direct result of PRIMIS facilitators or other IT / information initiatives working with general practices in the PCT.

PRIMIS – 17 out of 21 Practices have so far been brought into the PRIMIS scheme. The remaining four are progressing more slowly due to the type of clinical data system in use. Practices are reporting that the services provided under PRIMIS are of benefit to both Practice staff and patients. In particular, patient care is improved by the identification of those who belong on one or more Disease Registers. The data queries search the patient records for associated drug or monitoring codes where no diagnosis code exists and the resulting list of patients is reviewed by clinical staff to determine whether in fact they should be on the Register and therefore be correctly managed. The typical numbers being found by these data queries represent 10% of the existing register on average. So, for example, if the CHD Register contains 300 patients, there will be approximately 30 patients found who have associated codes but are not on the Register. This represents approx 6000 patients to be reviewed across the 21 practices and 10 Disease Registers.

9.8 Please describe briefly the PCT's managed systems and processes for ensuring that employed staff are aware of and comply with Caldicott. [NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

The PCT Clinical Governance lead (GP) is also the PCT Caldicott lead and is a member of both the PEC and Trust Board.

A Calidcott group has been established chaired by the Calidcott lead with representatives from both primary and community services.

National guidance drives the process locally and an audit of compliance was undertaken in 2003 in relation to primary cure. The audit will also be undertaken across community services in 2004.

An action plan was produced and is monitored via the Caldicott group, which is a sub group of the Clinical Governance Committee.

9.9 Please describe briefly the PCT's managed systems and processes for ensuring that independent contractors are aware of and comply with Caldicott.[NB Please refer to CHI's guidance above on how to structure your answer on your managed systems and processes.]

See 9.8

9.10 Please describe briefly the PCT's arrangements for sharing patient information with social services (e.g. around joint provision of health and social care etc).

The development and implementation of Information Sharing across the county is being led by Hampshire Children and Young People's Strategic Partnership (CYPSP). The CYPSP is a multi-agency group which will be accountable for delivering improved joint services for children, young people and their families. Representation includes:
HCC - councillors, Social Services, Education, Youth Services
District / Borough Councils
Primary Care Trusts
Strategic Health Authority
Connexions
Children's Fund
Early Years Childcare Unit
Drug Action Team
Community and Voluntary Sector

There is a sub-group of the CYPSP, the Information Sharing Strategy Group tasked with producing a strategy that will be acceptable to all groups and will be implemented across Hampshire. Consultation and multi-agency workshops are currently being held and this will be followed by a communications programme to include roadshows, a website and newsletter. The CYPSP is aiming for initial implementation of the information sharing protocol by the end of March 2004, with guidance for all who will need to use it. In the interim, a briefing document has been produced and distributed to all agencies explaining the process and the rationale behind the production of the document.

9.11 Please describe briefly either one or two examples of the electronic transfer of patient information between the PCT and secondary care providers (e.g. acute general hospitals, mental health providers etc).

PAS Merger

The objective was to create a single community-wide secondary care activity database by merging the Community Information System used by the PCT's provider services to record inpatient, outpatient and community-based nursing and therapy activity with the Patient Administration System (PAS) used by the local acute trust, Portsmouth Hospitals NHS Trust (PHT).

All hospital ward, outpatient clinic and community-based PCT clinicians and support staff. The initiative has delivered:

- Reduced data input time due to shared patient demographics data.
- Improved data quality.

- Potential to improve PCT management reporting through shared data flows / reporting mechanisms.

Clinical governance improvements due to the initiative have been

- Reduced clinical risk through improved data quality
- Reduced clinical risk through increased certainty of having details for correct patient
- Access for clinicians to information on the treatment of individual patients from other sectors

Pathology Test Requests & Results Pilot/Roll-Out

The objective was to pilot the ability for GP practices to electronically request pathology tests and receive results directly into their practice computerised patient records. If successful, to rollout to other practices.

Staff involved include Acute trust laboratory staff and 18 GP practices:

Outputs have been:

- Reduced time waiting for tests to be carried out and results received.
- Improved data quality – the following summarises the improvements against manual data entry achieved in the pilot:

On request forms	Type of form % complete	
Data item	Manual	ICE
NHS Number	49%	100%
Surname	100%	100%
Forename	100%	100%
Date of Birth	100%	100%
GP name or code	90%	100%
Location	99%	100%
Date of collection	59%	81%
Clinical Details	98%	100%
On Apex compared with request form	% data item missing	
Data item		
Missed NHS number at data entry	19%	0%
Incomplete C.D. due to illegible handwriting	3%	0%
Incomplete C.D. on Apex	2%	0%
Mis-typed C.D. at data entry	2%	0%
Mis-typed address at data entry	2%	0%
Different address on Apex to form	3%	0%
Mis-typed Postcode at data entry	5%	0%
Missed postcode at data entry	6%	0%
Missed Tests Requested on Apex	1%	0%

- Timesavings for laboratory staff in inputting data.

In terms of clinical governance improvements

- Improved clinical prognosis due to faster test results turnaround.
- Reduced chance of error over patient identity due to legible text on request.

9.12 Please describe briefly the PCT's arrangements for ensuring patient consent. In particular describe the arrangements for minors and patients who have guardians (learning difficulties, mental health problems etc)

- The national guidance on consent is currently with local services. The model policy is being individualised for each service including Children's services and Learning Disabilities. The team development facilitator will be working with teams to support implementation.
- In the Learning Disability Service consent is frequently discussed in team meetings to ensure raised awareness among all staff regarding the issue with this client group. A variety of methods are used to ensure consent to treatment. In particular the issue could be raised in individual case conference sessions, adapted communications around particular topics e.g. screening and management of desensitisation programmes. The Learning Disability Service have amended the National Guidance to meet the needs of their service.

Strengths and weaknesses

9.13 Please describe briefly either one or two examples of what the PCT considers to be best practice in respect of its use of clinical information. Please also describe briefly what arrangements are in place to spread these examples of good practice across the PCT.

Lessons learned from data extracted under the PRIMIS scheme. Where it is recognised that a Practice has notably high levels of completeness, accuracy and consistency in their clinical data, with the consent of the Practice, the system templates, protocols, training and processes are offered to other practices either through the PRIMIS facilitator or via PCT-led specialist groups such as Local Implementation Teams.

9.14 Please identify the PCT's priority areas for developing clinical information in the next 12 months.

The local PRIMIS scheme is due to continue until May 2005 within the PCT, although the future of the National project is a little uncertain as the Service in it's current form is due to terminate in July 2004 and is out to tender Europe-wide. Since the voting in of the new GMS Contract, the local PRIMIS programme has been condensed to ensure that all 21 practices have been visited and the Data Quality queries run where possible to establish a base line across the board. Whilst work will continue with all practices, those in the most need based on the completeness and accuracy of their Disease Registers will be specifically targeted, the aim being to bring all practices up to a consistently high standard of data quality. This work will be supported by the provision of templates and data analysis tools recently developed by Clinical System suppliers. The developments within the National Programme for IT (NPfIT) will be monitored to ensure that the right focus is maintained.

10.0 Overall strengths and weaknesses

a) Strengths

- Development of a PPI Framework and action plan, including Board approval during 2003 for additional resources to facilitate strategic and operation delivery.
- Commitment and a culture within the PCT at all levels to engage in Clinical Governance Development.
- Clinical Governance systems and processes, in particular the PCT Clinical Governance Development Plan and the provider service clinical governance development plans which informed it.
- GP personal development and support including GP appraisal, appointment of a GP tutor and TARGET days.
- Robust incident reporting and monitoring including critical incident reporting.

b) Weakness

- Need to invest more work in the development and implementation PPI at an operational level during 2004.
- Lack of PCT supported clinical governance systems and processes in all independent contractor services.
- Need to develop clinical audit systems and processes to meet clinical governance requirements locally and nationally
- Develop systems to enable use of clinical information.

Name and designation of person responsible for completing this section

Name: **Ian Piper**

Designation: **Chief Executive**

Any other comments you wish to add...

Thank you for taking the time to complete this questionnaire.
Please return to cgr.trust@chi.nhs.uk