Fareham and Gosport PCT
Evidence Base

June 2004

Evidence Base

Patient Experience

Report	Pre Review Week Evidence	Review Week Evidence
Patients told the Healthcare Commission that staff in both community and primary care treated them with courtesy and respect. The Healthcare Commission also met many staff committed to providing high standards of care.	Sample stakeholder comments: Receptionists are very helpful. I feel the doctor listens to me. Staff in surgery efficient and polite GP is very supportive Receptionists tell you if there is going to be a delay. I feel my doctor listens to me he is very supportive of my husband and offered to arrange care for him when he came out of hospital. I would like to praise the work of the community nurse- she is very caring and nothing is too much trouble. Some of the nurses at the acute trust are hostile and miserable. The staff at QA can't be faulted.	Review team observed staff being sensitive to patient needs

	Nobody wants to take responsibility at the QA. My husband went four days without a wash at the QA-they knew he was confused and answering inappropriately, but didn't do anything. We asked a nurse to clear my grandmother's throat and we got a very hostile response. We felt we could not approach the staff, they even started telling us not to visit. Physiotherapist was very good GP was wonderful-he diagnosed pneumonia. He knew our concerns about QA and tried to get her admitted elsewhere but couldn't. Can't complain about my GP services.	
Some general practices are making efforts to improve privacy for patients in reception areas for example, telephone calls can be made in a separate area and waiting rooms are separated from reception areas.		Observed during review week.
In community hospitals staff provide patient focused care. Patients are dressed in their own clothes, and the activities coordinator provides a range of activities on either a one to	Job description of activities coordinator	Observed by review team during review week.

one basis or in groups. Patients are given a choice regarding the type of food available, and are given assistance to eat their meals. There are appropriate facilities and welcoming environments for clients with learning disabilities. Staff are aware of the need of promoting individual clients' independence through patient centred care planning.		
The PCT performs well in terms of recent outpatient and inpatient waiting time figures. Recent figures indicare tht 86% of the PCT's outpatients were seen within 13 weeks, rising to 99.9% at 21 weeks. This is higher than the respective England averages of 79% and 99%. The PCT also performs well for inpatient appointments with 60% of patients being seen within three months rising to 89% at six months.. This is significantly better than the respective Engand averages of 58% and 84%.	During Quarter 2 2003/04, 86% of the PCT's 7,353 outpatients were seen within 13 weeks, rising to 99.9% at 21 weeks, significantly better than the respective England averages of 79% and 99.0% (Table 8.1b) During Quarter 3 2003/04, 60% of the PCT's 3,546 inpatients were seen within three months, rising to 89% at six months, significantly better than the respective England averages of 58% and 84% (Table 8.2b)	
In contrast the PCT performed less well in terms of waiting time to see a healthcare professional and underachieved in one of the key targets for the 2002/3 star ratings namely access to a GP. Patients told the Healthcare Commission	According to the National Patient Survey 2003, the PCT ranked within the worst performing 20% of trusts nationally in terms of waiting time for a	The appointments system was not working well. They did an audit and changed the system so that people could book only

they had no problem getting an urgent appointment, but the waiting time for non urgent appoinments for patients to see their own GP ranges from two days to three weeks. The PCT has also developed a range of initiatives to encourage female clients to attend the breast screening service	nationally in terms of waiting time for a GP appointment, waiting time to be seen by a health professional (in the GP surgery), and waiting time for a dental appointment (10.10.02) Fareham and Gosport PCT was awarded two stars in CHI's 2002/03 star ratings. The ratings contain nine key targets, of which the PCT achieved eight and significantly under achieved in relation to one, namely 'Access to a GP' (**www.ratings.chi.nhs.uk**) Sample stakeholder comments: Easy to get an appointment with the GP-I have rung on the day and managed to see him. It has taken me 3 weeks to get an appointment with my ownGP –it its an emergency you can be seen on the same day. Difficult to get a GP appointment –was told we would have to wait 2 week to see my GP. Have to wait 5-6 days if you want to see	one week ahead. Every day extra appointments were made available so that anybody who urgently needed to see a doctor would not have to wait more than 48 hours. After that had been working for a while it was audited and there was much satisfaction and a positive response. The staff found it a good team building exercise and the new system has been running for 2 ½ years TQ Staff told review team about how they had implemented the national guidance on this.

	your own GP. To get an emergency appointment you have to turn up at certain times of the day.. Can usually get an appointment within – 4 days. Sometimes you have to wait a couple of weeks to see your GP. Only thing I'm not sure about is what GP I will see every time I visit.	
A few patients commented on difficulties in accessing an NHS dentist. The PCT is aware of this, and is working with other PCTs and local dentists to improve access for example through the Dental Access Centre which provides emergency treatment and information about accessing ongoing dental treatment.	Sample stakeholder comments: NHS dentist is not available, have to go private. No NHS dentists in Fareham My son has an NHS dentist but I have to go private. There is a lack of NHS dentists- I have one but some of my family have had to go private. NHS dentists are not available.	Review team visited dental access centre.

	Need more dentists in the area as there are lots more houses being built Used to have an NHS dentist but they have now gone private and I have decided to stay with them. I couldn't find an NHS dentist in Gosport so I have to go to Cosham.	
For clients with learning disabilities the PCT provides health/health residential care, social care, respite care and residential, assessment and community health care services.	PCT questionnaire PCT presentations	
Patients commented positively on the environment in primary and community healthcare premises, and the Healthcare Commission found a good standard of cleanliness in premises visited. General practices have toilet facilities, baby changing facilities and disabled access.	The PCT has been awarded the two tick disability symbol (1.1) The PCT's annual report states that many general practices have undertaken a disability discrimination access survey in the past 12 months (1.1). The PCT states that it has received a number of comments from individuals via its public board meetings. As a consequence of comments the chief executive of the PCT has written to the chief executive at PHT outlining	Observations during review week There is a ramp outside to make disabled access available The location of disabled parking was just over the road from the car park but somebody with a sticker would be able to park on the double yellow lines outside the building Footpaths to the premises wide enough for wheelchairs and prams Disabled and mother and baby parking spaces are clearly identified at front of premises

	concerning regarding cleanliness. In addition, the district clinical governance committee has been working on a series of quality standards with PHT. Evidence has been supplied to support this statement (TC2, AD69, AD70). **Sample stakeholder comments:** Haslar is very clean whereas QA isn't. QA-the general air of the hospital is dirty. The surgery is clean GP premises are clean and comfortable Surgery premises very clean, tidy good disabled access. The room at the QA was dirty, there were needles on the floor. There are toilet facilities in the surgery and they are clean. When my son was in the A&E at QA the cubicle was dirty, there was blood on the floor and plaster of paris on the bed. QA hospital-cleanliness is disgusting. In	Practice, There were adequate toilets available including two disabled toilets, one female, one male GWMH-clean patient areas and kitchen. Looked like it had just been refurbished. Waiting room for relatives with toys for children. Wards were tidy.

	the patients toilet on E ward towels and flannels were on the floor and two urine samples –these were left there for 4-5 days.	
The staff at St Christopher's Hospital provide high standards of care but this is compromised by the building which is old and not built for purpose. The PCT is currently considering proposals for relocating the hospital to an alternative site/sites to ensure care is delivered in an appropriate environment.		Observed during review week and evidence from interviews A few staff raised concerns about the relocation of St Christopher and felt it would split up a good team.
There is a planned programme of work to improve accommodation for clients with learning disabilities.	Evidence from interviews during stakeholders. TQ	
The patient environment action team (PEAT) look at a range of cleanliness issues including wards, reception areas and corridors. Hospitals are awarded a traffic light colour to denote a good (green), acceptable (amber), or poor (red) performance. During 2003 two sites within the PCT received green ratings and one site received an amber rating.	During 2003, three sites within Fareham and Gosport PCT were rated, with two receiving green ratings, and one, St Christopher's Hospital, receiving an amber rating (Table 11.1	The food is reported to be very good in a recent PEAT report. Review team told that St Christopher's is very clean, has excellent nursing staff and it is the building which lets the whole operation down The ward was very clean and tidy
The PCT is engaged in a Local Implementation Finance Trust initiative (LIFT) This work is being carried out in partnership with East Hampshire PCT and will enable the	PCT questionnaire	Staff reported that they are involved in the lift initiative by means of the user

partnership with East Hampshire PCT and will enable the PCT to develop services/buildings in appropriate locations	PCT presentation	
Overall the PCT exhibits lower mortality rates for all ages when compared to the England and Wales average. Breast screening rates for women aged 53-64 years (screened in the past 3 years) is 79.06%, this is higher than the Hampshire and Isle of Wight Strategic Health Authority, and England rates. The PCT also performed better than the national rate for all types of child immunisation.	Fareham and Gosport PCT performed better than Hampshire and Isle of Wight SHA and England in terms of breast screening in the past three years, with its performance being over three percentage points above both comparator figures (Table 7.6a) Fareham and Gosport PCT exhibits an all age mortality rate of 93, significantly lower than the England and Wales rate (Table 7.1a) The PCT exhibits significantly low mortality rates for six indicators compared to England and Wales; Coronary Heart Disease (CHD), All Cancers, Lung Cancer, Bronchitis and Emphysema, All Accidents, and Suicide and Undetermined (Table 7.1b).	

Patient, User, Carer, Public Involvement

Report	Pre Review Week Evidence	Review Week Evidence
The joint directors of public health are the board leads for patient user carer and public involvement, supported by two non executive directors and the patient and public involvement manager. The PCT has developed a strategic framework and action plan for patient and public involvement. The PCT's commitment to improving patient and public involvement is also reflected in the 2002/03 annual report, local development plan and the business plan, all contain key targets for patient and public involvement.	The PCT states that management accountability for patient and public involvement (PPI) is with the director of public health. The PCT notes that 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 (TQ 3.2). The community hospital states that the director for public health is responsible for patient and public involvement across the PCT (CHQ1.3.1, CHQ2.3.1). The PCT states that the join director of public health is the board lead (TQ 3.0). The PCT notes that although it has nominated the director of public health to take the executive board lead for patient and public involvement, supported by two non executive directors, the organisation has no dedicated operational management	2nd Jan 2003 PPI Strategic framework.

	dedicated operational management resource to ensure the co-ordination, further development, delivery and monitoring of strategic action plans for patient and public involvement (3.1). The PCT states that the PPI and communication manager (1 WTE) appointed 1/8/2003 (TC1). The PCT has provided its strategic framework for patient and public involvement (January 2003). It outlines the timescales and progress to date in implementing the national initiatives for reforming the way in which patients and the public are involved in Fareham and Gosport (3.1). The PCT's annual report 2002/03 states that the PCT has produced a strategy for encouraging the wider involvement of patients and the public (1.1). The PCT's annual report 2002/03 states that the PCT has several priorities in the coming months which includes: 1) Communicating the vision clearly with the local communities	

	2) Holding regular board meetings in public and developing a programme to maximise involvement 3) Responding to and learning from all complaints 4) Working closely with the local patients' forum (1.1). The PCT states that its key priorities for 2003/2004 PPI action plan, include the following: expansion of PALS service; implementing the national patient survey; reviewing carer/patient involvement in planning structures (LITS/DITS); development of PCT website; expansion of expert patient programme and sustain staff engagement/communication mechanisms (TQ 3.12). The PCT's public, patient involvement action plan for 2003-2004 sets out a number of priorities for action in relation to user involvement in planning and service development (3.2.1). The PCT notes that a PPI steering group has been established as a sub	

A patient and public involvement steering group has been established, and is responsible for strategic planning and reporting patient, user, carer and public involvement activity to the board. Membership of the group includes representatives from the practice managers forum, but has yet to include patient and public representatives.	committee of board to oversee the strategic development and performance monitoring of the PPI agenda	Staff reported the PCT PPI steering group involves directors of public health from the PCT. This committee also has one non-executive director, the chair of the patients' forum Otherwise at present no user membership → check ≠ Martin Staff reported the PPI Steering Group is the main committee. There is no patient/public representation on the committee ?
There is patient representation on the local implementation teams for the national service frameworks for older people, coronary heart disease and diabetes. The learning disabilities service has user and carer representation on the local implementation group and partnership boards and there is also public representation on the clinical governance committee	The community hospital states that currently patients are involved in essence of care groups (CHQ1.3.1, CHQ2.3.1). The PCT notes that learning disabilities local implementation group has user and carer representatives. There is also involvement from users and family carers on the learning disabilities partnership boards (TQ 3.2).	Some staff reported there are user and carers on the essence of care groups. The hospital actually appoints the user and carer onto this group. There is a user on the PEAT action group Staff reported there are patients involved in the National Service framework LIT for elder people". There are some patients involved in expert patient programme, e.g. Parkinson's

	partnership boards (TQ 3.2). The Audit Commission's audit on fitness for purpose 2002/03 stated that robust planning mechanisms are established involving local stakeholders (1.15.1).	patient programme, e.g. Parkinson's patients. Staff told the healthcare commission there are patient representatives on all local implementation teams and stakeholder workshops have been held to plan services Interviews with staff and member of the public on the clinical governance committee.
Some stakeholders raised concerns about the planning of future services and the level of public involvement in the discussions. The PCT is addressing this through a series of public meetings prior to the statutory consultation. This involved commissioning an independent survey asking people their views on local services and if they are interested in being involved in planning local services. From the survey the PCT has developed a database of	The PCT states it is currently engaged in a major public process in relation to the planning of future services for Fareham and Gosport. This builds on previous public engagement in relation to Royal Hospital Haslar and Healthfit. In addition, there was patient and public involvement in the development of the intermediate care strategy. The PCT have provided evidence to support this	Staff reported the PCT commissioned a Mori poll t to ask people how they felt about local health services, especially access to local services. One thousand people were surveyed. People were asked would they be interested in helping the Trust to plan future services. Approximately 680 people responded that they would. The PCT has now set up a database

people who are willing to be consulted and involved in service development.. Examples of changes to services as a result of patient and public involvement to the appointment system in a general practice and development of a support group for families with children who have diabetes.	have provided evidence to support this statement (TC2, AD 71, AD 72, AD 73, AD 74, AD 79, AD 80). Some stakeholders commented that they didn't know if any consultation about QA has taken place. Additional information sent re; survey in learning disabilities.	with the information of all these patients. They will form part of a citizens panel. The PCT will now use the citizens panel to ascertain their opinion of any strategic development or commissioning issues Staff reported that the PCT is a very open organisation and has consulted with the public about the reconfiguration of services ahead of the statutory consultation. Interviews with staff. Staff reported that funding had been obtained to set up set up a meeting for the families of diabetic children. Out of this has come a group called Seahawks A survey was conducted with patients about the appointment system and made a changes as a result of responses. It was a good team building exercise for all staff.

In learning disabilities a service user survey, was undertaken in 2003.	The PCT has undertaken a service user survey, 2003, for Teekew care and support service. The stated aim of the survey is to obtain feedback from users about the services they receive and use this to shape services for the future. The results of the survey are analysed for three areas: Portsmouth, Havant, and Fareham and Gosport. It notes that areas for improvement include supporting communication issues, providing the right level of support relating to the use of money and helping to maintain links with the families. An action plan for incorporating these results into service provision is not included (AD109) The LBHU states that all services in the learning disability service use questionnaires. The service managers are responsible for ensuring implementation and co-ordination. The questionnaires are sent to all family carers and next of kin and then returned for analysis. Positive feedback was shared with staff teams and individuals	Staff told reviewers that input of service users was discussed in the running of the unit and as they have transient clients there isn't any direct process to look at this in a wider planning environment, but at the end of each admission they send out an evaluation questionnaire that the client and carer do return and they try to act on the responses. Responses include they would have liked to have access to television; they would have liked to have access to free drinks. They try to consider this with further future admissions

Links and support for GPs, dentists, optometrists, and pharmacists to develop systems to involve patients and public involvement is limited.	shared with staff teams and individuals and where areas of concern were noted or further information was required, this was followed up and actioned (LBHU 3.2). Response to GP/dentist/optometrist/pharmacy questionnaire indicates that patient and public involvement is not well developed.	Few examples of patient and public involvement. Staff reported there are no formal for patients to feedback within GP practices. Little evidence of how the PCT is supporting them. The pharmacy services have had a patient satisfaction survey conducted by the prescribing adviser for the PCT. The issues that this survey highlighted were in relation to confidentiality Staff reported that work with dentists is in the early stages. Staff reported that only a few GP practices had received visits from the complaints manager.

Information leaflets are available about services and medical conditions, and specific information is available for clients with learning disabilities. Staff also have access to translation services.	The PCT provides the following example of how it caters for the needs of individuals whose first language is not English: language line, which was launched in Fareham and Gosport GP practices in September 2003, is a telephone based interpreting service operating 24 hours a day, with unlimited and immediate access to professional, qualified interpreters in 100+ languages (TQ 3.8). The PCT states that most provider services within the PCT have information for patients, specific to their service area e.g. district nursing, health visiting and school nursing. In addition the PCT website has just become live (TC2, AD 78).	Leaflets observed in sites visited. Staff reported they have access to an interpreter service for non-English speaking patients and believe this service is accessible and works fairly well There are advice leaflets for patients, which are in a draft format at the moment, which have been produced As yet, patients and GPs have no input into the content of these leaflets. However, it is intended that they will do prior to the leaflets being printed Staff reported. there is now a pack at the end of each patient's bed for users and carers to use, which gives information about the doctor on the ward, what time ward rounds are, how to access facilities in the hospital
The Patient Advice and Liaison Service (PALS) is hosted by East Hampshire PCT and is based in the acute trust. A	The PCT states that it has a PALS service hosted by East Hants PCT (TQ 3.6).	A few staff mentioned the PALS service, that it was running through

feedback facility on the PCT's website has recently been developed. Quarterly PALS reports are sent to the patient and public involvement steering group.	The PCT states that it as part of a shared process to develop PALs. PALs is hosted by East Hampshire PCT (TC1).	Portsmouth Hospital , but didn't know anything else about it. Staff reported that the PALs service has been live just over one year and the co-ordination arrangements are hosted by East Hants PCT. Website checked.
The complaints manager is responsible for complaints relating to services provided by the PCT, and second stage complaints fro general practices. The complaints manager works closely with the PALS manager. The PCT has a complaints policy, and the clinical governance committee and board receive quarterly complaints reports. There are mechanisms for sharing learning from complaints at a local level in the PCT. Dentists, optometrists, pharmacists and GPs have their own systems for managing complaints.	63% of pharmacies that responded have a written complaints procedure for patients (PQ). The PCT's PPI baseline questionnaire noted that all respondents were aware of, and had encouraged patients to use the complaints services as a means of registering their concerns, although learning disability prefer to deal with issues directly, and older persons' service say they have never needed to direct patients to complaints (3.3.1). The PCT provided a copy of it complaints office procedure in relation to verbal and written complaints (3.8.1).	Review team observed information about how to complain and in some areas where information was not available staff were able to describe the process for making complaints. "Information about how to complain or comment is clearly displayed on a leaflet on which mentions PALS and other avenue". Staff reported that complaints are shared at team meetings.

	The PCT states that it complies with the national complaints requirements. Priorities are set via national guidance and driven by specific local focus. For example, complaints manager working with training and development regarding training in complaints (TQ 3.6). The PCT's annual report 2002/03 states that the PCT will publish an annual review of complaints and comments showing how services have changed (1.1). The PCT complaints system covers all provider service complaints including Learning Disability Services. In relation to contractor services the PCT has a responsibility for management only at the second stage. However, an annual report of Family Health Services complaints is compiled each year (TC2, AD77).	
Complaints awareness is included in the corporate induction programme. The PCT also provides	The PCT states that a collaborative training package has been initiated by the PALS service and local complaints team and has been developed by the	Staff reported they had received training on customer care and managing complaints and that it is included in the induction programmes

communication skills training for staff in general practices. The PALS manager is developing a training package and the learning disabilities service provides training on the use of sign language and picture symbols.	team and has been developed by the district training and development team. Its purpose is to: raise awareness of PALS/complaints processes and to increase the understanding of customer care (TQ 3.5). The PCT states that a PCT policy and information leaflet is available in all departments. Complaints awareness is a feature of induction (TQ 3.6). The PCT's national patient survey action plan states that training is provided for GP surgery receptionists to work sensitively with patients with disabilities, but limited take-up. Also, training in human communication skills is offered for all practice staff (3.4.1). The community hospital states that all newly appointed staff attend a two day induction programme, which includes customer care and complaints management training which enables them to appreciate needs of patients as individuals and identify potential complaints from issues and concerns raised by patients, carers or relatives	included in the induction programmes Training awareness events have been held in relation to PPI Staff also reported that PALS training is being developed and a bid has been put in for PPI training, training in customer care and complaint handling.

	(CHQ1.3.3, CHQ2.3.3). The LBHU states that it is developing communication skills for people who are learning disabled. The objectives are to increase staff awareness of communication systems; implement appropriate communication systems; increase communication training for staff and the development of a communication assessment tool including dictionaries. Communication training is provided on induction courses. Training is on the use of Makaton and picture symbols (LBHU 3.3).	

Risk Management

Report	Pre Review Week Evidence	Review Week Evidence
The PCT has a risk management strategy outlining the roles and responsibilities of staff and the risk management process. The director of finance is the board lead for non clinical risk and chairs the risk management committee. This is a sub committee of the board and has links with the audit and assurance committee and clinical governance committee through shared membership and minutes. The director of nursing and clinical governance is the board lead for clinical risk, and the risk and litigation manager supports and co-ordinates risk management activity. There is some evidence of integration of risk with other areas of clinical governance for example complaints.	The board approved the risk management strategy in March 2003. The strategy provides very detailed information on the staffing and committee responsibilities of risk management (5.2) The risk management committee was established in July 2002. It is chaired by the director of finance and is attended by representatives from all the PCT services, "including primary care" (5.1, TQ 5.2) The PCT states that risk management development is featured in the PCT CG development plan 2004/05. The PCT has provided evidence to support this statement (TC2, AD83, AD84, AD85, AD86).	Staff reported that there is pro-active approach to risk management exists. A risk management group feeds into the clinical governance arrangements. The group is multi-disciplinary and meetings of the group go through risk returns and analyse lessons to be learned Staff reported the committee is chaired by the director of finance. It meets every two months and has many standing items, controls assurance, the insurance framework which is linked to the director of finance's remit, they do performance indicator reporting quarterly to the Board from the risk management strategy, there's the Risk Register, there's emergency planning. The membership includes a PEC nurse, one GP from the Fareham practices and one GP from the Gosport practices, and the Risk Management Committee shares

		members between itself and clinical governance, for example Staff reported the meeting notes are shared between risk management and clinical governance, and the Health and Safety Committee minutes also go to clinical governance Risk Man Cttee.
Non clinical incidents are reviewed at the health and safety committee and reported to the risk management committee, and clinical incidents are discussed at the clinical governance committee. Risk management issues are reported to the board via performance reports and quarterly incident and complaints reports.	Quarterly incident and complaints reports are sent to the board (TQ 2.3, 5.1) The PCT states that a quarterly report on the PCT's response to complaints are produced (TQ 5.7) The local LHBUs have a system in place for reporting serious incidents. The clinical manager reports the incident to the service manger sends detailed information to the risk manager, occupational health and personnel. The operational director then sets up a critical incident review which feeds its findings to the chief executive and the	Staff reported that clinical risk is discussed predominantly in clinical governance and that non-clinical risk is with at the Risk Management Committee. The incident and complaints report and trends analysis are reported to the clinical governance committee and board. & RM Cttee

	findings to the chief executive and the strategic health authority (LHBUQ 5.2) Quarterly incident and complaints reports are sent to the board (TQ 2.3, 5.1) The PCT states that a quarterly report on the PCT's response to complaints are produced (TQ 5.7) The complaints manager generates an annual report which also goes to the board (TQ 5.7) The PCT states that 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. Potential claims are included in the board report, but less detail is provided (TQ 5.7).	
A clinical incident and medications error review group has recently been established, and reports to the clinical governance committee and the risk management committee.	Minutes of February 2004 meeting received.	Staff reported this group has recently been established.

this includes a checklist for Clinical Risk.

committee.		
The PCT has a risk register which is reviewed by the risk management committee, the majority of risks are non-clinical and it is unclear how clinical risks are incorporated onto the register.	The risk register lists over 400 potential risks. It describes the risk and gives a reference (5.4.5). The Audit Commission's audit on fitness for purpose 02/03 stated that risk management and controls assurance arrangements are in place and need further development. 1.15.1	Staff reported that the Risk Register is on Ulysses and it wasn't quite clear on the content. There are 400 items on the register, but these appear to be from health and safety assessments, not clinical risk assessments. Clinical issues are thought to be picked up through the quarterly incidence reporting which comes from Ulysses, which logs clinical incidents and gives information on trends, for example, infection control
Currently there is a single reporting form for clinical and non-clinical incidents and information from incident forms is held centrally on the PCTs database. The PCT is developing an adverse incident form to meet the requirements of the National Patient Safety Agency. This is being done in partnership with other PCTs. It is intended this form will be used by GPs, dentists, optometrists and pharmacists.	The PCT states that it 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 for reporting the outcome of the incident (TQ 5.4,	The PCTs are working to develop an adverse incident form based on NPSA which has had input from pharmacists and dentists though this is not yet in use. Staff reported that a single form is being developed.

Staff demonstrate a good knowledge of risk issues and the reporting system and feel there is a fair blame culture in the PCT. Some staff are also recording incidents in the PCT event book.	5.5). The PCT states that one of its aims is to develop risk management systems and processes in primary care and to roll out the new adverse incident form	Staff said they are encouraged to report events such as difficulties in accessing GP out of hours. Form is filled in which goes to Head Office. Severity of incident is graded. Staff reported that complaints and risks, and untoward incidents are brought to the clinic effectiveness group. Issues, which are addressed, are such as staffing and staff training Staff described a critical incident which had happened. A form was filled in. There was a meeting within a few days. She said people feel freer to express themselves. There is a culture of taking more responsibility but not taking the blame Moving and Handling Course - the person doing the course encouraged the nurses to keep sending in incident

		reports where the incident could have been avoided with better equipment. This helps to press the need for better equipment Staff said they were encouraged to use the incident forms there is "100% support and a fair blame policy". A few staff reported they do not always have time to complete the Incident book, as they're sometimes too busy There is a PCT risk events book which they use. They fill this in, in discussion with their manager. There is a Trust-wide incident report book where all incidents are reported
Many GPs, community pharmacists, dentists and optometrists are signed up to incident reporting and have their own systems for reporting and analysing incidents. However they do not routinely send incident reports to the PCT or share learning from incidents.	Questionnaires indicate that they have their own systems for risk management. 79% of dental practices felt that risk management was well developed. The PCT states that one of its aims is to	Staff commented that incidents that occur within GP practices are managed within the practice, rather than reporting them to the PCT. However, the PCT should be satisfied that there is this process in place for

	develop risk management systems and processes in primary care and to roll out the new adverse incident form. 37% of pharmacies and 58% of optometrists felt that risk management was well developed.	the monitoring investigation of incidents Staff reported that critical incidents are handled differently by different pharmacists and although they don't currently share this information between themselves the clinical governance facilitator with their agreement can use incidents as learning in a non-attributable manner. Staff reported that with regard to critical incidents reporting, they are going to have quarterly meetings on non-urgent cases, they feel that it is sufficiently important to have regular meetings, but on important critical incidents they'll have a separate one-off meeting. They have had a meeting recently and found it particularly useful. Staff commented that GPs do not routinely share information with the PCT, they are not required to at the moment. The independent contractors do not

		report to risk management, but practice managers can contact the PCT for help and support
There are some systems for disseminating information about risk management including a newsletter titled "Risky Business". Some staff groups including health visitors and physiotherapists have developed systems for sharing learning from incidents. Changes to practice have been made following incidents, for example a review of the storage system for some medicines and flooring replaced in some patient areas and the appointment of a pharmacist to the community hospital.	The PCT states that as a result of incident reporting by nursing staff, a very old, constantly out of action patient lift, was taken out of commission. A new external ramp was built which enabled patients, relatives and staff to access the ward in safety (CHQ1 5.3). The PCT states that locally based hospital units purchased and installed ceiling track hoists after a review of the environment relating to patient needs. This resulted in safer handling and potentially less injuries (LBHUQ 5.3). The PCT has provided examples of improvement in quality occurring as a result of risk management activities (TC2, AD81, AD82). A patient on a palliative care regime died after a nurse administered a drug after misreading a chart. The PCT investigated the incident and produced an action plan. This includes	Staff reported they had a critical incident about two months ago where a wrong injection was given and the reason related to the storage system and they have now changed that system From an environmental assessment, there were changes to provide resources to replace flooring and currently there is a proposal in, to change the environment in a kitchen and dining room all in one room to turn it into a partitioned kitchen with an area where clients can eat separately. This is deemed to be quite important for managing their clients, especially where at the moment, if they have a client who would be at risk for having cooking going on - e.g. throwing hot things - they have to prepare the food, put it away somewhere safely to keep warm, switch everything off, don't bring the patient in.

	an action plan. This includes competencies for different grades of staff. 5.7-5.73 TQ5.10 TC1AD23, 24,25,26 Induction programmes have been reviewed and all qualified staff undergo an annual medication assessment. CGQ25.3 All newly qualified staff are supervised for the first two weeks on drug rounds and new night staff have to spend time on days as part of their induction. TR1 TC1AD23, 24,25,26	bring the patient in. Other examples were given by staff in GP practices. Staff told the review team that a clinical services group also meets 6-weekly and reflects on clinical practice and the sharing of experiences and incidents - for example a Health Visitor experiencing a serious encounter at a home visit, discussion results in revision of the Lone Worker Policy. Staff told the review team that district nurses receive feedback on incidents reported on a monthly basis Some services have links with other similar units and are about to have a visit from staff to share and learn about a range of issues including risk Staff told the review team that the pharmacists' Clinical Governance facilitator is collating data relating to incidents and providing feedback to the pharmacists Risk issues identified in physiotherapy

		services are reported to the management Committee and also across the physiotherapy network Staff interviewed commented on the work of the hospital pharmacist.
Infection control polices are available for staff and infection control services are provided by the acute trust. The controls assurance for infection control and decontamination shows an improvement on last years assessment.	The infection control policy sets out mechanisms to ensure that appropriate action is taken to prevent, control and manage infection across primary care, secondary care and community services provided by the PCT. The policy also sets out how infection control support will be provided to independent contractors such as GPs, optometrists, dentists and pharmacists (5.9.39) The risk management annual report (October 2003) has an appendix that shows how the PCT's controls assurance scores for 21 standards along side the national average and two local PCTs (5.1, TC1) The PCT states that one of its aims is to improve controls assurance scores from	Staff reported there are structures in place in the practice for managing clinical waste and a Sharps injuries protocol in place Staff reported that infection control services are provided through an SLA with Portsmouth hospital Staff reported an improvement in the controls assurance for infection control and medical devices.

	last assessment (2002-03) (TQ 5.14).	
In line with national guidance the PCT has developed an action plan its child protection procedures. Training in child protection is provided by the named nurse for child protection for both primary and community care staff.	The child protection policy shows the symptoms that staff should look for and how they should respond. 5.8, 5.81.	Staff reported that the child protection management team has produced an action plan in response to the Climbie enquiry. This has been approved by the board. Staff reported that there is a named nurse for child protection and the director of public health is the board member responsible for child protection. Training has been provided for GPs and dentists as well as PCT staff. There is a large number of staff to train and only 10 training days per year.
Risk awareness sessions are included in the corporate induction and training in risk assessment is also provided. Both directly employed staff and staff in primary care have attended risk assessment training.	The PCT leads on risk assessment training for the local PCTs. By October 2003 86 staff had been trained as new assessors in seven training sessions (5.1)	Staff reported that training is available for dealing with aggressive patients Staff reported they had had training on managing complaints and risk assessment.

	Since February 2003 risk assessment training has been available for primary care staff (5.1) 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 folders (clinical, operational, personnel and occupational health) are stored in their department/ward (5.2, TQ 5.2) All managers are responsible for ensuring that their staff attend mandatory and statutory training (5.2). Risk assessment training info. AD28 Induction programme AD56	Training is also available in completing the risk forms

Clinical Audit

Report	Pre Review Week Evidence	Review Week Evidence
The director of nursing and clinical governance is the PCT lead for clinical audit. The PCT does not have a clinical audit strategy, and there is no systematic process for carrying out or reporting audits. However, proposed objectives for taking forward clinical audit are included in the PCT clinical governance development plan. There is a proposed list of audits for 2002/04, although it is unclear how this is monitored.	The PCT states that the lead for clinical audit is the director of nursing and clinical governance and is a co-opted board member (TQ 4.0). The PCT states that reporting mechanisms for clinical audit within both community hospitals are via the clinical governance committee, service review, PEC board and trust board (CHQ1 4.1, CHQ2 4.1, TC1). The PCT has provided minutes from the PEC meetings held between January 2003 and September 2003. It was noted that the data protection audit should include Caldicott issues (1.7.4). The PCT states that a priority area for improving clinical audit is the development of a strategy (TQ 4.9). The PCT's clinical governance annual report, 2002/03 includes the following clinical audit matters: 1) The structure, accountability and	Staff reported there is a need to look at clinical audit process. There is a willingness to deliver but they are unsure of the capacity to deliver.

	1) The structure, accountability and work 2) The future development of a clinical audit strategy 3) The implementation of the training action plan (2a.1). The PCT has a clinical governance development plan, 2003/04 which includes objectives for clinical audit (2a.2). The PCT has provided a proposed project priorities audit programme, 2002/04 which tabulates audits according to the clinical area and the topic that is being audited. The PCT has a draft set of objectives for the clinical audit, research and effectiveness committee (1.10.1). As part of its ToR.	
The PCT is aware that it needs to develop a more coordinated and integrated approach to clinical audit. In future the recently established clinical effectiveness group will be responsible for planning and monitoring audit activity, along with clinical effectiveness work and will report to the clinical governance committee. Currently there is little evidence of how clinical audit is integrated with other		Staff reported that the Clinical Effectiveness Group is now responsible for overseeing clinical audit. Staff told the review team that clinical audit happens, but there is no central

evidence of how clinical audit is integrated with other clinical governance activity.		system for recording clinical audit. Staff reported that terms of reference for the clinical effectiveness group have yet to be developed. The trust comments that the clinical effectiveness group and the NICE implementation group will develop the annual audit programme and monitor and evaluate action arising from individual audits (TR1).
There are limited examples of clinical audit being undertaken. In partnership with Portsmouth Hospitals trust the PCT undertook an audit to determine if women with learning disabilities had equal access to the breast screening service. This resulted in a number of recommendations being implemented including the development of a nurse with skills in working with clients with learning disabilities. An audit of compliance with the PCT policy for checking resuscitation equipment highlighted there was only 60% compliance with the policy. It also highlighted a lack of basic equipment in some areas. This has been addressed and a further audit has yet to be done to establish if practice has improved. The PCT has also	The PCT states that it undertook a joint audit with Portsmouth Hospitals NHS Trust to establish whether women in the learning disability service had equal access to breast screening services (TQ 4.6). The PCT states that it has participated in the national sentinel audit for stroke and will be re-applying to the programme (TQ 4.7). The PCT states that it undertakes a number regular audits such as the	Staff told the review team that an audit for Breast screening people with learning disabilities had resulted in a number of changes. Staff reported they are had been involved in the essence of care work. A few staff said that audit s were happening but were unable to give any examples.

participated in a national audit relating to stroke care. Some audit has been carried out through the Department of Health Essence of Care standards for example continence management and nutrition. Patients have been involved in this work. A baseline clinical governance assessment in community pharmacies has been carried out and action plans have been developed.	infection control audits at the community hospitals. CHQ1 4.2 Audit of compliance with policy for checking of resuscitation equipment.TQ4.5 A baseline clinical governance assessment has been carried out in community pharmacies. TQ Essence of care standards CHQ 2 4.2	
In general practice, audits have been carried out in relation to the national service frameworks for coronary heart disease and diabetes. There is some evidence of other audits being carried out in general practices but these are not reported to the PCT.	The Audit Commission's audit on fitness for purpose 2002/03 stated as a good practice point that the PCT undertakes annual coronary heart disease (CHD) and diabetes audits (1.15.1).	Staff reported that audit is included new contract she felt were extremely closely linked and integrated. More audit has been done in the last three months to come up with a baseline assessment, particularly in relation to financial incentives. Staff told the review team the appointments system was not working well. They did an audit and changed the system so that people could book only one week ahead. A few staff reported they had been

		Involved in several audits, one of these was related to reductions in blood pressure A thyroid audit carried was out and the computer system - was able to look at whether patients that were on Thyroxine had actually had their bloods taken and identified patients that hadn't. Although the formulary is widely used this has not been audited. Staff told the review team that PCT does not receive information about audits carried out in general practice.
The PCT is a member of the clinical audit network. Membership of this group includes other local PCTs and the acute trust.	The PCT states that works in partnership with the two local PCTs and Portsmouth Hospital on the clinical audit network group (TQ 4.8). The PCT states that representatives from all three PCTs and Portsmouth Hospitals trust contribute to the district clinical governance group which meets to determine district wide priorities for audit (TQ 4.3, TQ 4.8).	

There are no clear mechanisms for disseminating learning from audit and resources for clinical audit are limited. The clinical governance managers provide support and training on an ad hoc basis. Training is also provided by the training and development shared service, there is limited uptake of this.	The PCT notes that a priority area for improving clinical audit is the development of a mechanism for sharing audit results (TQ 4.9). The trust comments that quarterly training is provided through the TDSS and includes all staff. The trust comments that clinical governance managers also provide in-house training for services on request (TR1). The PCT states that a number of staff will have received training in clinical audit and effect under the auspices of Portsmouth Health Care Trust. Recording by the PDSS has been in existence since 2003 when new training commenced (TC2, AD87). Training records indicate that two staff have undertaken the achieving clinical excellence programme. FG Demand 03-04.xls	Staff said there were programmes available to support practices in disseminating information and training for IT and audits. EMIS user group had been set up, but they had not met for quite a while. Staff reported they were not aware of the structure that was in place to support audit or any training that was available A few staff said training was available if you wanted it. Other staff said they would contact the clinical governance managers.

Clinical Effectiveness

Report	Pre Review Week Evidence	Review Week Evidence
The PCT is reviewing and developing its systems for planning and monitoring clinical effectiveness. The clinical effectiveness committee has recently been established and will be responsible for implementing and monitoring clinical effectiveness work. The director of nursing and clinical governance is the PCT lead for clinical effectiveness.	The PCT states that the lead for clinical effectiveness is the director of nursing and clinical governance and is a co-opted board member (TQ 6.0). The PCT states that the clinical governance committee (CGC) is responsible for planning and priority setting for clinical effectiveness. The PCT notes that there is a clinical audit, research and effectiveness (CARE) group. A recently established NICE sub group reports to the CARE group and monitors the implementation of clinical effectiveness guidance (TQ 6.2, TQ 6.5). The PCT notes that all new developments are discussed and ratified at the clinical governance committee and if these are approved, they are reported to the professional executive committee (PEC) for approval (TQ 6.2).	Staff reported that the clinical effectiveness committee has been established and will be responsible for planning and monitoring clinical effectiveness work. Terms of reference have yet to be established. The committee is chaired by a non-executive.
Although the PCT does not have a strategy or plan for clinical effectiveness work there are a number of groups involved in clinical effectiveness work for example the	Minutes of physiotherapy clinical effectiveness meeting February 2004. Minutes of evidence based practice meeting	Staff reported that there is physiotherapy clinical effectiveness group. Staff reported that a clinical services group meets 6-weekly and reflects on clinical

physiotherapy clinical effectiveness group and the evidence based practice group.	March 2004 Nursing, children's services, physiotherapy and community hospitals have best practice/clinical effectiveness groups whose role is the sharing and dissemination of evidence best practice (TC2, AD88, AD89, AD90, AD94).	practice and the sharing of experiences and incidents - for example a Health Visitor experiencing a serious encounter at a home visit, discussion results in revision of the Lone Worker Policy
Improvements in services are also taking place through the implementation of the national service frameworks. Local implementation teams (LITs) are responsible for the coordination and delivery of the national service frameworks. Membership of the LITs includes managers, clinicians and there is also patient and public involvement.	The PCT's annual report 2002/03 states that stakeholders, partners, voluntary organisations and members of the public have helped in the planning following the release of the national service frameworks (1.1) The PCT states that it has local implementation teams (LITs) responsible for ensuring national service framework NSF targets are met (TQ 6.5). The Audit Commission's annual audit letter, 2002/03, noted that national service frameworks was rated as low risk due to the robust systems and arrangements which are in place (1.13).	Staff told the review team that there is public representation on the LITs and they are very active.

The PCT has recently established the NICE implementation working group. This group is responsible for reviewing and circulating NICE guidance to the appropriate LIT and reports to the clinical effectiveness committee.	A recently established NICE sub group reports to the CARE group and monitors the implementation of clinical effectiveness guidance (TQ 6.2, TQ 6.5). The PCT states that a sub group of CARE has been established to monitor the implementation of NICE guidelines (TQ 6.5, TQ 6.9). The NICE implementation group is a working group of the clinical effectiveness group, which is accountable to the clinical governance committee. New NICE guidance is retrieved weekly and reviewed monthly by the working group. It is then distributed to identified leads within the PCT. Progress monitoring is undertaken by the clinical effectiveness group; (TC2, AD88, AD89, AD90, AD94	A few staff reported that NICE guide lines are taken from the internet and there is also some helpful advice on the internet under sign guidance Staff reported that all NICE guidance are sent out to the Clinical Governance Leads in each practice. The PCT is at present not sure how the NICE guidelines are being actioned. The PCT is developing a clinical effectiveness database, which will include all the NICE guidance action plans and a process to monitor the implementation of the action plans. Staff reported that in future NICE guidance will be monitored by the clinical effectiveness committee.
There are examples of clinical effectiveness work. The district wide diabetes risk factor intervention to reduce vascular events guidelines (DRIVE) have been developed by a multidisciplinary team. . The prescribing team have implemented some projects to improve the quality and cost effectiveness of	The PCT has provided a pressure ulcer prevalence study report, October 2003. Outcomes of the study include an increased response rate, a decreased in the total prevalence of pressure ulcers and a high reduction of grade 3 pressure ulcers (6.4).	Staff reported they are using the DRIVE guidelines. Staff told the review team that women with learning disabilities can attend for pre visit and there is a process if they feel they can't complete the need for screening, A letter

prescribing including an electronic prescribing formulary and reviewing repeat prescribing with GPs. The PCT has also employed a clinical governance facilitator for community pharmacists. A booklet on breast screening information has been designed for clients with learning disabilities to encourage and support them to use the service. The department of elderly medicine has developed a fall service and appointed a falls coordinator. A pressure ulcer prevalence report shows a decrease in the prevalence and severity of pressure ulcers.	The PCT states that health protection nurses have visited many of the general practices to audit practice against essence of care guidelines and compile action plans for areas of practice that are sub-optimal (TQ 6.8). The PCT has provided examples of improvements occurring, and the dissemination of lessons, as a result of clinical effectiveness activity (AD91, AD92, AD93, AD95	goes back to the relevant community team who assess them, involve carers, GP's, psychologists, whatever they feel can be done to help prepare the woman to be successful and if that's process has gone through they'll then be rebooked. Booklet sighted by review team. Staff said they had received help with improving their prescribing practices.
Staff are using evidence based guidelines, however the system for approving and implementing guidelines is unclear. The PCT state that all new developments are approved at the clinical governance committee whilst other evidence indicates that the approval and dissemination of nursing guidelines is the responsibility of the strategic nursing network.	The PCT states that the following guidelines have been reviewed, disseminated and introduced into practice: 1) Management of the confused elderly 2) Fluid replacement in the elderly 3) Pain management (CHQ1 6.2, CHQ2 6.2). The PCT notes that all new developments are discussed and ratified at the clinical governance committee and if these are approved, they are reported to the professional executive committee (PEC) for approval (TQ 6.2).	Staff reported a number of revised guidelines in use around management of confused elderly, pain management and fluid replacement. Staff found the guidelines helpful Guidelines on sterilisation of equipment are available. The NHS guidelines for breast screening services have been implemented. Staff reported that guidelines at present are reviewed by the Clinical Governance

	approval (TQ 6.2). The PCT states that it has the following systems in place for the distribution, implementation and monitoring of evidence based practice: Nursing clinical guidelines – The strategic nursing network has developed an evidence-based proforma for nursing guidelines and is responsible for ratification and dissemination across primary and community services.	Committee, but in future this will be reviewed by the Clinical Effectiveness Committee.
Library and internet facilities are available at the community hospital and through the Portsmouth NHS Library Service. Training is provided for the development and use of clinical evidence, but there has been limited uptake. The PCT has recently appointed a team development facilitator who is working with teams to help them improve their effectiveness.	The PCT has provided details of resource allocated to support clinical audit and effectiveness (TQ 6.1). The PCT states that the budget is a joint budget (TC1). The PCT states that a team development facilitator has recently been appointed to work with teams developing evidence practice. The PCT notes that the Wight workforce development confederation (WDC) funds course provision to all qualified staff (TQ 6.7, TQ 6.9).	Staff reported that clinical effectiveness training is available through the research and development unit attached to Portsmouth University and is funded by PCTs. ICON centre at Gosport War Memorial Hospital visited. Staff reported that support is available for staff to learn how to use the internet. FG Demand 03-04 .xls –Two staff had undertaken the evidence for practice programme.

Staffing and Staff Management

Report	Pre Review Week Evidence	Review Week Evidence
The personnel director is the PCT lead for staffing and staff management. The personnel panel is a sub committee of the board and is responsible for the strategic direction of Human Resources (HR). The PCT has an HR strategy and implementation plan for 2003/04. HR objectives are included in the clinical governance development plan.	The PCT has a personnel panel, which meets quarterly and reports directly to the PCT board and links to the clinical governance committee. (TQ 7.2, 7.2, 1.10.4a, 1.5). The PCT's HR strategy sets out its current status and plans for the future under the national HR strategy's four pillars: making the PCT a model employer, providing a model career, improving staff morale and building people management skills (7.2). The PCTs five-year strategic direction document states "we will be a valued employer and contractor with staff who are trained and supported to provide patient-focused care in new ways and settings" (7.2). The business plan 2003/04, states that being a valued employer is an objective for that year (1.3). The PCT's clinical governance development plan, 2003/04 includes HR objectives, along with priorities, actions, leads and any target dates (2a.2).	Staff reported progress on strategy of the human resources plan – (a three year project), during this first year 90% has been actioned or is in the process. The next two years will be a process of highlighting more objectives in the workforce development plan

Within the PCT there are a range of sub groups undertaking HR work including the equality and diversity group and improving working lives (IWL) group. The sub groups numbering eleven in total report to the personnel panel, but it is unclear how they communicate with each other. Workforce information is provided to the board including sickness and absence and appraisal uptake.	The personnel panel receives information from and monitors the activity of a range of internal subgroups: leadership strategy group, equality and diversity steering group, improving working lives group, training and development group, Portsmouth health economy new roles implementation group, employee partnership forum and the recruitment group (TQ 7.2, 7.2, 1.10.4a, 1.5). The equality and diversity group are developing the PCT strategy on equality and diversity, by June 2004. Key priorities of the group include to identify and implement a race equality action plan (by March 2004) and the provision of positively diverse training for all staff. The PCT also plans to devise a training programme on diversity by March 20A diversity awareness-training course is provided by the training and development service (TQ 8.9). The board was scheduled to receive training on diversity awareness in February 2004 (TQ1.7, TQ8.9). The IWL assessment report (October 2003) noted a range of good practice including	Staff reported there are bi-monthly meetings, Staff Side representatives can attend the health and safety group. There are staff and management on both committees and policies come also to that forum. Staff told the review team that sickness and absences are reported to the Trust Board The board receives a report on the number of staff that have had appraisals. This report also includes the number of GPs that have had appraisals.

	noted a range of good practice including evidence of an equality and diversity action plan, the race equality scheme, staff knowledge that polices exist and confidence that the trust would support them if issues arose (7.9).	
A number of sub-groups are looking at workforce development planning and the PCT has recently employed a workforce planning manager, jointly funded by the workforce development confederation. The PCT is in the early stages of workforce planning.	The IWL assessment report (October 2003) noted that the PCT's HR committee structure should be reviewed to avoid committee overload or loss of momentum (7.9). The PCT's HR strategy notes key priorities for the PCT which include the identification of a community and primary care workforce plan that supports the implementation of the LDP and the monitoring of vacancy levels and the development of recruitment plans. A recruitment strategy group has been established to achieve the latter. In addition the community and learning disability services each have a recruitment group (7.2). Workforce projections were recently produced as part of the LDP and the PCT has a number of recruitment groups that focus on workforce planning. Monthly projections for community hospitals were established in response to	Staff told the review team here is a workforce development and planning strategy recruitment group within the PCT. Staff are required to forward employment statistics to the HR department. The number of vacancies in the PCT is higher than the national average. Staff reported there is workforce information produced and a workforce re-design manager is employed and is developing workforce data, workforce trajectories, vacancy forecasting, sickness, maternity, to project future requirements. An example of this kind of work is putting in bids for training, for example training for healthcare visitors where there is a shortage.

The PCT has systems in place for checking registrations of both directly employed staff and general practitioners. A few staff were unsure about the process for checking that registrations are renewed.	hospitals were established in response to difficulties in recruiting staff (TQ 7.5). IWL assessment (October 2003) notes the PCT has no workforce development plan, although a number of reporting mechanisms are being developed to report on workforce activity (7.9). The PCT has an aging workforce, a factor that needs further analysis to inform the workforce plan. 7.2 Registration checks are part of the PCT's pre-employment checks. The PCT's personnel information system automatically flags up staff approaching the expiry date of their professional registration. The PCT's SLAs with nursing agencies includes an agreement that they will carry out these checks. The practitioner and patient services agency Winchester, organise the process of checking registration of new independent contactors (TQ 7.13).	Staff reported that registration is checked on appointment and monitored by personnel who write to member of staff to remind them when renewal is due Staff reported that registrations were checked on appointment and copies were sent to personnel. Unsure what happens about re-registration, used to get reminders about registrations but doesn't any more. "Rely on staff to let them know when their registration is due". Staff reported that the checking of qualification is normally done by phone using the IPS system which flags up names of people

		needing to renew their registration annually. The information is sent out to staff.
The PCT has systems in place for local and corporate induction. Local induction programmes have been developed for example in learning disabilities, physiotherapy and community hospitals and the PCT provides an induction programme for practice nurses. This is coordinated by the practice nurse trainer.	Induction arrangements are set out in the PCT induction policy and the key elements of induction are identified in an induction checklist. A new starter pack is provided to all new employees. The PCT has a two-day induction programme for community and headquarters staff. The learning disability service provides a local induction with each house/team and in addition each new starter attends a one-week induction to the whole service, which includes many of the same items as the PCT's general induction (TQ 7.11). The PCT has a policy on induction training, which sets out the scope of training, defines who is responsible, sets out a checklist to be completed by the line manager and new starter, and the requirement for some employees to attend mandatory training (7.3.11). The PCT states that the learning disability services provide a weeklong induction for all	Staff reported the PCT has a very good induction programme, which all staff attend. Staff are also given a two-week settle in period. There is also a health centre specific induction programme for new staff. During this induction period, staff can get competences in their individual practises New staff induction programme offered by the PCT. Within the local areas, there are local induction programmes for staff. Staff reported that Induction is done over two days. Hands-on induction varies according to area and staff group, usually four weeks day shifts for night staff to ensure competency, especially in drug administration. Staff told the review team that agency nurses have induction and they felt that they had to make sure that they were up to date with mandatory training. They felt that the senior nurse checked this and they were unable to work on the ward unless they had had training.

	new staff. Evidence has been provided to support this statement (TC2, AD98	training. Induction organised within the first month. The corporate induction is led by HR. Staff told the review team their induction comprised one week orientation, which covered clinical governance, complaints and familiarisation with the ward, followed by a two day general induction course There is an induction programme for healthcare workers.
Staff are aware of the need for clinical supervision and some staff reported they have access to clinical supervision. Other staff who have not traditionally undertaken clinical supervision have support meetings to reflect on practice.	As part of the on-going review of clinical supervision arrangements a development group for service managers has been established. The group has multi-professional membership and provides the opportunity for experimental learning. The PCT provided a of the review of clinical supervision arrangements. TR1 AD46	Staff commented on their access to clinical supervision e.g. weekly or fortnightly supervision for team members and supervision meetings about every 6 weeks Clinical supervision is provided to physiotherapy staff. Some staff are encouraged to reflect on the practice and to have support meetings once a month Staff also have access to clinical supervision for child protection

There is a comprehensive appraisal system in place and the last year 70% of PCT staff have had an appraisal. In general practices some staff including all GP principals have had appraisals. Some staff reported their training and development needs are identified through appraisal and personal development plans.	The executive team identifies the business plan. Teams in each directorate then identify their priorities and translate them into team objectives at team away days. Individual objectives and priorities are established though individual appraisal meetings (TQ 7.6, 7.3.1). The PCT's performance review policy sets out how appraisals and PDP processes are linked into business planning, gives guidance on the purpose, format and undertaking of appraisals and personal development planning (7.3.1). In a survey (August 2003), over 70% of PCT staff reported having had an annual appraisal in the last 12 In the NHS national staff survey 2003, the PCT's score for the indicator "% of staff appraised within the previous 12 months" fell within the top 20% of trusts the PCT is benchmarked against (SS). All GP principals have been appraised during 2003/04. Non-principal GPs are being included from 2004/05 (TQ7.7).	Staff from all staff groups reported they had an annual appraisals and in some team 100% of staff have been appraised. Some staff groups have yearly appraisals with clinical managers involving individual PDPs and development portfolios "In relation to appraisals we have a cascade system. It's done on a yearly basis, "....had an annual appraisal and had identified areas of interest, and was being considered by the manager for some further development " In GP practices staff reported the practice manager does the appraisals for the administrative staff Staff reported the appraisal system "worked well and found it to be very helpful." Members of the executive team have had an appraisal with objectives set.

The PCT has a whistle blowing policy and has recently developed a performance policy. Management of poorly performing doctors is through the appraisal system and a disciplinary procedure for medical and dental staff is being developed.	Minor performance issues are informally discussed with staff and if no improvement occurs the line and personnel manager undertakes a performance management meeting with the individual. Again if no improvement occurs action may be taken under the disciplinary policy (TQ 7.8). The PCT has recently developed a performance policy that is in the process of being ratified (TQ 7.8). The PCT's current disciplinary procedure (March 2003) includes guidance on when the procedure may be used, formal stages of the procedure, options for action and the appeals procedure (7.3.4). The PCT states that the disciplinary procedure for medical and dental staff is going to the board in May 2004 (TC2, AD99).	A few staff said they would report concerns about poor performance of another member of staff, to the practice manager. A few staff reported they feel that there is an environment where concerns about staff practice can be raised and, depending on the issue, if it can be managed locally, this will be done. If it was a much more serious incident then it would be reported formally and dealt with through the policies that exist. Staff reported there is a system in place for the management of poor performance. The Board has not received any report of poor performance "With regard to the poorly performing doctors issues this is linked to the Clinical Governance Lead." Management of poor performance within pharmacists has been considered, but nothing has been developed yet.

In the annual staff survey some staff indicated they were experiencing bullying and harassment in their workplace from either other colleagues or patients and relatives. In response to this, the PCT has developed a series of interventions to raise awareness about managing and preventing this type of behaviour. There are a number of staff forums across the PCT including the practice manager forum, practice nurse forum and a GP group. These are used as methods to share information across the organisation. The PCT has a newsletter and there is evidence of good communication and team working among staff groups.	In the NHS national staff survey 2003, the PCTs score for the indicator % of staff experiencing physical violence in the previous 12 months fell within the top 20% of trusts the PCT is benchmarked against. SS The PCT has instigated a series of training events to raise awareness of how to manage and deal with this type of behaviour. A course was developed and is delivered through the TDSS on request. TQ7.15	Staff reported there is training in place for staff to manage violence and aggression, material form the RCN is used to inform the course. Staff reported they encourage good team working with other professionals " built up team working with the other professions, particularly over recent months and this is now working very well ". Staff try hard to attend multi disciplinary team meetings. Staff reported that district nurses meet regularly on a monthly basis "Team spirit is great".

		Staff described morale as "very good". There is good rapport between staff groups Executive team described as strong and work well together and there is a lot of informal networking. Copies of newsletter sighted.
Occupational health services are available for directly employed staff including a counselling service. The PCT also provides some occupational health services for GPs.	All staff have access to a confidential employee assistance programme, which is accessed via a 24 hour free phone help line. This provides counselling and support that extends to family members. GPs have access to limited occupational health services for employment and long-term sickness. The confidential telephone help service is also provided for GPs in Gosport (TQ 7.12, 7.2). Occupational health services are provided from Portsmouth Hospitals NHS Trust under an SLA (PCT staff have access to a child and elder care coordinator who provides advice and support under a SLA (with Portsmouth City PCT) to all staff within the local health economy (7.2). The PCT appear to have higher than NHS average absence rates, though the methods	Staff told the review team that occupational health services are available to staff. Staff reported the PCT has good care relief policies in place. Staff who have domestic problems at home either with children or elderly relatives, are allowed to take carer's leave. Staff said the PCT is "a good and sensitive employer and willing to be flexible where personal needs prevent staff from coming in on a particular day because of an emergency in their home or family." A few staff commented that access to occupational health services was difficult because of waiting times and travelling distance.

	average absence rates, though the methods for calculating rates is being reviewed. Average sickness levels in NHS trusts were 4.9% compared with an average of 6.4% for the PCT. A workshop including managers and staff side representatives was planned for January 2004 to develop an action plan to reduced sickness levels. 5.6%	The employee partnership forum deals with key issues such as policies, any new initiatives, working time directives, improving working lives and care relief. The PCT supports care relief flexible working. Staff reported the PCT has established an occupational health service for practice staff, which is appreciated. The PCT has also established a GP counselling service which is also felt to be a valuable initiative. Copy of action plan to reduce sickness levels obtained during review week.
In relation to staff safety the PCT has a lone worker policy and some staff have systems for reporting in at the end of the day. Other security systems observed include panic buttons in general practices and internal security cameras in community hospitals. The PCT has introduced the "Annual Award for Excellence, recognising individuals and team efforts for improving patient care.	The PCT has a system for recording and monitoring of staff accidents and incidents of violence to staff. Quarterly reports are produced and monitored by the health and safety committee, service reviews and board. 7.2 IWL report 2003	In some premises there are panic buttons and there is a direct link to the police. Internal security cameras were observed in community hospitals. A few staff reported they had a system for phoning in at the end of the day. Copy of newsletter sighted with information about award.

team efforts for improving patient care. The PCT has been awarded the practice status for implementing Improving Working Lives, a government initiative aimed at ensuring fair and governed working practices.	IWL report 2003	about award.

Education, Training and Continuing Professional Development

Report	Pre Review Week Evidence	Review Week Evidence
Education and training issues are coordinated through the training and development group. The personnel director is the PCT lead for training and education. The training and development group reports to the personnel panel. The PCT uses the training and development shared services (TDSS) hosted by the PCT and shared with two other PCTs. The TDSS provides and manages a range of training services, and the training manager is a member of the training and development group.	A PCT training and development group was established in 2002. The group reports to the personnel panel, a sub group of the board. A key objective of the group is the coordination of a PCT annual programme of development and training (TQ7.2, TQ 8.3, 7.2, 1.10.5). Training and development services (TDSS) are provided to the PCT by a central team based at St James Hospital in Portsmouth. The department is a shared service with East Hampshire and Portsmouth City PCTs and is hosted by Fareham and Gosport PCT (TQ 8.1).	Staff reported the training manager, provides the services for the three PCTs. There are different structures in each PCT.
The training and development manager is supported by a life long learning facilitator and a clinical placement liaison officer, these posts are funded by the workforce development confederation.	PCT questionnaire.	The clinical placements liaison officer, life-long learning adviser; and inter professional training adviser are line managed by the training manager.
The PCT's strategic approach to training and development is included in the human resources strategy, and the PCT is planning to develop an education strategy in 2004.	The PCT's strategic approach to training and development is outlined in the HR Strategy. A key priority for the PCT is the production of a	Staff told the review team that the PCT, prioritises training needs in the following way: within each service the training needs within

develop an education strategy in 2004. Education and training needs are identified in a number of ways and there is some evidence of personal development plans feeding into this process. The PCT does not have an annual training plan and it is unclear how education and training planning is linked to PCT priorities.	written training and education strategy (TQ 8.3). The PCT's HR strategy action plan 2003/4 states that a PCT annual training plan and training directory will be developed by March 2004 (7.2). The PCTs priority areas for developing education, training and CPD in the next 12 months include; production of a PCT annual training plan and developing a training and education strategy (TQ8.15). The HR strategy and appraisal and personal development policy outline how systems and processes for the planning and delivery of training and development are part of the PCT business planning cycle. The PCT has identified the need to develop a framework that coordinates this process into the production of an annual training plan (TQ8.3) Currently 70% of staff have a personal development plan (7.2). The PCT's performance review policy includes guidance on the purpose and use of PDPs and how they should be developed (7.3.1).	the services are identified. These are taken by a representative of the service to the training and strategy Group where the PCTs priorities are set. These are then taken to the personnel panel and up to the board. The process is obviously a two-way one. There is compilation of information from appraisals within the different services feeding into the system. The training manager is responsible for providing training to meet the needs of each PCT. When asked about the training and education strategy, the response was vague, it Is unclear what stage the strategy is at. Some staff interviewed commented that they had a personal development plan and a few staff reported that training had arisen out of their appraisal. A few staff reported that individual performance reviews fed into identifying what training needs.

	(7.3.1). Following the development of a new appraisal and personal development planning policy the PCT has recently created personal development portfolios for all staff. They provide a place to keep training, professional development and appraisal documents together (TQ 7.6, TQ 7.15). The head of primary care is responsible for PDPs for GPs. The PCT clinical governance lead receives information from appraisals and feeds it into the PCT educational process via the GP patch tutor (TQ 7.7).	
The PCT has developed good partnership working with a number of organisations including Southampton University, Portsmouth University and local colleges of further education to provide a range of courses including undergraduate, postgraduate degrees and national vocational qualifications. Many staff have accessed the range of training and education opportunities available, although a few staff reported difficulties in arranging cover to attend.	The PCT works closely with other local PCTs facilitated by a pan-PCT training group. The PCT has close links to the acute trust in relation to pre-registration training, post qualification courses, foundation degrees and sponsored training. TDSS has contacts with universities though life long learning advisers and clinical placement liaison officers. The PCT has a joint appointment with	Staff reported that there was a contract with Southampton University to deliver training in relation to intermediate care, which they had undertaken. Staff reported they had been on courses through different forums, from the university and the hospitals including a leadership course at Southampton University and MSc. Staff reported they had been encouraged to undertake NVQ training.

arranging cover to attend.	Southampton University Health Care Innovations Unit of a team development facilitator. The PCT has a strong link with PIMHS at Portsmouth University through the foundation degree programmes and the continuing education contract. The TDSS has membership of relevant WDC committees. The PCT has links, through NVQ and other programmes with a number of local colleges of further education (TQ8.5). The PCT is collaborating with the South East England Development Agency (SEEDA), which has supported the opening of an IT-based learning centre in Gosport (7.2). The PCT states that staff have access to national and internal leadership development programmes. The PCT provides a series of internal courses to support managers in the delivery of effective HR management (7.2). In 2002/03 the TDSS provided a range of training services to the three local PCTs; short course programmes, administration of	undertake NVQ training. Staff observed doing IT training at the ICON centre, facilitator was from a local college. The executive team are encouraged to attend local training days. Both directly employed staff and staff in practices comment positively on the training opportunities provided Staff reported that support for training is not usually a problem but there can be difficulties arranging cover.

	courses by other providers, clinical update courses and courses in conjunction with the WDC (8.1). The PCT appears to provide a range of in-house training (8.2.2). The WDC fund schemes that support staff in obtaining professional qualifications: salary support for pre-registration training, public health BSc, enrolled nurse conversion, foundation degrees, NVQs, post qualification AHP and nursing programmes (TQ8.1). Staff in community hospitals and the learning disabilities service report difficulty in finding cover for staff while they attend training. The community hospitals report no budget for providing cover. Occupational therapists plan half a day a month for training but physiotherapists and nurses in the rehabilitation service report difficulties releasing staff (8.2.2).	
The PCT has a training advisor for staff in general practice and a GP tutor and has introduced the time for target, audit, review guidelines, effectiveness and training programme (TARGET). Information from GP	TARGET protected training time is currently being implemented. TQ8.4 The post of training adviser for general practice (hosted by Fareham and Gosport PCT) acts as a central co-ordinator for	The PCT has provided financial support for TARGET days and they have already had two of these days,

appraisals informs the provision of this programme. Limited training is available for dentists, optometrists and pharmacists.	education, training and CPD for nurses, managers and administration staff employed in general practice in Fareham and Gosport, East Hants and Portsmouth City PCTs (TQ 8.4). A GP tutor has been appointed and is linked to the Deanery. TQ8.4	Staff reported that information from GP appraisals feeds into planning for TARGET days. Staff reported that little training had been offered to dentists, optometrists and pharmacists. Staff reported the in-house TARGET day worked extremely well.). Staff reported they attended the target days and also primary health care team meetings, which she found very useful in relation to training and dissemination of information
A range of mandatory training is provided for staff including fire training and basic life support. Some staff reported they had attended mandatory training, but the figures for moving and handling training and fire training for 2003/04 are low.	The PCT has provided figures for the percentage of staff by group attending lifting and handling (22-52%) and fire training (33-67%). This covers the period January 2003/2004. TR1,7.10.2 Health and safety executive improvement notice served on all three PCTs in June 2003 relating to the provision of manual handling. An action plan has been developed. TQ5.10	Staff reported they had done mandatory training including child protection, fire training. Staff also reported they had attended first aid training. A few staff reported that quite a few staff have yet to manual handling training. Staff reported that staff have to attend updates on manual handling following an accident at Portsmouth hospital.

Managers are responsible for ensuring staff attend training courses. The TDSS provides the PCT with quarterly reports of attendees at programmes they provided, although it is unclear how the PCT monitors all training and education activity. There are forms to evaluate the effectiveness of training but these are not routinely completed and it is unclear how they inform the planning process.	The TDSS SLA is monitored quarterly at a pan-PCT meeting and the TDSS provides an annual report (TQ 8.3). The annual partnership agreement with the WDC is monitored on a quarterly basis at a meeting with representatives of the PCT (TQ 8.3 The PCT is represented at a pan-PCT group, which monitors the provision of the Southampton University post qualification courses (TQ 8.3). Monitoring of training for primary care practice staff is through a quarterly report and is sent to each PCT (TQ 8.4). The PCT states that all training activity requires the completion of a T1 or T2 (undefined) by the individual undertaking the training. This is then reviewed between the Manager and the individual concerned (TC2, AD101, AD102).	Staff reported that these forms are not always completed and that feedback has not been very good. There are plans to develop a computer database to record feedback on courses.

Staff have access to a range of training and education resources including the ICON centre, an information technology centre located in the community hospital.	An information technology access centre was recently opened at Gosport War Memorial Hospital. The object was to increase the amount of training available to all staff (employed and contractors) by providing them with the facilities to study (TQ 8.14). Staff have access to a life long learning advisor who provides support and advice on the range of training and education opportunities (TQ 8.2, TQ 8.14, 7.2).	Visited during review week.

Use of Information

Report	Pre Review Week Evidence	Review Week Evidence
The director of finance is the PCT board lead for information and communication technology management (ICT) and represents the PCT on the ICT management board. This is the key decision-making forum for strategic direction, policy making and investment decisions across Portsmouth and South East Hampshire. Reporting of ICT is through the PCT operational management team.	The PCT has provided terms of reference for the PCTs and West Hampshire NHS Trust ICT steering group. Membership of the group includes the finance directors of the three local PCTs, the head of ICT operations, the director and the head of IT projects from Island and Portsmouth health ICT services and the head of information management and governance from IPHIS. The group's terms of reference include acting as a conduit between the mainland PCTs/WHT and the community wide ICT management board; acting as custodians for the PCTs strategy and plans; acting as the approval body for specific investment proposals; recommending strategic policies; and setting and agreeing performance levels (TQ9.2, 9.1, 1.10.7a). The PCT states that the board lead for IT is the director of finance and that reporting occurs through the operational management team and a named link (TQ1.6, TQ9.1, TQ9.2).	Staff reported there are two committees, the ICT Management Board which has representatives from the local PCT, Social Services and Strategic Health Authority, and also the Managed Information Systems Programme. In addition there is the PCT ICT Steering Group on which the three directors of the PCTs sit. These meetings are held monthly. Key decisions are taken here, looking at keeping the infrastructure active. Business cases will be discussed at this group, for example GP-related issues including infrastructure replacement, PCT replacement programme, also the data quality agenda ensuring each PCT is recruiting through a lead for ICT.

The PCT has a draft ICT strategy, and an ICT development programme for 2003/04. The strategy has been developed in partnership with three local PCTs and is based on the national programme for information technology. However, an action plan to implement the strategy has yet to be developed	The PCT states that a revised ICT strategy is being presented to the PCT Board in March 2004 and the PCT's annual report 2002/03 states that the PCT has produced a draft information technology strategy (TQ9.2, 1.1). An ICT board with members from local IT service users and providers provides strategic direction for IT in the local health economy. However, there is only limited evidence detailing the PCT-specific management structures for IT services (TQ1.6 IT developments are covered in the PCT's ICT modernisation investment programme for 2003/04, the local delivery plan for the period 2003 – 2006, the ICT development programme 2003/04 which outlines the planned development and costs for the current year, and the clinical governance development plan, 2003/04 (9.2, 2b.2.1, 2b.6, 2a.2). The PCT states that the draft ICT strategy is going to the board for adoption on 28 April 2004. A copy of the strategy has been supplied (TC2, AD103). The PCT has a local delivery plan for the	The service route IT is hosted by Portsmouth Hospitals and it's felt that they are trying to work with the PCT and the example of reference costs is a very good way of collaborative working bringing together a hosted service and staff on the ground. It's also felt that in the hosting arrangements the PCT is treated as fairly as any of the other PCT's and that hosting for a specialist (inaudible) spread service was probably the right way forward. The individual concerned has good natural networks and that's probably helping the process Clinician input was significant to the old strategy, however this time there were too many national agenda issues so clinicians were not really involved in developing the strategy. However the strategy was sent out to some consultants and GPs for comment. Staff reported that the strategy has been in draft format. Fareham and Gosport PCT have get to sign it off. The strategy is based on the national plan but a local action plan has not yet been developed but will be developed at some point

	period 2003 – 2006, which includes the following aims: 1) Deliver broadband access to NHSnet, it is noted that this is not PCT led 2) Implement electronic booking by December 2005 3) Implement the national prescriptions service by 2007 4) Implement key elements of electronic records by December 2005 (2b.2.1). The PCT states that these are Portsmouth wide targets and are handled by PHIS shared service on behalf of all (TC1). The PCT has a clinical governance development plan, 2003/04, which includes the following objectives, along with priorities, actions, leads and any target dates: 1) Ensure that information regarding the outcomes of patient care is easily accessible and useful 2) Ensure that the PCT meets national requirements regarding information and, TQ9.1, TQ9.2, 9.1, 1.10.7a).	

ICT support is provided by Island and Portsmouth Health ICT service. Resources for ICT include a public health analyst, information analyst and a primary care information services facilitator (PRIMIS). The PCT recognises that more resources are needed to progress the ICT agenda and is seeking to appoint a Head of Information.	The PCT, along with other PCTs, uses Island & Portsmouth Health ICT Service and the relationship is governed by the SLA (TQ9.2). The PCT has 2.1 WTE staff allocated to information technology (IT): a PRIMIS facilitator, a public health analyst, and an information analyst. The PCT's non-pay IT budget was £212,515 for 2003/04 (TQ9.1). Health Service Journal 15/4/04	
The PCT receives information on performance indicators related to key national targets. This is reviewed at the performance monitoring committee using a traffic light system and the board receives quarterly reports.	Copies of minutes of meeting. The PCT states that the performance monitoring committee receives a "traffic light" table showing performance against the key national and CHI targets TR1 The PCT uses information to note performance and make suggested actions each quarter as part of the performance indicators action plan. The plan includes key targets, current CHI rating, performance, comments and actions and a lead for undertaking them. The system operates a	Staff described this committee to the review team., "The information goes to the board and the Performance Monitoring Committee, which is a sub-group of the board"

There is some evidence of reporting on clinical governance activity including quarterly PALS, complaints and incident reports.	undertaking them. The system operates a traffic light system and indicates underperformance in the following areas in quarter four of 2003/04: access to GPs, total time in accident and emergency less than four hours, dug misuse shared care, infant health and commissioning of NHS plan deliverables (AD68). See previous sections. (7.4)	A few staff reported that the PCT doesn't always get all the clinical governance information they would like from GPs, for example, all the complaints, all the risks, but its still early days with them. Staff reported that service managers get information on complaints to put into their service review reports.
A single community wide secondary care patient administration system has been developed and is available to local clinicians and support staff. Although access by staff outside general practices to computers is variable. Work is also being undertaken to review and improve the recording of activity of community staff as the current system fails to capture the breadth and depth of their work	The PCT reports that a single community-wide secondary care activity database has been created through the merger of the community information system used by PCT provider services and Portsmouth Hospital NHS Trust's PAS. The new database is available to all local clinicians and support staff (TQ9.11).	Staff reported that they are not getting 100% data collection and not getting information that they should get. This is because of the data pen system issues Staff reported there were some initial problems with the quality of information when there was the PAS merger. This lasted for about a month or so and it wasn't that we weren't get any data from the

capture the breadth and depth of their work	The PCT currently provides Korner data to clinicians in community settings. However, the PCT reports that clinicians are not satisfied with the data and that it is working on improving data collection and production (TQ9.3). The PCT states that there is an ongoing programme to enable all clinicians to have access to the internet, email and the PCT services (TC1).	wasn't that we weren't get any data from the acute sector, there was a delay in the data and the accuracy was questionable. This has now been resolved and we did actually go back and look at the data and it wasn't as bad as initially thought. Other issues with obtaining useful information are around paediatric surgery. We want to look at a case mix of the current waiting list. There has been difficulty obtaining the case mix of the current waiting list for paediatric surgery from some of the providers. The head of commissioning is picking it up with the directors in the provider trusts. They're providing numbers of people waiting, but not the procedure t they're waiting for, which doesn't really help if we want to out source those cases Staff in community services are sharing computers and reported problems with a lack of infrastructure and access to some systems. Staff reported that some staff are not yet on email and "a lot of staff are sharing computers from two to nine people whilst admin consultants and managers have their own computers".

		Although staff have access to the ICON centre, in some areas there are few computer terminals.
The majority of information used by the PCT relates to activity rather than patient experience and outcomes. There are limited examples of information being used to improve services information A summary of health needs information taken from existing data has been used to support a partnership approach to health improvements to reduce coronary heart disease, stroke and cancer mortality. In relation to prescribing, quarterly reports on practice specific prescribing are collated and shared across practices.	The PCT states that its public health information analyst has been trained to analyse morbidity and mortality data by ward through utilisation of mapping package. It states that as a consequence, a comprehensive data package has been produced to inform Fareham and Gosport re-provision of local services project. It further states that this work is supported by the information analyst for commissioning and performance management who ensures that information is used in commissioning and planning decisions appropriately (TR1) The PCT uses de-identified GP practice data as a check against drug usage patterns (TQ9.5).	Evidence sighted during review week. Staff reported they are receiving information in relation to prescribing. .

The focus for ICT development has been in general practice. All general practices are computerised, although a number of systems are in use. GPs have templates to improve services for chronic disease management and the PRIMIS facilitator works with them to improve data quality through improved coding. GPs also receive information relating to prescribing.	17 of 21 GP practices are now part of PRIMIS and report improved patient care through identification of patients who had not previously flagged as needing to be put on a disease register (and hence receive care) (TQ9.7). The PCT states that its PRIMIS project has helped to standardise data in primary care by helping provide consistent coding and improving recall of patients. It states that this has also helped to identify gaps where patients do not appear on disease registers (TR1). The PCT has provided practice development plans which include any improvements required in terms of staffing and staff numbers, computer equipment and premises (AD65, AD66, AD67). The PCT reports that it has piloted a system for GP practices to request and report pathology test results electronically at 18 practices with positive results. The PCT states that pathology links are in place across all practices and local hospitals, with the exception of Royal Hospital Haslar, and that work is underway to incorporate this hospital	Staff in general practices reported they get support and advice from the PRIMIS facilitator and he will visit on request. The PRIMIS facilitator looks at system and presents findings to practice regarding quality of data. Practice is in local first wave for PRIMIS. Staff feel the PRIMIS project has been a success. In other areas of data quality Fareham and Gosport is a year behind the other PCTs, but it is now back on the agenda. No information regarding plans for IT systems for community care staff

	as well (TQ9.11, TR1). The PCT began planning for a PRIMIS project in 2002 and a project plan dated May 2003 is in place (9.9). No evidence regarding plans for improving or developing systems used by community care staff. The audit commission's annual audit letter, 2002/03, noted that there were incidents where the PCT was at high risk for misreporting data, although low risk was noted in clinical coding, progress in the implementation of PRIMIS, and vacancy rates data (1.13).	
The GP clinical governance lead is the Caldicott Guardian. The PCT has a Caldicott group and membership includes staff from community and primary care. Staff are generally aware of the need to treat patient information confidentially. A few staff reported they had attended training in confidentially and data protection.	The clinical governance committee (June 2002 - December 2003) discussed information related issues including; the production of a Caldicott outturn report, the standardisation of the referral letter and pathology results, progress with the Caldicott report timetable (1.9.1.2, 1.9.1.3). Items discussed at PEC meetings (January - September 2003) included a presentation of the Caldicott outturn report (1.7.4).	Staff reported they were aware of training Caldicott principles and a few staff reported they had attended training including data protection training. A few staff are unsure who the Caldicott is but know there was one in the PCT. Staff described systems used to maintain confidentiality e.g. locked cupboards.

	the Caldicott outturn report (1.7.4). The PCT clinical governance lead and chair of the CG committee, a GP, is also the PCT Caldicott lead and sits on the PEC and PCT board. The lead chairs a Caldicott group that covers primary and secondary care (1.5, TQ9.9). The PCT reports that it carried out a primary care audit of Caldicott compliance in 2003 and that it will carry out a similar audit for community services in 2004. The PCT reports that the primary care audit resulted in an action plan that is monitored by the Caldicott group (TQ9.9, 9.10). A summary review has been completed following the theft of several computers that held patient identifiable information. This review raised concerns about data protection, which are being addressed through an action plan (5.1)	
The PCT provides training courses for staff to improve IT skills including the European computer driving licence. While some staff	The PCT provides IT training for staff for the European Computer Driving Licence (ECDL) (2a.1).	Staff reported that approximately 120 staff have signed up to do the ECDL training and so far about 40 have actually completed the

have done this course, a few clinical staff reported that they have not accessed training because of limited access to computers.	The PCT states that its PRIMIS project is aimed at training and education in primary care in relation to standardisation and use of data (TR1).	programme Staff reported they did not sign up for training because of limited access to computers.

Strategic Capacity

Report	Pre Review Week Evidence	Review Week Evidence
In July 2002, shortly after the PCT was established the Commission for Health Improvement's investigation report into Gosport War Memorial Hospital was published. The investigation was concerned with events prior to the PCT coming into being. Managing events after this, including implementation of the subsequent action plan has absorbed a great deal of the board and senior management teams efforts. However, the implementation of clinical governance is a key priority for the PCT and progress has been made. The strategic health authority is carrying out a reappraisal of management structures across the local health community with a view to closer integration of senior management roles. The PCT has an open culture, and the executive team are seen as supportive and approachable. There are good working relationships within the executive team, and	Gosport and War Memorial Hospital Investigation Report July 2002.	Staff told the review team about the proposed management restructures. Staff comment that the PCT wanted to establish a clinical governance committee and were very efficient about getting clinical governance leads into post and Clinical governance was already relatively well developed in the primary care groups and in the health authorities. The PCT though it was important to establish a strong clinical governance structure and develop a positive culture for clinical governance to flourish in the PCT Staff reported the current management review that is udnerway Staff commented that it was an" excellent organisation and very democratic" and the chief executive is accessible

the chair has carried out a review of the non executive roles to ensure they are compliant with national directives.		chief executive is accessible Staff reported they do no have any problems in raising issues at the PEC and feels confident that they can approach the Chief Executive, or other senior managers, with any issues that he wishes to discuss Staff reported the managers are visible in the hospital and have visited clinical areas. Staff commented that the management team are sensitive to staff issues and there are good relations. Staff reported that in order to comply with national directives a review of the role of non executives has taken place, they no longer chair so many meetings or get involved so much operational work.
There are professional forums for different professional groups, and staff from all professional groups comment that the PCT is an inclusive organisation.	See staffing and staff management section	Staff commented that it is an inclusive organisation and they feel supported in their roles. Staff reported that the practice manager forum is main means of managers' interface with PCT. The forum shares good practice and aims to ensure consistency of matters across

		practices
The PCT has a clinical governance development plan for 2004/05 and is developing a strategy. Some services, learning disabilities and children's services for example have developed their own clinical governance plans and priorities, and the PCT needs to ensure there is a more integrated approach to clinical governance. There are two clinical governance managers responsible for primary care services and community services. The director of nursing and clinical governance is a co-opted member of the board, and the GP clinical governance lead is a member of the board and professional executive (PEC). There is a clinical governance committee with sub committees responsible for components of clinical governance. Minutes of the clinical governance committee are sent to the board and risk management committee. The professional executive committee (PEC) does not regularly receive minutes.	The PCT states that the clinical governance committee is responsible for the development, management and scrutiny of all clinical governance activities (TQ2.3). The clinical governance framework 2004/05 notes that the clinical governance committee has mutual relationships with the board, the audit and assurance committee, the executive team, the patient and public involvement steering group, the performance and monitoring committee, the personnel panel, the operational management team, the direct commissioning group, the pan-PCT district clinical governance committee, the risk management committee and the PEC (1.5). The PCT states that there is a district dental advisor who provides advice to all three PCTs. The dental clinical governance baseline assessment, which has been undertaken, is with the dental advisor to identify future action for the PCTs (TC2, AD83).	A few staff reported that clinical governance is well embedded in the organisation, due to the previous CHI enquiry, A few staff reported that the PEC receives information from the clinical governance committee, but that it tends to be when there are specific issues to discuss rather than on a regular basis Staff commented that the PEC is less involved in the clinical governance committee than the board. Staff commented that clinical governance reports directly to the board. Clinical governance is not a standing item on the board agenda. However, the board does receive minutes of the clinical governance committees. Staff told the review team the Clinical Governance Committee reports directly to the Board and exceptional reporting only comes to the PEC. "Clinical governance is not

not regularly receive minutes.	The PCT states that there is between the PCT and the LOC (TC2, AD83). The PCT has two specific lead roles for clinical governance that are seen as mutually supportive: primary care clinical governance and provider services clinical governance. The roles have responsibility for co-ordinating programmes of clinical governance including research and effectiveness, clinical risk management, audit, information and patient and public involvement (1.5). Membership of the clinical governance committee includes: the chief executive, the medical director, the nursing and clinical governance director, a non executive director, practice managers, the professional executive committee (PEC) nurse, a lay member, the head of commissioning, the clinical governance managers, the pharmaceutical advisor and the complaints manager (1.5). The PCT states that the clinical governance committee meeting notes are routinely sent to the board and the risk management committee (TQ2.3). ▪ .3).	picked up as a standard responsibility at PEC meetings" Staff reported that the learning disabilities service has clinical governance plan and the MDT has fed into it. Staff commented that the Clinical Governance Committee is responsible for receiving reports from all Clinical Governance Sub-committees. They are now involved in looking at action plans from the sub-committees to make sure that they are closing the loop on highlighted clinical governance activity

	The PCT states that the clinical governance committee is responsible for the development of the annual clinical governance development plan. Provider services clinical governance plans are monitored as part of the quarterly service review process. The Strategic Health Authority monitors the PCT clinical governance plan with a half yearly outturn report October, full year outturn report April and an annual report June. Evidence has been supplied to support this statement (TC2, AD106). The PCT states that a strategy for clinical governance, separate from the clinical governance development plan, is being developed by the clinical governance committee and is in draft form. A copy of a discussion draft of the clinical governance strategy (March 2004) has been provided (TR1, AD13).	Staff reported that progress has been made with GPs and pharmacists. There is a GP group and one GP from each practice meets regularly with the PCT management
The PCT has focused on engaging with GPs and has made good progress in this area. The GP forum enables the PCT to share information and discuss issues such as proposals for the out of hour service and the	GP questionnaires indicate they are undertaking clinical governance work.	

new GP contract. Although many practices are carrying out clinical governance work, information is not routinely shared with the PCT.		All Some GP practices have GP leads for clinical governance. Staff reported GP practices are not obliged to share information relating to incidents and complaints etc, except second stage complaints. GPs represented on a number of forums and the PCT supports the TARGET days. The PCT has met with GPs regarding the new GMS contract.
Progress has also been made with community pharmacists with the appointment of a community pharmacy clinical governance facilitator. This is a joint appointment with Portsmouth City and East Hampshire PCT. A community pharmacist is also a member of the PEC, and the PCT has had meetings with community pharmacists to discuss clinical governance issues.	The PCT states that a pharmacy clinical governance facilitator is funded by the three PCT's. This post has undertaken base line assessment and clinical governance planning activities across clinical pharmacy. A local pharmacist is also a member of the PCT professional committee. Evidence has been supplied to support this statement (TC2, AD83). The PCT states that the community pharmacy clinical governance facilitator coordinates clinical governance management for community pharmacists. There is a local community pharmacy clinical governance	Staff commented that the pharmacist works well with the PCTs.

	community pharmacy clinical governance group which meets monthly and has representation from the local PCTs (TQ2.4). The pharmacy questionnaire notes a range of support provided by the PCT. These include providing information on training sessions, education and training, adverse incident reporting (PQ). The pharmacy questionnaire notes a range of issues, which would be supportive if provided by the PCT, including advice on use of information, standard operating procedure and general pharmacist involvement (PQ).	
Relationships with dentists and optometrists are not as well as established. A baseline clinical governance assessment has been undertaken in dental practices and there are plans to invite a dentist to join the PEC.	The PCT states that a baseline assessment in dentistry has been analysed and the deanery has examined the results (TQ2.3). The optometry questionnaire notes a range of issues, which would be supportive if provided by the PCT, including advice on general clinical governance and diabetic referral guidelines (OPQ). The optometry questionnaire notes a range of	There is no dental representative on the Clinical Governance Committee, however there are plan to appoint one and a job description has been developed. Staff reported that they have little contact with the PCT. Relationships with optometrists in very early stages.

	support provided by the PCT. These include providing information on diabetic screening protocols, fast track contact referral and further information (OPQ).	
The PCT is active in partnership working and has established effective working relationship with local borough and county councils. The PCT also works in partnership with other health organisations in the local health community The PCT works closely with local councils in relation to child protection arrangements and learning disabilities services. Other examples include addressing local issues such as improving transport services. Representatives from voluntary organisations are involved in the local implementation teams	The PCT's annual report 2003/04 states that the PCT is committed to working with Fareham and Gosport borough councils, Hampshire county council and voluntary organisations (1.1, TC1). The PCT's annual report 2002/03 states that there have been advances in social care learning disability services with 18 homes transferring to New Downland Housing Association which it is expected will lead to refurbishment and re-provision of the housing (1.1). The PCT's annual report 2003/04 states that the PCT is committed to working with Fareham and Gosport borough councils, Hampshire county council and voluntary organisations (1.1). The PCT's annual report 2002/03 states that there have been advances in social care learning disability services with 18 homes transferring to New Downland Housing	Stakeholders commented that there had been an improvement in working relationships with social services over the last two years There is a multi-agency child protection forum for Fareham and Gosport and this feeds into the District Child Protection Forum which is a pan-PCT and hospitals forum Staff reported that the learning disabilities work jointly with Social Services to address clinical governance issues Staff commented that joint programmes with partners such as Sure Start and education of partnership have made a difference to service users within the Trust. Staff commented there is good partnership working with social services. Although there are good working relationships with colleagues and good pockets of work "there are still issues around the different cultures of the two services"

There are examples of patient and public involvement at both operational and strategic level and further development of this a key objective in the both the business plan and primary care strategy. Performance monitoring is through the performance monitoring committee. The committee monitors progress on the local	Association which it is expected will lead to refurbishment and re-provision of the housing (1.1). See PUCP section. The PCT states that there is lay representation on the clinical governance committee (TQ2.3). The business plan 2003/04, states that involving patients and carers in decision making and re-shaping of services is an objective for that year. The business plan notes successes for 2003/04, including the development of PALS, an annual patient prospectus, an annual patient survey and the expert patient programme. The plan also notes that future development in reforming the NHS complaint's procedure and involvement in the "fit for the future" and "healthfit" schemes are planned (1.3). The PCT's primary care strategy, 2003/06, states patient and public involvement in the development of services as a priority (2b.4).	Stakeholders commented there is a commitment to partnership working and they feel "very optimistic about partnership working."

committee monitors progress on the local delivery plan, financial targets, health improvement targets and commissioner and provider targets. The PCT also produces a quarterly report on performance indicators. The joint directors of public health are the board leads for health improvement /public	The PCT produces a quarterly report on performance indicators. The report includes commissioner and provider targets for priority one service and financial framework targets 2b.1). The PCT states that quarterly service review are circulated within the PCT and have contributions via service managers from all levels of the organisation (TQ 2.2, TC1). The PCT has a performance monitoring committee, membership of which includes the PCT chair, the chief executive, the director of finance, the director of strategic development, the director of public health, the PEC chair and a non-executive director. Issues discussed in the meeting notes for August and October 2003 include issues surrounding health improvement targets, CHI targets, finance and financial targets and the role of IT and information collation (1.9.2.5, 1.9.2.6). Copy of minutes of performance monitoring committee	Staff discussed the performance monitoring committee with the review team.

health and are supported by a public health team. In addition other managers and staff contribute to the public health agenda including school nurses and health visitors. The PCT has a public health development plan and public health targets are reflected in key documents including the local delivery plan. The annual business plan also supports the delivery of health improvement. The PCT actively participates in a number of health improvement initiatives including smoking cessation services, Many initiatives are carried out in partnership with local borough councils and voluntary groups. To achieve effective engagement of public and patients the PCT has established a range of mechanisms to seek their views including stakeholder days for specific areas of work.	The PCT states that there are two joint directors of public health. The position is a board level lead for health improvement. Part of this role is to lead the development of strategies and programmes to improve health, establish local targets, develop and implement programmes to meet targets and ensure that the public health function of staff is fully realised (1.1, TQ2.17). The PCT states that the lead responsibility for the local delivery plan process has passed to the strategic planning and commissioning directorate. The PCT states that there are two multi-agency partnerships working as sub groups of the two local strategic partnerships (TR1). The PCT has provided minutes from the board meetings held between January 2003 and December 2003. Issues discussed include that breast screening in the over 65's was not a priority and that resources could be better allocated elsewhere; the local delivery plan priorities were noted and how that matched local health issues; and the local delivery plan was approved during the	Staff reported that the Annual Public Health report is currently in draft form. See partnership section.

	meeting on 25 June 2003 (1.6.1, 1.6.7). The PCT states that improving health is one of the PCT's eight main priorities outlined in 'Working Together for our Future Health'. As a consequence health improvement is central to all the local planning groups 'NSF LITs' and in Pan PCT Planning Groups 'Healthfit' (TC2, AD108). The PCT states that there are two multi-agency partnerships working as sub groups of the two local strategic partnerships. The health and well being sub group in Gosport is focused entirely on health improvement strategic development and implementation. In Fareham the network Fareham officers group has a wider remit including public health. The director of public health sits on both committees to provide a link with the PCT (TR1). The PCT states that there is a strategic level health liaison panel which has been established with the two borough councils and the PCT. The group, which meets monthly aims at joint working to improve the health of the population including the development and implementation of health improvement	

	initiatives (TR1 The PCT has provided minutes from the Fareham and Gosport joint health liaison panel for meetings dated 16 December 2003 and 10 February 2004. The panel includes members from the PCT and the two local councils. Matters discussed include improved communications with patients and residents, community strategies, the future of health services on the Fareham and Gosport peninsula, progress regarding LIF and details of the CHI clinical governance review (AD5, AD6). Gosport has a health improvement modernisation plan (HIMP) partnership plan which outlines priorities for CHD, cancer and education. Each priority has a target date, a lead, action points and stated outcomes. The leads include the PCT, Gosport Borough Council and the Gosport/Fareham accident prevention group. Issues highlighted include increasing the number of quit smoking drop-in sessions and the promotion of walking for health (2c.1.1). The PCT has a public health development plan for 2003/04 which highlights objectives,	

	actions, timescales and attainments. Objectives include producing an annual report for public health, support the development and implementation of the prison HIMP, developing a joint patient and public involvement strategy, developing approaches to increase public health capacity and lead on the children's NSF framework (2c.3). The PCT has a provided the health improvement partnership plan 2003 – 2006. The plan, which only covers Gosport, includes a review of local health needs and a review of key themes including areas such as involving the public, inequalities and partnerships. The action plan incorporates key interventions, such as CHD, along with a target date, a lead, action required and a set of outcomes to achieve (AD1, AD2). The PCT states in the public health development plan 2003/04 that the PCT has made progress in establishing partnerships with key stakeholders including the local borough councils, Fareham Community Action, Gosport Voluntary Action and Hampshire County Councils (2c.4). The PCT states that it holds stakeholder days	

The PCT works in partnership with regard to commissioning and is part of a district wide commissioning group. The director of strategic development is the board lead for commissioning, supported by a commissioning team. The commissioning strategy is contained within the local delivery plan. Monitoring and reporting of commissioning is through the performance monitoring committee. The clinical governance plan 2003/04 includes objectives to strengthen the links between commissioning and clinical governance.	around focused areas of work, which includes older people's services (TR1, AD9). The PCT is a member of the district commissioning group, which includes membership from the Isle of Wight, Portsmouth and South Hampshire health community (1.9.2.2 – 1.9.2.4). The PCT states that the national service framework implementation teams and commissioning sub groups set the priorities for local commissioning and provide advice to the PEC on their areas of expertise (TR1). The PCT is a member of the district commissioning group, which includes membership from the Isle of Wight, Portsmouth and South Hampshire health community. Issues discussed by the group include: 1) The management of specialist services across the ten PCTs in the area (1.9.2) 2) The provision of extra clinics for neurology and the share of the costs involved (1.9.2)	Staff reported that In relation to planning for commissioning this is included in the LDP.

	and the share of the costs involved (1.9.2) 3) Problems with volume recording methods on activity, which is impacting on the signing of SLAs with providers (1.9.2) 4) The LDP was signed off (1.9.2.1) 5) Support for a service regarding digital hearing aids (1.9.2.1) 6) It was agreed to circulate a paper on patient choice (1.9.2.2) 7) Proposals was discussed for the provision of critical care services (1.9.2.2) 8) It was agreed to review the current CHD commissioning arrangements (1.9.2.3) 9) A review of voluntary agencies with the aim of considering providing support, this included a homestart proposal (1.9.2.3) 10) Processes for SLAs for hosted services (1.9.2.4). The PCT states that the commissioning strategy is contained within the local delivery plan. The PCT also states that there is a panel associated with out of area treatments and services not usually purchased (TP1)	

Engagement of clinicians in the commissioning process is through the local implementation teams (LITS) and the GP lead for commissioning. Members of the commissioning team also attend the LITs meeting. Until recently commissioning was not routinely discussed at the PEC, and the PCT is trying to strengthen the role of the PEC in the wider planning of services. Presentations at PEC meetings by the local implementation teams is one method they are using to achieve this.	and services not usually purchased (TR1). The PCT states that there is clinician representation on the PCT PEC each of the NSF LITs and the district clinical governance committee. Evidence has been provided to support this statement (TC2, AD107, AD108). SEE PEC Boards (Informal) 1.7.1 → 1.7.14 PEC MINS	Clinicians commented that they feel engaged in the commissioning process. The PEC meets monthly, but one month in three the meeting is a clinical meeting to which all commissioners are invited. There is a GP commissioning lead on the PEC Staff reported that commissioning decisions are made on a pan-PCT commissioning group. Staff said that presentations from the LITS are now given at PEC meetings, this is way to strengthen involvement of clinicians. Local Implementation Teams are consulted in relation to involvement with commissioning of specialist services Staff reported there is a GP Commissioning Lead and he feeds into the process. There are a number of clinicians on the National Service Framework.

The PCT has regular meetings with acute trusts to monitor secondary care commissioning and quality indicators are being developed for inclusion in the service level agreements with acute trusts.	The PCT produces a quarterly performance indicators report, which indicates performance against commissioner and provider performance against priority one SAFF targets. These include waiting times targets and access to primary care staff (2b.1). Monitoring of the delivery of the memorandum of understanding for health protection services is undertaken by the director of public health through quarterly meetings with the local consultant in communicable disease control (TQ2.18). The PCT's clinical governance development plan 2003/04 aims to strengthen links to the commissioning process to ensure a clinical governance reporting system is in place. The target date for this objective was September 2003 (2a.2). The PCT states that annual reporting on commissioning issues is undertaken through the performance monitoring sub committee	National Service Framework. Clinicians feel there is clinical input into the commissioning process. Staf f reported that the Performance Monitoring Committee was established to enable the PCT to have better grasp of what was happening on some issues for example commissioning. Staff reported there are regular meetings with the acute trust , there are monthly service level agreement monitoring review meeting Staff reported the PCT is develop a series of quality indicators for commissioning. List of indicators seen but document is not dated.

	which reports on national targets, local priorities, CHI indicators and finance. The PCT also notes that there are monitoring reports which are fed by the business plan and a quarterly review with the strategic health authority (TR1).	
The joint directors of public health lead the prescribing and medicines management team, and the PCT is developing effective prescribing advice and structures. The medicines management committee reports to the board and prescribing issues are discussed at the PEC.	The PCT produces a quarterly performance indicators report which indicates performance against commissioner and provider performance against priority one SAFF targets. These include waiting times targets and access to primary care staff (2b.1).	
	The PCT states that there are two joint directors of public health. The position is a board level lead for prescribing and medicines management (TQ2.23).	
The PCT has an electronic prescribing formulary and is developing a medicines management strategy and a prescribing monitoring framework. The formulary covers the majority of prescribing in primary and secondary care. Work plans have been developed for the prescribing advisor and pharmaceutical advisor. The PCT also	The PCT states that prescribing and medicines management issues are reported to the board (TQ2.4). The PCT states that a medicines management strategy is being developed and remains a priority area for the next 12 months (TQ2.23, TQ2.26)	

employs practice support pharmacists who are linked to GP practices. Staff find the level of the support given by the advisers and support pharmacists very helpful.	(TQ2.23, TQ2.26). The PCT states that a priority for medicines management in the coming year is to improve medicines management action planning, monitoring and reporting (TQ2.26). The PCT's board received a paper on prescribing in primary care which outlined the PCT's position in relation to setting prescribing budgets, current pressures, national pressures, generic drugs, current trends in prescribing and specific initiatives to support effective prescribing (2d.3, 2d.3.1). The PCT has a prescribing advisor work plan for 2003/04, which includes key objectives, action required including leads and monitoring notes on how to check progress. Objectives include: 1) Development, such as the monitoring, supporting and targeting ten practice support pharmacists 2) Performance monitoring, such as developing robust performance monitoring processes to support prescribing monitoring trends in general practice	Staff reported that the formulary is now widely used, and there is a planned audit. Staff reported there is a prescribing incentive scheme and they are please with the level of support they receive in relation to prescribing. Practices reported they are benefiting from the prescribing scheme. The PCT states that as a result of a CHI

The PCT has developed some links and mechanisms for medicines management across the local health economy. This includes representation on the care home services and community pharmacy group, and the medicines interfacing with social services group. Nurse prescribing is also being implemented and a nurse prescribing group has been established. A part-time community pharmacist is employed at the Gosport War Memorial Hospital	3) Strategy, such as supporting the development and implementation of the prescribing/medicines management strategy across the PCT 4) Communications, such as supporting the development and implementation of a strategy 5) Pharmaceutical advice, such as providing and supporting pharmaceutical advice across the PCT (2d.2.1). The PCT is represented on the administration of medicines and care workers group. The group also includes representation from the other two local PCTs. Issues discussed include training, issues surrounding social services, the rapid response team and funding (AD11). The PCT has representation on the medicines interfacing with social services group, which includes representation from a range of local PCTs, the workforce development confederation and social services. Issues discussed focus on joint working (AD10). Nurse prescribing group TQ2.2	investigation at Gosport War Memorial Hospital a clinical pharmacist has been appointed to the hospital in order to improve prescriber support and prescription monitoring. The PCT also notes that critical pathways are in place for concerns regarding prescribing and that ward usage of specific medications has commenced (TQ2.25). Staff reported that the level of nurse prescribing – is 67% of the nurses with the qualification are prescribing.