Witness Name: William Price
Statement No: First
Exhibits: WP1 – WP17
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP1 [____] to the Witness Statement of
William Price
Our ref ME/ch

Mr G Smith  
Director of Performance Improvement  
NHS Executive West Midlands  
Bartholomew House  
142 Hagley Road  
Birmingham  
B16 9PA

Dear Graham

Mid Staffs NHS Trust

Further to our recent conversations please find attached the confidential report of the PCG.

I have also attempted to sketch out how things need to happen over the next few weeks on the basis of our discussion. I think you said you would arrange a date for item 6.

Best wishes.

Yours sincerely

Melvyn Ellis  
Chief Executive

enc

Cc  Dr R Beal, Chairman, Stafford PCG  
    Mr W Price, Chief Executive, Stafford PCG  

 copy done 2005
Programme of Key Events

1. Stafford PCG report on commissioning now complete
2. Melvyn Ellis to share PCG report with Graham Smith (RO) – 6 August
3. PCG report to PCG members – 13 August
4. PCG report to HA members – 15 August
5. HA Board discussion 21 August
6. Melvyn Ellis discussion with Stephen Day/Graham Smith – by end of August
7. PCG Board discussion 4 September
8. Roger Beal/David Murray/Julia Jessel discussion – Mid September

Points to note

The underlying issues are:
- lack of engagement and leadership of clinicians in the Trust
- lack of engagement with the whole health economy
- failure to implement agreements

Resolution will require:
- change of leadership at CEO and Strategy Director level
- supported process of diagnosis of problems
- supported development for the whole leadership team at the Trust

ME/cld 3 August 2001
Subject: Commissioning with Mid Staffordshire General Hospital NHS Trust

Background Information:

The merging PCGs of Stafford and South Staffs to form a single South Western PCT need to agree a commissioning model as commissioning of hospital and community services will be one of the main functions of the PCT.

Recommendation:

The Board is asked to:

- Consider whether the current model, which has not been fully implemented, remains the best model.

- The PCG is responsible for a significant proportion of management costs of the Trust. As a result, the PCG considers it appropriate to comment on management arrangements and their adequacy. Recognising the impact on patient care, the Board is asked to support the recommendation that management arrangements at the Trust should be revised in order to address the issues identified.
Commissioning with Stafford District Hospital

1. Introduction

1.1 Please note this paper is strictly confidential due to the potentially serious issues and sensitivities under discussion.

2. Background Information

2.1 At the Confidential Board meeting of the PCG held on Wednesday 27\textsuperscript{th} June 2001, Board members were made aware of the problems of Mid Staffs Hospital NHS Trust in achieving their waiting list targets with the requirement to submit recovery proposals. Members were also told that the same Trust had appointed a consultant paediatrician with an interest in gastroenterology. This news was greeted with dismay by the Board, as there were specialties in the Trust experiencing enormous pressures, which from a Primary Care perspective could have been helped by the resource allocated to this particular post.

2.2 It was also noted that the Trust were losing a number of good consultants and that a briefing paper of all the issues of the Trust should be prepared.

2.3 At the May accountability meeting last year, a model of commissioning was proposed and subsequently presented to the Board in the July Board papers, (Appendix One, Commissioning - a discussion) this received broad support with the notable sole exception of Mid Staffs Hospitals NHS Trust, whose official response was (and remains) fairly negative. (Appendix Two). This model is patient focused and addresses needs of care providers.

2.4 A subsequent Away Day with the Directors of the Trust on 15 September 2000 elicited support, with an offer to lead the implementation of a local health priorities forum, but, despite repeated promptings, this has not been acted upon.

2.5 Concern is shared by our colleagues and commissioning partners in Cannock Chase PCG (Appendix Three).

3 Demand Management

3.1 Demand Management is obviously key to any commissioning process and if it is not to mean denial of access to services then it can only be delivered through a seamless care pathway approach, incorporating primary, secondary and tertiary care. An example of this having been developed in partnership with other organisations, and which is a model of partnership working, is the cataract project:

The problems of access to cataract services were identified as an area to be addressed when the PCG first came into existence. Over the past two years, the PCG developed a needs based scoring system in conjunction with the local optometrists. Commissioning for eye services led by South Staffs PCG, and Improving the efficiency of Cannock Hospital (run by Mid
STRICTLY CONFIDENTIAL

Staffs Hospitals NHS Trust) have resulted in a model of excellence, which epitomises the Win-Win-Win approach for patients, primary care and secondary care, which should be the aim of all such developments.

3.2 A similar approach is being adopted with Orthopaedics, but this is taking much longer to develop.

3.3 However, other proposals, some of which are relatively easy to implement were presented to the Medical Directorate and Board members of the Trust in February. These include:

1. Improving the quality of hospital to GP discharge letters.
2. Redesign of referral letters to include an option for consultant's opinion only.
3. The formulation of agreed care plans in hospital letters.
4. Reinstatement of out patient prescribing with adherence to the agreed prescribing Formulary, therefore not having patients make a second unnecessary trip to a GP for hospital recommended treatment.
5. Improving the access to diagnostic facilities, thereby reducing the need for an outpatient attendance.
6. Agreeing local priorities with commissioners (through the HmP/health priorities forum).
7. Developing corporacy, which aligns values and objectives in order to prevent unnecessary local conflict over service policies and priorities.

All show little sign of moving forward.

4. Related Issues

The requirements to tackle such matters are underlined by a number of subsequent events. The issues raised below are included by way of examples in order to highlight the nature and extent of the problems being encountered over the last 2½ years, and are not meant as a comprehensive list.

4.1 Prescribing

There is no doubt that the development of a joint Stafford, Cannock and Mid Staffs Hospital Formulary has been a big step forward in helping to address spiralling costs and an overspend on the prescribing element of the unified budget. However, there remain examples where the Trust purchases cheap loss leading drugs of no superior clinical benefit to alternatives, which have a higher cost and detrimental effect in Primary Care.

4.2 Unmanaged and Unresourced Workload Transfer from Secondary Care to Primary Care

A survey conducted earlier was presented to Directors of the Trust involved in commissioning and was derided by the Trust. This issue has since been taken up with the Chief Executive of the Trust and such issues will be fed
back through him. It is important that any such transfer ensures patients 'safety' through 'The System'.

4.3 **Diabetes Services**

A unilateral proposal by consultant physicians to start discharging patient with diabetes back to Primary Care commencing the beginning of August is of grave concern. This is in spite of a joint multidisciplinary PCG/Hospital working group set up to discuss the imminent arrival of the diabetes NSF and designed to prevent this very scenario from happening by taking a needs based approach to diabetes services. (Appendix Four).

4.4 **Information Technology (IT)**

There is a perception that there is little input sought from Primary Care into the planning phase of the Trust's IT Strategy with the result that the Primary Care requirements (part of the modernisation agenda) are not being addressed. There is also a feeling that the Trust are trying to foist a non nationally supported clinical support system in the form of Pathfinder onto primary care without proper evaluation.

4.5 **Loss of consultants by the Trust**

A number of these staff have recently left Mid Staffs Hospital. Interviews conducted with key staff cite lack of management support, delays in replacing broken instruments and lost equipment, reduction to half to two thirds the number of cases that used to be performed on lists due to poor theatre management and an over reliance on agency nurses who don't know the systems or equipment. The requirement to perform waiting list initiatives at short notice has led to intolerable strains with general deterioration in standards.

4.6 **Waiting list initiative money**

Views have been expressed that this money may result in the perverse incentive of the development of sub sets of patients requiring short appointments who are used to access this money.

4.7 **Access to diagnostic facilities**

Access to diagnostic facilities in particular imaging facilities for potential breast cancer has deteriorated and has been drawn to the attention of Region, at the Regional Review meeting held on 17 May 2001. Appendix Five details an anonymised letter from a practice within the PCG as an example of the problem.

4.8 **Communications**

The retirement of the single-handed consultant urologist (despite the required notice period) was only communicated to GPs in the last week of that consultant's service.
Failure to secure a replacement resulted in a large number of patient referrals being sent back to GPs, amongst these were suspected cases of cancer. This was a clear abrogation of responsibility by the Trust who are contracted to provide urology services and represents exceedingly dangerous practice on their part. A recent similar episode, which arose when a consultant chest physician left the Trust, was quickly rectified with admission by the Trust that their actions were inappropriate.

4.9 Proposals for Stroke Unit

In December 2000 at a joint commissioning meeting, the Trust confirmed that they were not developing a Stroke Unit. In April this year, this issue was again raised, and the Trust agreed there would be a presentation at the May meeting.

In May 2001 the Trust's Elderly Care Physician with an interest in Stroke also attended the meeting to hear the presentation, which had been cancelled by the Trust!

In June 2001 details of the Trust's Stroke Unit, which had been in operation since January, were presented at the commissioning meeting (Appendix Six).

5. Summary

4.1 Whilst there is a desire by the PCG to continue shared planned developments based on our commissioning model, too often there is mere lip service paid to areas of work that require the Acute Trust to take a broader view than their own agenda. This lack of alignment of values and objectives is leading to unnecessary local conflict over service policies and priorities, which in turn is rooted in behaviour influenced by organisational culture. Such attitudes and relationships need to be urgently transformed to a true patient focus, and not just the needs of professionals.

Recommendation:

The Board is asked to:

- Consider whether the current model, which has not been fully implemented, remains the best model.

- The PCG is responsible for a significant proportion of management costs of the Trust. As a result, the PCG considers it appropriate to comment on management arrangements and their adequacy. Recognising the impact on patient care, the Board is asked to support the recommendation that management arrangements at the Trust should be revised in order to address the issues identified.
Commissioning – A Discussion Paper

1. Outline Principles

AIM

From a Primary Care perspective, we need to adopt the philosophy that what can best (from an NHS performance perspective) be provided in Primary Care should be, and that which can't should be purchased.

However, we also need to understand and take into account that in time of rapid technological change, change in consumer expectations and political imperatives, the focus of service provision may change from Secondary Care to Primary Care and vice versa. At present, there are no management arrangements to support this e.g. if work is being devolved from Secondary Care to Primary Care and patients are being discharged from Acute Hospitals to Primary Care, the current concern and responsibility of the Acute Trusts ends as soon as the patient leaves their doors. They have no current concern as to the level of service support and provision in the environment to which the patient is being discharged. I believe we need to adopt a commissioning model that looks at the service provision across Primary and Secondary Care, which pools the resource and allocates according to need. This will enable resource to be allocated in the appropriate setting, and if this philosophy is adopted - across Trusts, Social Services and Voluntary Organisations - will facilitate joint working and breakdown the past historic territorial boundaries. It is quite clear that this model will require intensive working, understanding the precise allocation of resource within provider units in each service area e.g. if we look at physiotherapy services, the Acute Trust provides physiotherapy services to inpatients and Primary Care outpatients, with service also being provided by First Community Trust. If we take a whole service approach, then we would need to identify the current total resource allocated to inpatients and Primary Care together with an understanding of the requirements of each in terms of health need, and jointly agree an approach that provides for the overall level of requirement within the resource available. This may also include Social Services who are seeking to provide re-enablement services. Once allocations have been established, then regular audit needs to be undertaken in order to address any changes within the system as time goes by and respond accordingly. We therefore need to adopt the commissioning philosophy presented by Lynne at the May Public Accountability Meeting:-

- We need to establish a common view of developments across all agencies, organisations and interested parties (including Primary Care and NCL GMS, Secondary Care and tertiary care).
- We need a shared view of existing services and needs in order to have a shared understanding of priorities and agree commissioning intentions. It is important to be realistic in how much we can review and alter.
- The annual contracting cycle needs to be further developed with emphasis on quality markers and building on previous achievements.
- Once we have reviewed services, we should be able to develop and agree service specifications selecting the most appropriate provider, either in Acute or Primary Care.
- Once we have these agreements in place, we must then set standards for performance review, rather than the numbers game.
We also need to include those areas of demand management which are easily applicable, and start to consider ways of implementing waiting list management at either the PCG or practice level. We may need to consider piloting one area within a number of practices to see whether it is feasible and could be rolled out across the PCG.

We need to take into account the new allocation to Primary Care of resource and see how this is best spent with respect to our overall priorities (both National and local) together with the IT support that the above requires i.e. what we have at the moment, what we need, when and where we go to get it! I believe that, following our discussion, we need to obtain the agreement of Trust Chief Executives, Directors, including Medical Directors, PCGs, and Commissioning Managers to the philosophy of our approach together with an agreement to consider perhaps setting up a PCG Priorities Forum which looks at the priorities of Primary Care and each provider within the overall HfM requirements and local needs. It would be useful to give consideration as to the process by which this would work in terms of agreeing priorities and implementing the practicalities of delivery.

We also need to consider the currency by which we contract in the future:-

We need to understand the benefits of the different currencies i.e. FCEs versus HRGs versus HBOs versus WTE within the context of National reporting requirements and establishing mechanisms which provide clear information on cost effectiveness, clinical effectiveness, accessibility, user views, and addressing inequalities.

Clinical and managerial issues that may arise as a result of commissioning proposals may need to be addressed by some sort of governance arrangements and how these are fed into such arrangements also needs to be considered.

We need to consult with other PCGs as to the benefits of breaking down individual contracts by individual PCGs and providers and whether this is currently feasible or desirable. We also need to have a forum by which commissioning decisions and work done is shared between PCGs so as not to waste resource repeating similar exercises across the patch.

Dr R M Beal
Chair, Stafford PCG
14th August 2000

Mr William Price
Chief Officer
PCG
SSIHA

Dear William

Further to your letter concerning commissioning, I apologise for not responding within your deadline. This is in part due to the fact that we did not receive it until after this date.

I view the paper with some scepticism and dismay. It’s unashamed focus on Primary Care is in-balanced.

Surely we should focus on a whole systems approach to care, and what is best provided by any sector should be. I would be particularly interested to how this fits with a level 2 PCG and whether the Health Authority support your paper. Roger was particularly keen that purchasing reflected on HiMP and SSR processes and I believe that this model could lead to unplanned strategic change outside of these arrangements.

We note and welcome the use of HRG’s/IBG’s and I am sure you will note our reference costs. We also welcome the waiting list devolution linked to capacity.

I am not sure whether your paper reflects the changing face of general practice in Cannock and that it is supported by the Cannock PCG.

In summary I do not feel that this reflects a genuine collaborative and whole systems approach. The physiotherapy example is confusing and does not reflect training requirements, professional development etc.

Perhaps it would be appropriate to allow time for a detailed briefing at a future monthly meeting or if time permits at our 15th September time out.

Yours sincerely

[Signature]

Derek Pamment
Director of Healthcare Strategy & Corporate Development
Re: Mid Staffordshire General Hospitals NHS Trust

The Stafford and Cannock Chase Primary Care Groups jointly commission secondary sector services; Stafford PCG taking the contract lead with the Mid Staffordshire General Hospitals NHS Trust. A number of difficulties have been encountered with the Trust, the majority of which would appear to result from a lack of management direction. There is little evidence of teamwork amongst the ‘top team’ and there is an absence of an Operations Director to take responsibility for the delivery of corporate objectives. Members of Cannock Chase PCG therefore share the concerns of colleagues at Stafford PCG and this paper is presented to supplement and support the more detailed briefing provided by Dr Beal, Chairman of Stafford PCG. Examples are given of the types of difficulties encountered ranging from the ‘strategic’ to the ‘operational’.

- Lack of Management Commitment and Action to Undertake Key Tasks Agreed between the Parties

In 2000 Dr Beal presented a proposal, fully supported by Cannock Chase PCG, that we should attempt to commission services on a ‘disease’ basis, rather than through a process of purchasing ‘blocks of services’ from different providers. This was discussed at two facilitated Away Days with the Trust in late 2000 and it was agreed the Chief Executive of the Trust would arrange a further session early in the New year to include all the local key clinical stakeholders i.e., primary care, community services, ambulance and hospital. This would also provide the opportunity for the wider group of stakeholders to share their ‘priorities’ for service development. As we enter the second half of 2001, it would appear that no action has been taken on this, effectively hindering our ability to take a patient focus to the commissioning of services.

- Lack of Management Co-ordination within the Trust, particularly between Trust Management and Clinicians

There is little evidence of ‘corporacy’ within the Trust and this has been raised on a number of occasions. Despite the need for the Trust to have an agreed approach to managing relationships with PCGs, individual Consultants continue to approach GPs directly with initiatives aimed at progressing their own personal or specialty agendas rather than those which reflect the priorities of the Trust. The PCGs have emphasised the need for the Trust to be clear as to its priorities. Such approaches which do not have the support of the Trust result in confusion both amongst individual practices and the PCGs as regards the priorities of the Trust.

- Lack of Management Action to Ensure that Key Objectives are Delivered

There are a number of examples where projects have been initiated but have taken an inordinate amount of time to complete e.g. TTO’s. This was raised within the Strategic Services Review and seen as a positive way to contain prescribing expenditure on a health economy-wide basis. The exercise
required a combined contribution from Consultants, Hospital Pharmacy, Hospital Management and General Practice. Whilst recognised as a priority within the health economy, key personnel within the Trust did not afford the exercise the same degree of emphasis. There was clearly a lack of Trust direction on this with the result that some two years later, the project remains incomplete. If all parties had given the TTO project their total commitment, it is considered that the work involved could have been completed within one year.

- An Inability of Trust Management to Address the Basics

An issue raised repeatedly by Cannock Chase PCG, and recorded in the minutes of contract monitoring meetings, is the quality of communication, particularly discharge letters from Hospital Consultants to GPs. Invariably, relevant details are illegible or are not provided resulting in the GP having to telephone the hospital for the information involved. This results in unnecessary additional work for both the hospital and the GP, and potentially makes the GP look uncaring or ridiculous in front of his patient (the GP due to lack of information being unable to have an informed discussion with his patient about the outcome of the hospital investigation/consultation). Despite being raised repeatedly for over two years, no improvement has occurred.

Dr Selvan
PCG Chairman

Mr J P Parsons
Chief Executive
POSITION STATEMENT

1. The hospital is Stafford cannot provide a satisfactory service for patients with diabetes. This is because our department is under-funded and under-staffed. In order to provide proper care of in-patient emergencies, it has become necessary to withdraw all junior medical staff from our clinics. This process will begin in August and be complete by the end of the year. The number of diabetic out-patients who can be seen at the hospital will be reduced considerably and many will be discharged to the care of colleagues in General Practice.

2. The Consultant Diabetologists intend providing a proper service, but for fewer patients. It is hoped that the new arrangements will allow diabetic emergencies and problems will be dealt with quickly and colleagues from General Practice will know that their patient are being seen by specialists and not by trainees.

3. The position we find ourselves in will place a greater burden upon our Diabetes Specialist Nurses, who may also have to modify their present service.

4. The PCGs are charged with providing comprehensive care for patients with diabetes and it is hoped that services once provided in the specialist clinics will now be devolved to the community.

5. There will be NO cost savings at the hospital because of these changes. Consultant run clinics in Endocrinology and General medicine will continue unchanged and the junior staff removed from the clinics will be re-deployed on the wards. The resources needed will NOT be diminished. It is therefore imperative that the PCGs find "new money" to provide a service in the community for diabetic patients.

6. The PCGs and their advisers need to be aware of what cannot be done now and what will never be done without considerable extra funding:

   - Annual review clinics
   - Archiving of patient data in a comprehensive diabetes register
   - Education of newly diagnosed and established diabetics
   - Modern foot care to prevent amputations
   - Proper retinal screening to prevent blindness
   - Correct supervision of elderly patients in nursing homes

7. This group must tell the PCGs the facts of the matter now. Prevarication and setting up of study groups or working parties will achieve nothing. The NSF will make recommendations that will not be implemented in this health district and the PCGs must be made aware of this.
20 July 2001

Director of Surgery
Staffordshire General Hospital
Weston Road
Stafford
ST16 3SA

I am writing on behalf of the Surgery to express some concerns about the Fast Track Breast Cancer Referral Service. The reason for wanting to draw this to your attention was that the cases will not show up in your statistics, because following internal referral to Stafford, both patients were subsequently seen at the "Walk in" Breast Clinic at Walsall Manor Hospital.

The first patient aged ______ was seen initially by myself on the 10th January 2001 and referred using the proforma on the same day. A covering letter was faxed with the proforma which described the breast lump as being irregular. On Monday 19th March she telephoned me to say that she had found out about the "Walk in" Clinic in Walsall and requested a referral. Her Stafford appointment had been made for the 30th May 2001. Following her appointment in Walsall she was diagnosed with a carcinoma of the breast (grade III) and has subsequently had a mastectomy and is currently having chemotherapy.

The second patient aged ______ was seen initially by ______ on 26th April 2001 and referred on the same day to the Fast Track Breast Cancer Referral Service. Her appointment was scheduled for 30th May 2001. She then requested to be seen sooner and was seen on 10th May 2001. Histology of FNA showed sclerosing lymphocytic lobulitis as did a core biopsy. She had a suspicious mammogram and USS. She is to undergo regular 3 monthly reviews for 12 months and to have an excision biopsy if there is any sign of recurrence.

We understand that patients referred under the Fast Track Breast Cancer Referral Service, would be seen in Clinic within 2 weeks. Both of these patients had discrete breast lumps which fulfill the criteria for urgent referral. We appreciate that the Service may be under pressure, but having seen and referred a patient with potential carcinoma we need to have confidence that they will receive an appointment within the standard set out in your protocol. If these referrals are being triaged, we need to know what additional criteria are being applied.

Yours sincerely

Dr C Bramley

cc: Mr B Gwynt
Mr R Beale Chairman PCG

Dr. David J. Wheeler
Dr. Keith Pringle
Dr. C. Nicholas Barnes
Dr. J. Patrick Hannigan
Dr. Carol Bramley
Dr. Mary MacSharry

WS0000016149
Mid Staffordshire General Hospitals NHS Trust
Developments on Valley Ward Stroke Unit - Cannock Chase Hospital
June 2001

Valley ward is a 28-bedded Acute Care of the Elderly Ward. On 29 January 2001 8 of the 28 beds were designated to the Care of patients who have suffered a Cerebral Vascular Accident i.e. Stroke. The Stroke Unit is an Intermediate Care Unit, within the acute unit, providing a multi-disciplinary approach to care that encourages patient and carer involvement. An evidence-based Stroke Care Pathway is in the process of being developed to meet the individuals physical, psychological, spiritual and social needs.

The main objective is to maximise and maintain the individuals independence and functional ability prior to discharge.

As a consequence of the aim the following objectives will be achieved: -


2. Transitional phase: Address issues relating to the discharge process and planning. Development of a Stroke Care Pathway -effective, efficient use of service for the benefit of the patient and all concerned. Promote Collaborative Working. Improve liaison with primary, social and voluntary sectors.

3. Intermediate Care: A Lecturer/Practitioner in Intermediate Care is to commence in post on 4 June 2001. This role will include networking with other practitioners working in the field of intermediate care. Increase the team’s knowledge regarding Intermediate Care and the adoption of “Best Practice” that is evidence-based. Critically evaluate the role of Lecturer/Practitioner in Intermediate Care.


ENVIRONMENTAL CHANGES ON VALLEY WARD

♦ The Ward has become more "open plan" by removal of the Nursing Station Desk. This has resulted in further integration of the Nursing Team with Patients and Carers. The Ward Receptionist is based at the entrance to the ward.

♦ Mobile Telephone access in all ward bays- this enables patients and relatives to actively communicate and encourages the nurse to be at the patient’s bedside.

♦ Resource Room- this area has recently been acquired and is multi-purpose providing a quiet area for patients and carers. An area for confidential case conference, a Teaching area for all levels and disciplines of staff working on Valley ward and Informal Clinical Supervision, Peer support and development. Visits from the Stroke Association for informal meetings with Patients, Carers and Staff occur on a weekly basis. Collection of journals, Internet access and other learning resources. Including promotion of a problem – solving culture. Development of a Care Library.

♦ The Ward operates a policy of completely open visiting in order to meet the needs of patients and their relatives/carers.
♦ The Ward has been recently decorating and includes a selection of prints by Monet providing a calm therapeutic environment.

♦ All Staff have been provided with new uniforms from the Government Environmental Grant. This has provided improved Manual Handling in line with EEC Guidelines and reduced barriers regarding Inter-personal Interaction.

♦ Practice Review- A Clinical Bench – Marking co-ordinator has been actively involved on Valley Ward. Areas currently being addressed are :- Record-Keeping, Nutritional Assessment, Tissue Viability, Risk Assessment specific to Manual Handling.

♦ A learning culture is promoted. A team of Senior Staff Nurses are currently reviewing Primary Nursing on Valley Ward.

♦ Regular Monthly Ward meeting take place to regular issues as they arise and support staff and to further ward development.

♦ Clinical Leadership- The Ward Manager and the newly appointed Lecturer/ Practitioner are both participating in Leadership Programmes.

♦ Two Staff are currently pursuing First level Degrees Courses.

♦ All Nursing Staff have recently undergone the Trust's individual performance review.
Witness Name: William Price
Statement No: First
Exhibits: WP1 – WP17
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP2 [ ] to the Witness Statement of
William Price
Our ref SFWP/eh

04 March 2004

Mr David O'Neill
Chief Executive
Mid Staffordshire General Hospitals NHS Trust
Weston Road
Stafford
ST16 3SA

Dear David

Waiting Times - Incident Meetings

You will be aware that weekly incident meetings have been arranged between your senior representatives, the SIHA, myself and Jean-Pierre Parsons to discuss concerns on the year end.

The first meeting took place on 3 March, and I am disappointed that no representative attended from your Trust, although both PCTs and the SIHA attended. Therefore, I am writing to obtain assurance on the following points in respect of the year end position for inpatient and outpatient waiting times (and potential breaches of the 9 month/17 week wait targets):

- Confirmation of the current position
- Actions taken to redress any potential breaches
- TCI dates issued by 9 March in accordance with SIHA guidance
- Risks inherent in achieving (and particular specialty issues)
- Contingency arrangements to secure no breaches

At the meetings we also wish to seek assurance that actions are being taken to continue to avoid breaches in the early months of 2004/05, and the same details as the above would be requested.

The PCTs will continue to work with the Trust to deliver jointly agreed plans, and will continue to continue to work on a weekly basis to avoid breaches. More particularly, we wish to support plans which deliver the work throughput to avoid these weekly-based planning meetings.
David O'Neill
Chief Executive, Mid Staffordshire General Hospitals NHS Trust

Page 2 of 2

4 March 2004

I would appreciate a response on the details requested above by return, and your assurance that the weekly meetings will be attended by the Trust representatives in future.

Yours sincerely

William Price
Chief Executive

CC: Jean-Pierre Parsons, Chief Executive, Cannock Chase PCT
Prof B Crump, Chief Executive, SIHA
John Newsham, Director of Finance & Planning, MSGH NHS Trust
Miliar Bownass, Director of Patient Access, MSGH NHS Trust
Susan Fisher, Director of Finance, SWS PCT
Martin Harris, Head of Performance Management, SIHA
Lynne Deavin, Commissioning and Service Development Manager
THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP3 [ ] to the Witness Statement of William Price
South Western Staffordshire PCT

Service Level Agreement
2004/2005

with
Mid Staffordshire General Hospital NHS Trust

£45,551,432

G:Finance Directorate/commissioning 2004-2005 SLA/SLA Mid Staffs 04_05.doc

TRUST00030012066

WS0000016156
SIGNED on behalf of lead PCT

Name
Susan Fisher

Designation
Director of Finance & Performance

Date

for and on behalf of Provider

Name

Designation

Date

Draft 2 South Staffordshire PCT’s SLA

TRUST00030012068

WS0000016158
Section 1: PURPOSE OF THE AGREEMENT

The aim of this SLA is to secure a level of service for patients on the lists of PCTs in South Staffordshire, in terms of activity, quality and cost, that meets national and local targets and the requirements of the PCTs' Local Delivery Plans and Health Improvement and Modernisation Plans. The priority areas identified within the LDP are:-

- Access
- Cancer
- Coronary Heart Disease
- Mental Health
- Older People
- Children
- Patient Experience
- Health Inequalities
- Drug misuse
- Information Management and Technology
- Physical Capacity
- Workforce

All services provided by the Trust will be guided and measured by the six dimensions of performance within the National Framework for Assessing Performance:-

- Health Improvement
- Fair Access
- Effective Delivery of Health Care
- Efficiency
- Patient/user Experience
- Health Outcomes of NHS Care
Section 2: Names and Contact Details

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<td>Commissioner Lead</td>
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<td>Lynne Deavin</td>
<td>South Western Staffordshire PCT</td>
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<td>Mellor House</td>
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<td>Corporation</td>
<td>Stafford ST16 3SR</td>
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South Western Staffordshire PCT wishes to secure the provision of secondary and tertiary healthcare and ancillary services to patients and Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS Trust wishes to provide such services.

The provider and Commissioner have agreed to enter into a NHS Contract as defined by section 4 of the National Health Service and Community Care Act 1990 for the provision of services to patients.

Service agreement duration
This Service Level Agreement (SLA) will be for a period of 12 months with effect from 1st April 2004 until 31st March 2005. Activity targets and funding will need to be negotiated in year for the following year through the usual process, reflecting Provider performance, local and national issues together with guidelines for good practice. This agreement will be updated to reflect updated DH guidance on SLAs. Either party can make reasonable changes to the service requirements at the reviews without incurring a penalty.

Section 3: Activity and Resources

Services to be Provided:
The Provider is expected to deliver the services set out Appendix 1 in return for the funding described in Appendix 2.

Payment Mechanism
Payment will be made on the 15th day of every month, or the nearest working day, and will be 1/12 of the total service agreement value.
Year end settlement
The final value of the agreement will be calculated and settled prior to the financial year end and will be based upon a 10 month bottom line activity/financial variance pro rated to month 12. Any agreed over or underperformances must be settled in the financial year in which it occurred and cannot be carried forward into subsequent years.

Section 4: In year variances
The parties recognise that it may be necessary to vary the Service Agreement in year. Variations will be subject to prior consultation and agreement will be subject to confirmation in writing between the Commissioners and the Provider.

The resources set out in appendix 2 represent the agreed funding for the agreed services and activity. The only other circumstances where the PCT agrees to consider providing further resources for these services and activity are:

a) Where there is a change to the national tariff in year. This might occur in 'exceptional' circumstances for example if NICE publish guidance or recommendations that will have a significant and unforeseen impact on the cost of delivering a service

b) Where unforeseen circumstances, such as a major structural fault to the Trust's infrastructure or a major illness outbreak amongst the staff, lead to an enforced closure to part of the Trust's facilities.

Section 5: Choice
Choice at Six Months
Information Management

- To provide on a bi-weekly basis an information upload onto the Choice Management Module of those patients who have waited for a surgical procedure between 4 months and 7.5 months. Excluding those patients who can be provided with a booked appointment before 7 months wait.

- To upload onto the PIMS or equivalent system all patients who are excluded from Choice at Six Months, following the exceptions criteria issued from the Strategic Health Authority.

Administration

- To ensure medical staff are made aware of Choice at Six Months and adhere to agreed procedures.
To liaise with the Patient Care Advisor in identifying the patients notes and x-rays for all those who have chosen to accept a transfer to another hospital.

To transfer patient notes and x-rays following agreed procedure with the PCTs.

To validate via the consultant those patients wishing to move to another provider.

To provide clinical information to representatives of the PCTs on an Ad hoc basis; in particular the Patient Care Advisor.

Management

To work with PCTs on the development of patient pathways.

Choice at Point of Referral

Information Management

Work with Primary Care to develop change management systems across the Trust, to facilitate a booked appointment at the point of referral with or without an E-Booking facility.

Administration

To work with PCT representatives in commissioning services for Choice at Point of Referral patients, taking into account future 'Payment by Results' methodologies.

To work with PCT representatives following Government Guidelines for the introduction of Choice at Point of Referral

Management

To work with PCTs on the development of patient pathways.
Section 6: Information Flows and Performance Monitoring

The provider will provide the PCTs through the Clearing Service with all necessary information on a monthly basis to enable monitoring of the agreement and to satisfy national requirements as outlined in Appendix 3.

Both parties acknowledge that in order for the parties to achieve accurate forecasting, activity monitoring and prompt and accurate payment by results, there needs to be timely regular exchange of detailed and accurate information and accordingly the Provider shall:

- comply with current NHS data standards in relation to the information collected and provided on the services provided;
- adopt new and revised standards as approved by the Information Standards Board;
- collect Commissioning Data Set (CDS) as specified in the CDS Manual;
- establish and maintain systems and procedures for recording information in accordance with the NHS Data Dictionary and Manual and the NHS CDS Manual;

Submit data to the Nationwide Clearing Service on a [monthly] basis within 15 days of the end of the [month] to which the data applies; submit to the Commissioner all that information required by the Commissioner and set out in Appendix 3 (Information Flows) such information to be sent.

The Commissioner shall on a monthly basis notify the Provider of any predicted variation to the [forecast level of activity/ [activity plan]] that is likely to occur in the next month.

The Provider will provide other information reasonably requested by the Commissioners to enable monitoring of the agreement to take place.

The Provider will facilitate visits by the Commissioners to any part of the Trust for the purpose of Service Agreements performance monitoring. Visits to areas not open to the general public will be subject to prior notification to the Provider. These arrangements will also extend to visits by other organisations undertaking monitoring activities on behalf of the PCTs.
Payment by results
The trust will provide information on all specialities in both FCE and RVU terms in order that both the Provider and the Commissioner are able to prepare for the full implementation of PBR in 2005/06.

The Provider will work towards developing spells based activity reporting during the year for the 48 HRGs as a priority and then all remaining activity in order to inform the 2005/06 LDP process.

Section 7: TERMS AND CONDITIONS OF SERVICE

LEGAL STATUS

This Service Level Agreement (SLA) is not a contract enforceable at law. However, it is expected that all parties will adhere to best practice for negotiation and monitoring of the agreement. In the case of disputes emanating from this agreement parties will, in the first instance, be expected to attempt to reach a local resolution to the problem.

In the event of a dispute remaining unresolved after a period of one month, and if the delivery of services are threatened, the dispute shall be referred for conciliation to the Shropshire and Staffordshire Strategic Health Authority and . The SIHA has the right to refuse to intervene if it is considered that sufficient local dialogue has not taken place. If a different Strategic Health Authority area hosts a Trust then Shropshire and Staffordshire SIHA will assist in the conciliation process.

STATUTORY REQUIREMENTS

All parties must recognise their respective obligations to comply with the requirements of all current legislation in relation to, for example: Child Protection; Controls Assurance, Health and Safety.

REPRESENTATIVES

For the life of this Agreement the NHS Trust shall appoint a representative (the "NHS Trust Representative") and shall notify promptly any change in the identity of the NHS Trust Representative to the PCT(s) in writing. The NHS Trust Representative shall be the key point of contact at the NHS Trust for the PCT(s) to whom the PCT(s) may refer all queries and day to day communications regarding the operation of the Agreement in the first instance.

For the life of this Agreement the PCT shall appoint a representative (the "PCT Representative") and shall notify promptly any change in the identity of the PCT Representative to the NHS Trust in writing. The PCT Representative shall be the
key point of contact at the PCT for the NHS Trust to whom the NHS Trust may refer all queries and day to day communications regarding the operation of this Agreement in the first instance.

The names of the NHS Trust's Representative and the Lead Commissioning PCT's Representative are shown on page 3.

SERVICE DEVELOPMENTS

For activity not covered by the new system of financial flows, service developments will continue to be negotiated and agreed. The planning guidance for 2003 – 2006 'Improvement, expansion and reform' showed that where service developments are supported by commissioners amounting to 75% of a Trust's funding by value, other commissioners would be expected to fund their share.

NICE GUIDANCE

Trusts are required to produce 3 monthly reports on their progress towards Implementing NICE Clinical Guidance and Technology Appraisal Guidance. This should include details of the number of patients treated and associated expenditure.

SUB-CONTRACTING

(For newly contracted-out services, or upon renewal of a contract), where any party subcontracts the provision of all or part of the clinical service (to an NHS or non-NHS provider) the PCT will be informed beforehand. This will allow discussion between interested parties of whether the service might be provided at the same, or higher quality, and for better value for money by another provider. Subcontracted services will remain the responsibility of the original provider i.e. NHS Trust. The PCT will have access to the full range of monitoring material as agreed with the original provider in the main SLA, where appropriate.

INFORMATION REQUIREMENTS

Monitoring, Liaison and Review

Summary reports of activity and achievement against the performance standards will be shared as set out in Appendix 3. More frequent exception reports may be requested where there are concerns about performance. The PCT may request further detailed 'ad hoc' information from time to time. Sufficient notice will be provided for such requests.
The PCT has a responsibility to performance manage the SLA and will in consultation with the provider take appropriate steps to facilitate the process.

Data Definitions

All data supplied to the PCT must conform to national standards regarding definitions, codes, classifications and field lengths and formats.

Security and Confidentiality


The Provider and its staff shall not disclose to any other party any information concerning the provision of services to an individual patient, or the medical condition of that patient. As detailed within the disclosure of confidential information contained within the provisions of the Data Protection Act 1998 and EL(92)60 "Confidentiality in information and contracting".

RESPONSIBILITY FOR ACCESS TARGETS

Ultimately both commissioners and providers are jointly responsible for delivering access targets. Underpinning that however, specific roles and responsibilities can be assigned.

Joint responsibilities

- Estimating the activity required to meet targets for the commissioners’ patients
- Active monitoring throughout the year and taking action accordingly
- Working in partnership to share information

It is the commissioner’s responsibility to:

- Commission the activity required to meet targets for its patients
- Base those estimates on realistic assumptions
- Monitor the reality against the original assumptions and to take action accordingly

It is the provider’s responsibility to:

Draft 2 South Staffordshire PCT’s SLA

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• Deliver the required activity and/or ensure that it is done to acceptable standards elsewhere
• Provide the information needed to allow the commissioners to carry out their responsibilities as set out above
• Deliver activity to an agreed profile so that the commissioners aren’t called into re-evaluate whether they need to commission extra activity (note that where numbers are small, profiles will need wide tolerance limits and it will be more informative to look at all the profiles of the Trust’s activity across all commissioners than just a single one)
• Manage the list efficiently, according to clinical priorities and access targets.
• Where a provider anticipates that access targets may be under significant threat of a breach they will notify the commissioner with the details and a proposed rectification plan immediately. Refer to contacts on page 2.

Action should include:

• Analysing the sources of under-performance eg are referral rates from primary care rising, emergency admissions, ‘conversion rates’ from outpatient to inpatient, tertiary referrals?
• Taking steps to address the sources of the increasing activity
• Re-estimating the amount of activity required
• Commissioning or providing that activity
• Early notification of threat of breaches to target.

SERIOUS UNTOWARD INCIDENTS

Parties within the SLA must have effective procedures for the management of all serious untoward incidents. The Strategic Health Authority will be notified by the relevant NHS organisation.

CIRCUMSTANCES BEYOND CONTROL

If circumstances arise which prevent the delivery of services that are beyond the control of one of the parties to the agreement then this SLA may be renegotiated in consultation, as necessary, with the Strategic Health Authority.
COMPLAINTS

The NHS Trust agrees to keep the PCT informed about complaints in order to inform discussions about service quality.

QUALITY AND CLINICAL GOVERNANCE

The Trust has statutory responsibilities in relation to Clinical and Corporate Governance and the PCT will need to be assured that the Trust has an overall strategy to comply with all the requirements of Clinical and Corporate Governance. For Clinical Governance, the Strategy will address the following areas:

- Risk Management
- Clinical Effectiveness
- Continuing professional development
- Quality of Care

The provider shall carry out the Services in accordance with best practice in health care and shall comply in all respects with the standards and recommendations;

- Contained in the Statement of National Minimum Standards;
- Issued by the National Institute of Clinical Excellence; or
- Issued by any relevant professional body;
- From any audit and Adverse Incident Reporting;
- And such other quality standards agreed in writing between the Parties.

The Provider shall ensure that:

- All Staff employed or engaged by the Provider are informed and aware of the standard of performance they are required to provide and are able to meet that standard;

- The adherence of the Provider's Staff to such standards of performance is routinely monitored and that remedial action is promptly taken where such standards are not attained.

For the avoidance of doubt nothing in this Agreement is intended to prevent this Agreement from setting higher quality standards than those laid down under the Provider's Terms of Authorisation.

The NHS Trust is expected to provide the same standard of service to all patients in accordance with national standards such as embodied in National Service Frameworks and CHAI except where it is agreed otherwise.
Where concerns are raised over the quality of clinical services at a particular NHS Trust, service providers, PCTs and Strategic Health Authorities will be able to use the mechanisms set up through the clinical governance system.

Following investigation that does not result in satisfactory re-negotiation and rectification, this SLA may be terminated and services sought from alternative providers, in consultation with the Strategic Health Authority. In these circumstances, a period of sufficient notice will be agreed between all parties.

Clinical audit
The provider shall on request provide the commissioner with any results of any audit, evaluation, inspection, investigation or research undertaken by or on behalf of the Provider or any third party of the quality of any or all of the services of a similar nature carried out by the provider.

PARTNERSHIP WORKING
All parties to this agreement recognise the importance of effective partnership working and the involvement of clinicians, staff and stakeholders in this process. This work will include both primary and secondary care clinicians to develop appropriate models service redesign and modernisation.

NOTICES AND AMENDMENTS
This SLA may be amended by written agreement from both parties. Any amendment should be signed and dated by an authorised representative of both parties and be recorded on an agreed form.

Period of notice will be six months except in the case of serious untoward incidents or circumstances beyond control.

DISCRIMINATION
Neither party shall discriminate unlawfully within the meaning and scope of any law, enactment, order, regulation or similar instrument relating to discrimination (whether in relation to race, gender, disability, religion or otherwise) in employment or performance of the services.
Risk Agreement

Where either party identifies a significant threat to the delivery of any part of this SLA then the identifying party should inform the other party immediately to enable discussion and action plans to be developed and agreed.

Quality and Waiting Lists

Inpatient and Day Case Waiting Times

Guaranteed Standard:
Maximum waiting times of 9 months up till 31st December 2004 and maintained maximum waiting time of 8 months from 1st January 2005 to 31st March 2005, will be achieved maintained for elective in patients and day cases. The Trust must provide the PCT with monthly monitoring information on waiting lists so that the PCT can monitor performance. The Trust will comply with the profile agreed with the Health Authority and Regional Office.

Outpatient Waiting Times

Guaranteed Standard:
The Trust will have 0 GP patients waiting over 13 weeks for first outpatient appointment by 31st March 2005.

Appendices

1 Activity information
2 Financial contract reconciliation
3 Information flows
4 Tolerances
5 PCT exclusions
6 Provider exclusions
7 Prescribing
8 Quality indicator for Acute Trust
## Appendix 1

### Middessex General Hospital NHS Trust

<table>
<thead>
<tr>
<th>Activity</th>
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| Elective       |                               |              |          |
| General surgery| 787                           | 1,758,771    | 787      |
| Urology        | 519                           | 553,077      | 519      |
| T&O            | 746                           | 1,954,161    | 746      |
| ENT            | 385                           | 466,815      | 385      |
| Ophthalmology  | 128                           | 154,905      | 126      |
| Oral surgery   | 30,744                        | 17           | 17       |
| Anaesthetics   | 1,707                         | 1            | 1        |
| Gen Med        | 128                           | 154,905      | 126      |
| Haem Clinical  | 24                            | 133,303      | 24       |
| Rehabilitation | 7                             |              |          |
| Dermatology    | 9                             | 31,258       | 9        |
| Neurology      | 16                            | 44,772       | 16       |
| Rheumatology   | 96                            | 221,233      | 96       |
| Paeds          | 147                           | 71,128       | 147      |
| Geriatric Medicine | 20                        | 48,667       | 20       |
| Gynae          | 420                           | 707,894      | 420      |
| GP beds - other than maternity | 2                             | 2,101        | 2        |
| Obstetrics     | 1                             |              |          |
| Clinical genetics | 1                         |              |          |
| Clinical oncology | 13                       | 5,295        | 13       |
| **Sub total**  | **3,318**                     | **6,183,622** | **3,308** |

| Non            |                               |              |          |
| General surgery| 1,400                         | 2,136,757    | 1,395    |

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## Mld Staffordshire General Hospital NHS Trust

### Appendix 1

#### MSGH SŁA 2004/05 - SWS only

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<th>2004/05 August model</th>
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#### Outpatients

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## Appendix 1

### Mid Staffordshire General Hospital NHS Trust

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### Mid Staffordshire General Hospital NHS Trust

**MSGH SLA 2004/05 - SWS only**

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<th>£ 2004/05</th>
<th>£ August model</th>
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<td></td>
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<td>Consultants concord 9.4% of total SLA</td>
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<td>exclsuo supersuensation cost pressure - alloc not yet rec'd</td>
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### Appendix 3

#### Information Flows

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<td>15 days after month end</td>
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<td>(by Specialty and Responsible PCT)</td>
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<tr>
<td>Outpatient long wait MDS</td>
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<td>15 days after month end</td>
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<tr>
<td>(Specialty and Responsible PCT)</td>
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<td>Inpatient &amp; outpatient waiting list Primary Targeting</td>
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<td>List (PTL - tail gunner)</td>
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<tr>
<td>Outpatient referrals (GP and Other) MDS</td>
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<td>15 days after month end</td>
</tr>
<tr>
<td>(by Specialty and Responsible PCT)</td>
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<td>Admitted Patient Care Data Set</td>
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<tr>
<td>(by Specialty and Responsible PCT)</td>
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<tr>
<td>Outpatient MDS</td>
<td>Monthly</td>
<td>15 days after month end</td>
</tr>
<tr>
<td>(by Specialty and Responsible PCT)</td>
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<tr>
<td>Direct Access (data set to be confirmed)</td>
<td>Monthly</td>
<td>15 days after month end</td>
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<tr>
<td>(by Responsible PCT)</td>
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<tr>
<td>Conversion rates of Outpatients to Inpatients, by</td>
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<td>15 days after month end</td>
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<td>Specialty</td>
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<td>HRG Analysis for Financial Flows</td>
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#### Central Returns

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<tr>
<td>Quarterly waiting list returns</td>
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<tr>
<td>SITREPS</td>
<td>Weekly</td>
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<td>NHS Contract Monitoring (Planned versus Actual and Forecast to contract end period)</td>
<td>Monthly</td>
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## APPENDIX 4

### Tolerances

Tolerances applicable to the 2004/05 Service Level Agreements:

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<td>Block contract</td>
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</table>
Exclusions From Contract

APPENDIX 6

Ineffective Treatments

The following treatment will not normally be funded because it is known to be ineffective:

- Chelation therapy

Treatments of Unproven Benefits

The following treatments are of unproven benefit, and will not normally be funded:

- Homeopathy
- Reflexology
- Osteopathy
- Chiropraxis
- Bionucleoplasty (for disc degeneration)
- Laparoscopic surgery for colorectal cancer
- Transmyocardial revascularisation (TMR) for intractable angina
- Carotid artery surgery for asymptomatic patients with carotid artery disease
- Laser disc surgery and ligament procedures for low back pain
- Use of dilators or microwaves for benign prostatic hyperplasia
- Use of lithotripsy to treat small asymptomatic renal calculi
- Radiotherapy for age related macular degeneration of the eye
- Neonatal extra corporeal membrane oxygenation (ECMO)
- Continuous hyperfractioned accelerated radiotherapy for carcinoma of the bronchus or head and neck cancer
- Enzyme potentiated desensitisation
- Clinical ecology/environmental medicine
- Neutralisation provocation tests neutralisation vaccines
- Leucocytotoxic tests
- Hair analysis
- Vega testing
- Applied kinesiology
- Auricular cardiac reflux method
- Any treatment which involves a diagnosis of candida hypersensitivity syndrome
- Any treatment purporting to treat allergy as a cause of the chronic (post viral) fatigue syndrome
- Any treatment using acupuncture to treat allergy
- Any other treatment for which there is no proven benefit

Exclusions from Contract
Page 2 of 3

Myalgic Encephalomyelitis (ME)  All referrals must in the first instance be made to a consultant neurologist or psychiatrist from a local (i.e. within contract) provider, acting in an NHS capacity.

Eating Disorders  Adult eating disorders should be referred through the South Staffordshire NHS Trust. Please contact the Eating Disorders Service at the SSHT NB Under 16s should be referred through a child and adolescent psychiatrist. Inpatient admissions are taken via North Staffs Combined.

IVF and Other related Techniques  A service level agreement is held with the Queens Hospital, Burton. Strict eligibility criteria published -- see contract portfolio (NB there may be long waiting lists).

Gastroplasty  There is evidence of effectiveness in some patients. Criteria for treatment includes a body mass index above 40 an all other methods failed. Psychological assessment must be undertaken. A small number may be done on a named patient basis at Walsall, although there is likely to be long waits.

Plastic Surgery  Service agreements are in place with a range of providers. It should not be undertaken purely for cosmetic reasons.

Laser Surgery  Available within contract at Lasercare and Lifestyle Medical. All referrals should be tertiary through a consultant and for significant cosmetic abnormalities (e.g. congenital/vascular) leading to psychological distress.

Allergies  Providers must be accredited by the British Society for allergy and clinical immunology.

Detox (Drug or Alcohol)  In contract with South Staffs NHS Trust. Not routinely funded out of county.

Draft 2 South Staffordshire PCTs SLA

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<table>
<thead>
<tr>
<th>Residential Rehabilitation</th>
<th>This is not funded by the NHS. Refer to Social Services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicose Veins</td>
<td>Patients will not normally be offered surgery (including Sclerotherapy and Lazer-therapy) for varicose veins unless the varicosities are accompanied by one or more of the obvious condition changes, including:-</td>
</tr>
<tr>
<td></td>
<td>- Ulceration</td>
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<td></td>
<td>- Odema</td>
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<td></td>
<td>- Venous Eczema</td>
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<td>- Podermatosclerosis</td>
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<td>- Recurrent Phlebitis</td>
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<tr>
<td></td>
<td>- Bleeding from a varicos (Class 1 &amp; Class 2)</td>
</tr>
<tr>
<td>Reversal of Sterilisations in Men &amp; Women</td>
<td>This procedure is not funded by the PCT</td>
</tr>
</tbody>
</table>

**Category C SERNIP Procedures**

Clinical trials undertaken on South Staffordshire residents would not be supported for category C procedures unless they are conducted as part of a separately funded and high quality research programme, using appropriate methodology, and registered with SERNIP/NICE.

Individual patient exceptions to these general policies will be accommodated, but in each case the responsible clinician will need to discuss with the relevant commissioning group the exceptional circumstances that lead to a view that the individual patient will benefit, what alternatives have been considered, and value for money.

**Category D SERNIP Procedures**

The PCT will not commit resources to Category D Procedures.
List for Low Priority Cosmetic Dermatological Procedures

- Androgenetic Alopecia in Men
- Tattoo Removal
- Isolated Spider Naevi in Children and Adults
- Thread Veins
- Skin Tags (Unless Inflamed)
- Constitutional Hirsutism

The following conditions will require a number of criteria to have been met before being seen:

Viral warts

Will only be treated in exceptional circumstances particularly if they are interfering with the patient’s daily living routine or causing severe pain, and only after having been thoroughly treated with wart paint and abrasion for a minimum period of three months.

Molluscum Contagiosum

Normally respond to pinching followed by treatment with a topical antibiotic or antiseptic preparation to prevent secondary infection. Any referrals would be met with a letter of advice to the patient and referral back to the GP. Only exceptional cases will be seen by the dermatologist.

Seborrhoeic Keratoses

Not to be removed for cosmetic reasons alone. May sometimes need to be distinguished from a SCC especially when inflamed, and when causing irritation by catching on clothing etc, which may justify removal.

Xanthelasmata

The recommended form of treatment being surgical excision by an ophthalmic surgeon.

Considerations of exceptional cases
Appendix 7

PRESCRIBING CONTRACT 04/05

Introduction.
The prescribing of drugs, dressings and appliances is an important part of healthcare provision. This prescribing contract is intended to reflect an understanding between clinicians and managers in both primary and secondary care i.e. that they must strive towards optimising rational prescribing at all times.

Barber (Ref 1) defined rational prescribing as a process whereby drugs are used in such a way that clinical effectiveness is maximised, both risk and cost are minimised and patient choice is respected.

The prescriber will be the clinician who responds to the clinical needs of an individual patient at a particular stage in their treatment by taking lead clinical responsibility for them and signing their prescription. The lead responsibility will be passed between clinical specialties during an inpatient stay and transferred to the patients GP according to the needs of the patient at a particular time.

In order to act competently and safely the prescriber must ensure that they understand the mode of action of the prescribed drug, its side-effects, contraindications and interactions and that they are competent and have the capacity to monitor the patient effectively and determine whether a desired outcome is achieved.

Implementation of new hospital prescribing policies affecting prescribing by general practitioners should only occur after full consultation and agreement with the Primary Care Trusts (PCTs). This should normally occur via the Drugs and Therapeutics Committee.

Formularies/Prescribing Guidelines

- GPs should not be asked to prescribe drugs that are not approved as a formulary drug by the Trust D&T committee unless there are clear reasons for this and the GP is happy to do so.
- Hospital clinicians should not ask GPs to prescribe drugs which expert assessment (DPTAC, MTRAC, NICE) does not recommend for GP use or that are unlicensed in the UK for that indication.
- Trusts will ensure that prescribers use generic names at all times except when this would be inappropriate.
- Trusts will ensure that clinicians recommend a drug class rather than a specific drug, whenever possible.
- Implementation of new hospital prescribing policies affecting prescribing by General Practitioners should only occur after full consultation and agreement with the PCTs.

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Page 1 of 5

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• Implementation of new hospital prescribing policies or continuing hospital prescribing policies that are not compliant with NICE guidance should be notified to PCTs.

Supply Of Medicines By Hospitals
• When a patient is discharged from hospital, medicines and dressings will be supplied to last a minimum of 7 days unless other specific arrangements have been made (e.g. to provide 28 days supply on discharge). In all cases sufficient medicines and dressings will be supplied to ensure that on-going treatment is maintained. This will allow sufficient time for:
  • The general practitioner to receive the relevant clinical information detailing diagnosis and drug therapy.
  • The patient to make a routine appointment to see the GP.
• If the hospital embarks upon a form of treatment that is not available in the community or designated ‘hospital only’ in the formulary, the hospital is to assume the supply function.
• Patients attending day clinics for minor surgery will receive supplies (antibiotics/dressings etc.) in sufficient quantities for their post operative needs from the Trust.

Patients attending out-patient clinics who do not require medicines immediately will be asked to obtain a prescription from their GP, unless provision of the medicines is included in the contract with the clinic. The patient will be informed that this medicine is not required urgently. The GP will require legible, sufficient and timely clinical information to enable the supply to continue on FP10.
• If the Consultant considers that the patient requires treatment before seeing the GP the Hospital should provide 14 days supply (and ensure that the clinical information reaches the GP surgery before the patient attends).
• Patients attending the Accident & Emergency Department will receive a minimum of seven days supply. If referral is made to the GP sufficient treatment must be supplied to ensure all the clinical information reaches the GP before the patient attends.

Information For Patients
As part of their medicines management arrangements the Pharmacy Department in each Trust must ensure that when patients are discharged from hospital they are offered sufficient information about their medication. This will include:
• What the drugs are for and what outcome should be expected from treatment.
• What to do with drugs at home.
• How to use medicines correctly.
• What to do if a dose is missed.
• How drugs should be disposed of safely when they are no longer needed.
Medicines Brought Into Hospital

- The Trust must have a policy in place that ensures that there is no inappropriate destruction of 'patients own' medicines.

Clinical Trials

- Prescribing for patients recruited into clinical trials, or continuation of prescribing, when the medicine has previously been funded by a third party or the acute trust, is the responsibility of the hospital, except where agreed with the PCT and the patients GP, prior to prescribing.
- Patients who are recruited into clinical trials must receive a full explanation of the nature of the trial. (Patients should understand that involvement in a clinical trial is not a guarantee that funding for the treatment will continue once the trial has ended). South Staffordshire District now has a policy on the prolonged funding of medicines after the end of a clinical trial.
- Where a trial drug cannot be stopped the arrangements for continuing the prescribing after the trial will be agreed with the patient, the PCT, and the patient's GP before the patient is entered into the trial.
- Trusts will inform PCTs annually of any sponsorship of research and hospital departments by the pharmaceutical industry.

Essential Shared Care Agreements (ESCA) For High Tech/High Cost Drugs

- When clinical and prescribing responsibility for a patient is transferred from hospital to a general practitioner it is important that the GP has the full confidence to prescribe the necessary drugs.
- ESCAs should be drawn up by hospital consultants, expert in the use of the drug, together with local PCTs. All ESCAs should be agreed at the Trust Drug & Therapeutics Committees and be copied to the District Prescribing & Technology Advisory Committee (DPTAC).
- The clinical and legal responsibility for prescribing lies with the doctor who signs the prescription. A general practitioner has the right to decline to prescribe on clinical responsibility grounds. Refusal based on drug costs alone is not acceptable.
- Cost shifting from Trusts to primary care without observation of the above steps is not acceptable.
- If recommendations state that GPs can prescribe against an essential shared care agreement (ESCA), the Trust must ensure that ESCAs are written, discussed and agreed at D&T Committee meetings and reviewed when necessary.
- ESCAs must be agreed with all the PCTs with which with the Trust interfaces.
- Trust clinicians must be made aware of the content of such agreements and adhere to them.
- Patients should be responding to treatment and their condition stabilised before they are considered suitable for an ESCA.
- Each case should be discussed and agreed with the GP prior to informing the patient.
• A suitable time period for specialist reassessment, involving review of
treatment, must be agreed with the patient and/or carer.

The Managed Introduction And Prescribing Of New Medicines
• The West Midlands Region has established a Regional Prescribing
Committee (MTRAC) to ensure that high cost/high tech drugs are
introduced and utilised appropriately.
• The recommendations of MTRAC and DPTAC will be copied to the
Chairs of the Trust Drug & Therapeutics Committees via their Chief
Executives and should be brought to the attention of Trust doctors as
appropriate.
• South Staffordshire PCTs purchase healthcare on behalf of the
population based on a budget fixed for a financial year. Within
contract allocations to Trusts is funding for packages of care for
individual patients and not for individual drugs. Therefore all
contracts will be deemed to include the anticipated cost of
drugs.
• Substantial developments in-year will necessitate business cases
being made unless the drugs are approved for use by NICE when
allocations will be made from centrally held reserves to support their
use within a 3 month period following publication of the NICE
Technology Appraisal Guideline (TAG). Trusts will provide PCTs with
regular updates (at least six-monthly) on implementation of all NICE
TAGs.
• GPs should not refer patients for specialist high cost drug treatment
unless they are aware that funds have been identified in advance by
negotiation between the Trust and the PCT.

Patients With Special Pharmaceutical Needs (Non Formulary)
Some patients with special pharmaceutical needs will require support at
home.
The following are the main groups of patients who fall into this category:
• Patients receiving continuous ambulatory peritoneal dialysis.
• Cystic fibrosis patients receiving intravenous or nebulised
antibiotics.
• Cancer patients receiving intravenous chemotherapy agents.
• HIV patients receiving intravenous or nebulised anti-
infectives.
• Patients receiving total parenteral or specialised enteral
nutrition.
• Thalassaemic patients receiving deferoxamine.
• Patients receiving parenteral anticoagulant treatment.

Providers must notify the Director Of Public Health of any patients who
require packages of care at home and must make arrangements for the
support of patients at home when this has been agreed with purchasers.


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Annex A

Policy On The Prolonged Funding Of Drugs By Providers After The End Of A Clinical Trial

This policy is to clarify that PCTs in the South Staffordshire District will not agree to fund an ongoing treatment with hospital trusts where other third parties have been used as interim funding sources unless there has been prior agreement. The situation has arisen where the treatment for patients has been continued after a clinical drug trial with the funding coming from pharmaceutical companies.

It is regarded that there is an ethical obligation for the current organiser and/or funder of a treatment to have identified the continuation of funding in advance of initiation otherwise they need to continue that funding from their own resources. That is notwithstanding the needs of the patient having changed or other agreement being reached.
Witness Name: William Price
Statement No: First
Exhibits: WP1 – WP17
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP4 [ ] to the Witness Statement of William Price
SOUTH WESTERN STAFFORDSHIRE PCT, CANNOCK CHASE PCT AND MID STAFFORDSHIRE GENERAL HOSPITALS NHS TRUST

COMMISSIONING MEETING

MINUTES OF THE MEETING HELD ON WEDNESDAY 23 JUNE 2004
AT 12.30PM, ROOM 3, POST GRADUATE MEDICAL CENTRE

Present

Lynne Deavin
Commissioning Manager, SWS PCT
John Smith
Commissioning Manager, CC PCT
Dr Phil Coates
Trust Clinical Lead, NICE Guidance, MSGH
John Newsham
Director of Finance and Planning, MSGH
Andrew Crawshaw
Director of Partnerships and Service Development, MSGH
Tom Travers
Director of Finance, CC PCT
Susan Fisher
Director of Finance, SWS PCT
William Price
Chief Executive, SWS PCT
Dr Andi Selvam
General Practitioner, CC PCT

Notes of pre-meeting held at 12.00pm - A&E and Waiting List Incidents

John Newsham reported that on Monday morning (21.6.04) the hospital had 44 outliers. As a result, elective work for that morning had been cancelled. These patients had no underlying conditions and the hospital had not made any changes to its admittance process. There is an increase in numbers compared to data collected during the same time in the previous year. Particularly, it has been noticed that numbers surge on Saturdays and Monday mornings.

After discussion, it was agreed that once the questionnaire produced by Millar has been fine tuned, the data will be analysed and results circulated to the PCTs.

John Smith highlighted the fact that discussions need to take place in the near future to agree how to get the VIP waiting times down to 13 weeks by the end of 2005. John Newsham added that these discussions also need to include how this was going to be funded as hospital resources cannot be committed until the SaFF is agreed.

Susan Fisher agreed that all aspects regarding provision of a 13 week waiting time service would be discussed together. She added that plans were in place to halt the stem of inappropriate referrals. A screening process was being looked into that specifies basic minimum referral requirements being included on referral letters.

1. Apologies

Apologies were received from Karen Bray, Jean-Pierre Parsons and Roger Beale.
2. Minutes of the Meeting held 26 May 2004

The minutes were accepted as a true and correct record.

3. Matters Arising not appearing on the agenda

BPAS – this is ongoing.

ECGs – Lynne has received a letter from Dr Woodmansey regarding quality outcomes framework for GPs included in waiting times. Agreed to have a CHD meeting on Friday afternoon (25.6.04) with the PCTs.

Dr Fairfax has written to the Trust to ask for a discussion with GPs regarding initial spirometry referral to secondary care for full lung function.

4. Presentation by the Parkinson's Disease Nurse Specialist

Annette Logan, the Parkinson's Disease Nurse Specialist gave a power point presentation to the group. A printed handout was given to everyone present.

After a very well informed presentation and discussion among the group it was decided that because of the small number of patients involved no significant cost impact was anticipated and therefore was not an issue for the group to discuss further.

It was agreed that Andrew would provide a copy of the report produced by Annette Logan to William Price. William would in turn speak to Jan Titley regarding the decisions made.

5. Coppice Ward

It was reported that Jean-Pierre was expecting a report from Jan Harry on Coppice Ward.

John Newsham highlighted the fact that at the next Executive Directors meeting on Monday morning (28 June 2004) an activity/review of Coppice will be presented. Elaine Evers will be present at that meeting and so information will be shared with the PCTs via Elaine.

He also told the group that after the 28th, a joint forum regarding Coppice would take place to enable all concerned to be kept informed of the current and future situation of the ward.

6. Foundation Status

Andrew reported that the Trust's application was sent to the Department of Health on 18 June 2004 together with a letter of support from Cannock Chase PCT. Discussion took place around the fact that South Western Staffordshire had felt unable to also provide a letter of support. William will be discussing this matter with David O'Neill later in the week.
7. **SLA Progress**

Discussion took place regarding the SLA. It was agreed that a recovery plan was needed to address an £8 million shortfall. A meeting was arranged to take place on Monday 28 June to agree the recovery process. William agreed to speak to Jean-Pierre regarding the involvement of the Health Economy Board.

8. **Appointment of New Consultants**

John Newsham informed the group that no new consultant appointments are currently in the system due to the on-going negotiations regarding the SLA.

9. **Any Other Urgent Business**

Andi Selvam reported that some of his patients were not receiving copies of DNA and cancellation letters. He thought that this process had already been agreed by the group and asked if this could be checked. John Newsham agreed to do this and follow-up if necessary.

A draft Service Delivery Plan had been received by the Acute Trust from Cannock. The principles were supported and it was agreed that thought would be given as to how this would fit into the recovery plan.

ABC £100k 'booking money' may well be available to support the local health economy. Susan Fisher to forward documentary evidence to Millar Bownass and John Newsham.

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

The next meeting will take place on Wednesday 28 July 2004 at 12.30 – 2.30 pm in Room 2, Mellor House, Corporation Street, Stafford.
Witness Name: William Price
Statement No: First
Exhibits: WP1 – WP17
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP5 [ ] to the Witness Statement of
William Price
South Western Staffordshire PCT, Cannock Chase PCT and
Mid Staffordshire General Hospitals NHS Trust

COMMISSIONING MEETING

MINUTES OF THE MEETING HELD ON WEDNESDAY 17 November 2004
AT 12:30PM, ROOM 2, MELLOR HOUSE

Present:-
John Newsham  Director of Finance and Planning, MSGH
John Smith    Commissioning Manager, CC PCT
Tom Travers   Director of Finance, CC PCT
Susan Fisher  Director of Finance, SWS PCT
Phil Coates   Trust Clinical Lead - NICE Guidance, MSGH
Helen Perren  Head of Patient Access, MSGH
Andrew Crawshaw  Director of Partnerships and Service Development, MSGH
Andi Selvam  General Practitioner, CC PCT
Lynne Deavin  Commissioning Manager, SWS PCT
William Price  Chief Executive, SWS PCT
John-Pierre Parsons  Chief Executive, CC PCT
Elaine Evers  Director of Primary Care & Service Development, CC PCT
Karen Bray  Modernisation Support Manager, MSGH
Roger Beal  General Practitioner, SWS PCT

1. Apologies
   None were received.

2. Minutes of the meeting held 8 September 2004
   The minutes were accepted as a true and correct record.

3. Matters arising not appearing on the agenda

   Coppice Ward
   Lynne Deavin is currently reviewing patients and where they could best be
   accommodated. John-Pierre Parsons is carrying out a piece of work that will
   review CCH, including Coppice, for end of year delivery – SWS to link in. The SHA
   are to carry out a long-term review of the Treatment Centre, which will link with
   MSGH and possibly other Trusts.
   MSGH to meet with Wolverhampton re increased ophthalmology work at Cannock.

   Lynne Deavin/
   John-Pierre Parsons

4. FP10
   A discussion took place re the cost of FP10. It was agreed that the out of area
   TTO’s would be reviewed by John Newsham and Susan Fisher.

   John Newsham/
   Susan Fisher

5. Catheter Lab Business Case
   North Staffs PCTs have commented re the pace that activity will move at, which
   may lead to pressure on wait time delivery. The PCT’s committed 600 patients
   moving to MSGH from UHNS.

   Andrew Crawshaw reported that there could be problems recruiting key members
   of staff, including radiologists and therefore pre recruitment is a key issue. He
   went on to say that the decision to delay the development of the catheter lab to

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April next year, which was taken by the group, could impact on the wait times, as the lack of funds for pre recruitment will mean that the lab is not up and fully running until June 2005. This was accepted.

The Catheter Lab business case will be submitted to the next Trust Board in early December. Planning permission is awaited, however this is not anticipated to be a problem. The flow of patients to the south of the county has to be taken into consideration. William Price expressed some concern due to the pressure to solve the Wolverhampton issue (funding empty beds) that pressure may be bought to send patients south however, he reiterated the support for the catheter lab at MSGH.

6. A&E Waits
MSGH are currently joint first in the country. For 11 days the hospital has had no 4-hour breaches. The pressure is very tight though on Mondays, Tuesdays and Wednesdays. The hospital is reporting and monitoring every breach due to the 98% target. Also every 3-hour breach is being analysed.

It was reported that Geoff Hackett, GP had attended A&E. A report was carried out that concluded that 3 to 4 patients each day might be considered inappropriate. It was recommended that staffing problems be resolved by hospital management. CC PCT are withdrawing GP input.

7. Sending letters to patients following consultation
A policy guidance note is to go to HMB in January 2005. The plan is to pilot this as part of Information governance in order to understand the impact. It was agreed that this process should be proceeded at the current pace due to other more demanding pressures.

8. ENT Emergencies – Out of Hours
A flow diagram is to be tabled at the next meeting. Sarah Rose is to be asked to do this. John-Pierre Parsons would like to see a formal response sooner as this is a potential Clinical Governance issue. He has had no response to emails - Andrew Crawshaw to pick this up with David O'Neill and John Gibson.

9. Anti-TNFs
A meeting was held on the 16th November. Cathy Riley and Chris Riley to report back to SWS PCT tomorrow. John Newsham requested an indication for next year.

10. Back Pain Clinic/Screening
Lynne Deavin reported that Claire Ward is undertaking a report - to be completed by March 2005. Claire is looking at a model for the back pain service (triage for back pain) that aims to keep patients out of secondary care. This protocol is to be used across PCTs. It was asked whether the hospital staff were able to collect data on chronic lower back pain. Claire Ward and Catherine Simpson are to meet to discuss data availability. John Newsham suggested a work stream via IPH.

CC PCT are putting in triage – evaluating the service and making the data available to SWS PCT.

11. 24-hour post neonatal checks
Patient details were requested - Elaine Evers to provide John Newsham with this information for further investigation. The hospital Consultant's view is that GPs have altered the way they work.

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12. Dermatology
Nurses are currently being trained at Cannock. There are no monies available at present to invest into this service. There has been no progress following the process mapping session.

13. Any other business

Discharge Letter
Lynne Deavin shared a post surgery note with the group - it was agreed that this contained sufficient information and that a discharge letter would follow.

Practices are monitoring the issue of certification. Roger Beale reported that there has been an improvement. Helen Perren suggested that notices informing patients to ask for a certificate, if required, should be displayed in GP practices.

Payment by Results (PBR)
The deadline for this is Monday to share the data. John Newsham said that the guidance is altering. John Newsham is releasing on a capitation basis, going against national guidance. The PCTs require a week to work through the model. John Newsham and Susan Fisher are meeting on the 15th November to discuss Wolverhampton and Dudley and moving the deadline.

10 High Impact Changes
There are PCT representatives on each work stream. The objectives are to be agreed on Friday at the IPH Steering Committee.

Stars Recovery Plan
Deferred to next meeting – Lynne Deavin to table.

GMS Contract
MSGH would welcome a presentation on the GMS contract -- Andi Selvam and Roger Beale to arrange for the next meeting.

14. Date and time of next meeting
15th December, 12:30, Room 3, Post Graduate Medical Centre.
South Western Staffordshire PCT, Cannock Chase PCT and Mid Staffordshire General Hospitals NHS Trust

COMMISSIONING MEETING

MINUTES OF THE MEETING HELD ON WEDNESDAY 12 JANUARY 2005
AT 12:30PM, ROOM 4, PGMC

Present:-
John Newsham Director of Finance and Planning, MSGH
John Smith Commissioning Manager, CC PCT
Tom Travers Director of Finance, CC PCT
Susan Fisher Director of Finance, SWS PCT
Phil Costes Trust Clinical Lead - NICE Guidance, MSGH
HeLEN Perren Head of Patient Access, MSGH
Lynne Deavin Commissioning Manager, SWS PCT
William Price Chief Executive, SWS PCT
Elaine Evers Director of Primary Care & Service Development, CC PCT
Karen Bray Modernisation Support Manager, MSGH
Roger Beal General Practitioner, SWS PCT
John-Pierre Parsons Chief Executive, CC PCT
Andrew Crawshaw Director of Partnerships and Service Development, MSGH

In attendance:-
Greg Tuff, placement year from university, shadowing Lynne Deavin

01/05 Apologies
Were received from Andi Selvam, General Practitioner, CC PCT.

02/05 Minutes of the meeting held on 17 November 2004
The minutes were accepted as a true and correct record.

03/05 Matters arising not appearing on the agenda
There were none.

04/05 A&E Waits
Helen Perren reported that there had been a number of breaches of the 4-hour wait target since Sunday – the worst day being yesterday with 22 breaches.

Sean Nakash and Pam Ledgard are reviewing the last 130 referrals to A&E, once this piece of work is completed the trust will work with the PCT's intermediate care teams and the ambulance service to ensure that patients are treated in the appropriate place.

Both PCTs requested a copy of the amended escalation policy; this needs to be shared with the SHA.

Helen Perren

John Newsham reported that there was feeling that the problem in A&E was anecdotally linked to an increase in GP admissions partly linked to nursing homes. These issues will be picked up as part of the review of the last 130 admissions.

A discussion took place around the achievement of the inpatient and outpatient

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targets by March 2005. John Newsham reported that non-urgent elective patients had been cancelled this week due to the problems in A&E however these patients would have to be listed before the end of March.

SWS PCT reported that the intermediate care team was unable to locate a doctor on Friday. This will be picked up by the trust.

Jean-Pierre Parsons said that the contract this year had bought the targets. He went on to say that he was happy with the intermediate care link and that patients are taken appropriately.

05/05 ENT Emergencies – Out of Hours
Both PCTs had received a copy of the ENT flow chart. John Newsham agreed to discuss the ENT emergency service with Dr John Gibson before the next meeting.

John Newsham

06/05 Diabetes
Both PCTs agreed to pick this up.

Roger Beal
Andi Selvam

07/05 24-hour post neonatal checks
MSGH await patient details - Elaine Evers to provide.

Elaine Evers
Karen Bray

08/05 Catheter Lab Business Case
Andrew Crawshaw reported that there was to be no pre recruitment. Andrew Crawshaw to work with John Newsham on a recruitment plan.

It was reported that for the first 3 months of the next financial year work would continue to be undertaken at UHNS. UHNS are happy to undertake this work on a risk share basis. Susan Fisher said that there had been no risk share to get MSGH up and running.

Andrew Crawshaw said that Dr Paul Woodmasey would be meeting with Dr John Creamer to discuss the third session and to model activity over the next 12 months. Andrew Crawshaw agreed to set up a meeting with John Smith, Lynne Deavin, UHNS and MSGH representatives to discuss the management of activity over the next 12 months.

Lynne Deavin has written to UHNS re the third cardiology session and for clarity on the transfer of 600 FCE’s.

09/05 Stroke Co-ordinator
Susan Fisher, Tom Travers and John Newsham agreed to discuss this post. Lynne Deavin agreed to discuss at the next Older People NSF meeting. Andrew Crawshaw and Karen Bray to take forward operationally in the trust.

John Newsham suggested using this as an example to see what impact tariff has on service.
Minor Injuries
John Smith, Liz Onions and John Newsham to meet to discuss.

Elderly Care Strategy
Liz Onions is working with Jan Harry to design the service. SWS PCT will take patients into a rehab facility as of February 2005. Lynne Deavin to share the protocol with John Newsham and Jan Harry once completed.

Back Pain Clinic/Screening
Paper to go to the PEC once re investment principle is added.

John Newsham requested that Mr Phil Shaylor, Orthopaedic Surgeon is involved and that the scoring system should not be altered.

Diagnostics
Andrew Crawshaw said that the cancer network had been discussing PET scanning. There has been a provision for 200 whilst the project is being pulled together. Lynne Deavin reported that following a meeting with Andrea Green at the SHA, PET scanning would be provided for 5 years by the private sector. John Newsham said that there was a need for more joined up working between the cancer network and the local health economy including identification of the number of PET scans that will be required for cancer patients.

Future Clinical Discussions
COPD - Jan Hollins from SWS PCT would like to input into the development of this service.

Chronic disease management - COPD would be picked up as part of this project. Jan Warren, Jan Harry and Liz Onions are looking at this.

Any other business
GMS Contract
Andrew Crawshaw to discuss setting up an informal meeting with the clinical directors to discuss the GMS contract.

Heart Failure
It was reported that the GPSI budget would be used to fund a technician to undertake echo's. Karen Bray to liaise with Kathy Harding re the scrutiny process.

Pbr - phasing of outpatients
To be discussed separately.

Outpatient Follow-ups
A discussion took place re capping the number of follow up outpatients and transferring patients from secondary care into primary care. PCTs are working through the impact including infrastructure.

SLAs
John Newsham reported that the SLAs have been tighter than ever before. The trust is currently looking at activity in November, as this was unusually high.

Trajectories
John Smith requested the data; a draft submission needs to be made to the SHA by the end of today.

LDP
To include the 10 High Impact Changes. John Smith and Lynne Deavin to share the document which indicates the shift from secondary to primary care and use of the independent sector.

16/05 Date and time of next meeting
Witness Name: William Price
Statement No: First
Exhibits: WP1 – WP17
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP7 [ ] to the Witness Statement of William Price
South Western Staffordshire NHS
Primary Care Trust

Professional Executive Committee

Minutes of a meeting held on 18 January 2005 at 12:30pm in the Boardroom, Mellor House, Corporation Street, Stafford.

Present:  
Dr Roger Beal (Chair)  
William Price (Chief Executive)  
Andrew Morrison (Pharmacy Member)  
Susan Fisher (Director of Finance & Performance)  
Jack Nunn (Therapist Member)  
Jan Warren (Director of Primary Care & Professional Development)  
Jane Brown (Therapist Member)  
Dr Zafar Iqbal (Director of Public Health & Partnership)  
Dr Eddie Fong Lee (GP member)  
Elaine Tinkler (Nurse Member)  
Dr John Hearn (GP Member)  
Carolyn Parker (Optometrist Member)  
Dr Peter Maidment (GP Member)  
Bernard Bester (Social Services Member)  
Dr Mark Bland (GP Member)  
Frances Sutherland (Health Visitor Member)

In Attendance:  
Glyn Ravenscroft (Non Executive Director Representative), Lynne Deavin (Commissioning Manager), Claire Ward (Physiotherapy Professional Lead/Adults Manager), Tilly Flanagan (Head of Health Improvement), Anne MacLeod (Practice Nurse Facilitator) and Jennie Thomas (Secretary to the Board & PEC).

PEC (04) 185  APOLLOGIES

Apologies for absence were received from Julie Phillips and Dr Stuart Lloyd.

PEC (04) 186  MINUTES

The minutes of the meeting held on 16 November 2004 were amended as follows:

Glyn Ravenscroft was listed to be in attendance as the PCT Board Representative. This was amended to read Non Executive Director Representative.

With this exception, the minutes were approved as a true and accurate record.

PEC (04) 187  MATTERS ARISING

PEC (04) 161: Nurse PEC Vacancy

The Chief Executive reported that a nomination for the above
vacancy had been received from a nurse based in the South of the PCT area. It was agreed to close nominations and for the Chief Executive and PEC Chair to begin the formalities of appointment as appropriate.

PEC (04) 165 Continence Service:
The Director of Primary Care & Professional Development confirmed that Cate Astbury (Clinical Nurse Specialist) was in the process of developing an effective dependency scoring system for the re-assessment of patients.

PEC (04) 178 Mental Health Local Directory:
The omission of The Samaritans from the directory was to be rectified.

PEC (04) 188 GMS/PMS MID YEAR FINANCIAL REVIEW
Members noted a summary report outlining the changes to GMS and PMS financial allocations as a result of the implementation of the new GMS Contract on 1 April 2004. Issues highlighted were as follows:

GMS and PMS Budgets:
The baseline budgets for GMS were calculated using a national formula and list sizes were reviewed quarterly with appropriate adjustment.

PMS budgets were based on capitation, with a mid year review of list size and adjustment as appropriate.

The difficulties caused by fluctuation of capitation between quarters was noted and the Director of Finance & Performance reported that it may be possible for an overall tolerance of this in future. A group had been set up, of which she was a member, with representation from all PCTs in Staffordshire and this issue was being considered along with value for money.

Quality & Outcomes Framework:
This had been shared with the Local Medical Committee and it was noted as a result of recent practice visits that the average number of aspiration points for practices within the PCT was likely to be an average of 948 out of a possible 1050. (This had initially been estimated as 926). As national funding would meet 735 points per practice, the PCT was left with a significant shortfall of approximately £400K in total for both GMS and PMS contracts. This had already been reflected in the forecast PCT deficit. However, although further minor overspends were predicted, this was not likely to affect break even at year-end.

Seniority:
It was confirmed that this was only shown under GMS, as the PMS seniority expenditure was part of the PMS basic contract sum.
PEC (04) 189  ACTIONS FROM REVIEW OF SMOKING CESSION SERVICE

Members considered a report which proposed to increase the follow-up of smoking cessation clients at 52-weeks.

In March 2004 a paper had been presented to the PEC, which recommended that “the advisors should monitor the smoking cessation rates at one year to monitor progress towards achieving the health improvement goals.”

To achieve this, it was proposed to develop an incentive scheme that would include a payment for the 52 week follow up of patients as below (to be implemented from April 2005):

For correctly returning monitoring forms per client:
- £15 (Payment A)
- An additional payment for each client quit at 4-week follow up:
  - £15 (Payment B)
- A further payment per quitter for practices achieving agreed targets:
  - £10 (Payment C)
- A further payment for correctly completed 52 week monitoring form received:
  - £5 (Payment D)

After discussion, the proposal was agreed, on the understanding that those who did not provide support by directly employed staff would not receive payments B, C and D and that Payment D would only be available to those clients validated by carbon monoxide testing.

It was noted that national smoking cessation targets had almost been achieved, although the year was not yet complete.

PEC (04) 190  LOCAL DELIVERY PLAN

Members noted a report giving an overview of the financial position for 2005/06 and the implications for service modernisation.

The PCT had been required to submit an extract of the LDP for 2005/06 to the Strategic Health Authority on 4 January 2005. This had covered a financial plan and activity levels for the year. On 12 January a draft three year plan for the period 2005/06 – 2007/08 had also been submitted, which required finalisation by 14 March 2005.

The PCT had a recurrent deficit of £4.2m and all new investments therefore had to deliver savings even before adding to services. £3.4m new investments were estimated which included Capacity (£1.1m), Specialised Services (£1.0m), Free Nursing Care (FNC)/Complex Cases (£0.6m), GMS including QOF (£0.6m) and £0.1m for other new
investments. The plan submitted had predicted financial balance based on the assumption of £4.4m savings across the areas of Modernisation targets - GP referral, CDM (£2.1m), Reduced Specialised Services (£0.5m), Baseline Issues - e.g. Shared Services (£0.3m), Reduction of NICE Investment (£0.2m), Out of Hours recurring allocation assured (£0.3m) and an increased assumption on modernisation/further CIPS (£1.0m).

Service pressures were noted relating to the cost of Cardiac activity at the new unit at Royal Wolverhampton Hospitals NHS Trust and also the capacity to achieve Cancer and Mental Health targets.

Prescribing uplifts were significantly below previous years on a national scale and discussions were taking place with the prescribing lead based on a framework of a 3% uplift on GP budgets.

It was agreed to discuss these issues at the next Informal PEC on 8 February 2005, along with potential local targets, which the PCT were required to include in the final LDP.

PEC (04) 191 MODERNISATION PROJECTS UPDATE

Members considered a report summarising the progress to date of modernisation projects. Verbal reports were received from the Project Leads as follows:

Rehabilitation Provision:
The aim of this project was to assess usage of Coppice Ward with a view to provide an alternative in order to reduce the level of expenditure via Payment by Results and provide a more appropriate community based rehabilitation service.

The PCT had given notice on the Coppice Ward at Cannock Hospital and it was proposed to contract with Manor House Nursing Home, a new establishment, for the 6 beds to be re-provided from Coppice Ward. An increase in the Intermediate Care Team would be required to manage admission and discharge of patients in accordance with agreed protocols. The contract was initially to be short term, in order to ensure that the arrangement was acceptable to both parties and was to commence on 1 October 2005.

It was considered that the service provided would be at a reduced cost but with an increased quality, as more therapies would be provided for patients.

Chronic Disease Management:
The aim of this project was to provide a structured approach to Chronic Disease Management, in order to reduce the level of admissions to hospital.
The project was based on COPD and other related conditions that could be cost effectively and clinically safely cared for at home (including residential and nursing homes). It was proposed to increase the Intermediate Care Teams in the north (to care for a minimum of 15 patients) and south (to care for a minimum of 8 patients) and develop a multidisciplinary team, providing a service for individuals within their chosen setting.

There was to be a primary focus on preventing COPD related admissions to hospital, with the introduction of Generic Workers, working across social, nursing and therapy. Closer working partnerships would be established with social services and an essential 24 hour community Team would be developed for the south of the Trust.

It was noted that community teams were already working pro-actively with patients on their current case loads.

Heart Failure:
The aim of this project was to provide a structured approach to Heart Failure in order to reduce the level of admissions to hospital.

A team of 3 Heart Failure nurses were currently being funded from New Opportunities Funding, taking referrals only from Mid Staffordshire General Hospital. The team was providing after care for 16 patients and planned to offer a service to GP practices from Summer 2005. They would deliver palliative care in relation to this client group.

The project was considering options for either developing a service in the south or expanding the existing team, and the financial implications of these. It was recognised that in the medium term the project could have a very significant impact on hospital admissions.

Arthritis/Back Pain:
The aim of this project was to produce a proposal for the treatment of arthritis and back pain in a community setting that would be clinically safe and cost effective.

An alternative model of service provision was being considered by the project team in the form of a triage service by physiotherapists. This model had demonstrated substantial cost savings in a study in Southampton, along with more appropriate and efficient care pathways for patients. Figures for the PCT based on current data were discussed, along with the issue of securing appropriate premises in appropriate areas for the PCT population. These issues were to be presented to the Board at their next meeting on 27 January 2005.

Palliative Care:
The aim of the project was to establish community based Palliative Care services with particular reference to Heart...
Failure, COPD and Stroke and to ensure that palliative care
was available to all patients with end stage disease.
Hospice at Home was a key element of the project, and as
Care Managers were put in place the service would begin to
evolve. In addition to this, the Palliative Care Sub Group was
being widened to encompass more than cancer services and
dialogue was being established with local Hospices regarding
wider provision.

Gastroenterology:
The aim of the project was to implement a revised protocol with
a view to reducing referrals.

A revised protocol had been agreed which would save
approximately 250 endoscopies a year when implemented.
Data relating to 2004-5 and 2005-6 would be analysed to
determine the impact of the new protocol.

It was noted that at present there was no Direct Access
endoscopy service available for patients in the South of the
PCT area.

The Medical Director of Mid Staffordshire General Hospitals
NHS Trust had recommended that the H Pylori test be made
available to patients on prescription. The issue of patients
incurring charges for an investigative test was discussed and
the Director of Public Health & Partnerships agreed to
investigate this on behalf of the PEC.

Ophthalmology:
The aim of the project was to establish Diabetic Retinopathy
and Glaucoma services.

Three optometrists within the PCT had undertaken training to
be accredited to maintain patients with stable glaucoma in
Primary Care. They were to meet with Consultants from Royal
Wolverhampton Hospital on 20 January 2005 to identify
conditions that could be treated in Primary Care and begin in
the first instance to work alongside them for half a day a week
undertaking an audit of referrals.

Complex Cases:
The aim of this project was to develop more cost effective local
services through repatriation of Out of County placements.

A Learning Disability strategy had been agreed and Cannock
Chase PCT had agreed to share the nature, scale and costs of
Out of County placements with effect from April 2005.
Negotiations were taking place to extend shared arrangements
across all four PCTs and South Staffordshire Healthcare Trust.

GP Referrals:
The aim of this project was to examine GP referrals with a view
to sharing good practice, improving patient care and effective

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resource usage.
An action plan had been devised for short term initiatives, covering the following issues: GP feedback, Open Access investigation, Minor Surgery, Major Surgery, Memory Clinics, Scoring tools, Clinical Pathways and Emergency. Discussions were ongoing with regard to prioritising work strands and engaging key people for effective delivery.

PEC (04) 192 - PRACTICE BASED COMMISSIONING

Members considered a report summarising guidance on Practice Based Commissioning, as issued by the Department of Health in October 2004 and suggested proposals for incentivising practices to become involved.

Proposals for the commencement of the Payment by Results system had been significantly altered with only Elective procedures being subject to PBR for 2005/06. Non Elective, A&E and Outpatients were to be deferred until 2006/07.

A system of incentives to involve practices from the outset in Practice Based Commissioning was in the process of being developed by the PCT. A number of proposals were put to members for consideration.

Proposal 1 would involve the issue of individual referral and associated cost data to all practices, irrespective of formal expression of involvement in the scheme, with incentive payments to practices dependent upon attendance at referral meetings.

Proposal 2 would involve any referrals being admitted to a formally established PCT Admission Avoidance Scheme being assigned a notional budgetary saving of £xxx per case or x% of the planned saving per patient (as published in advance by the PCT at inception of the scheme).

Proposal 3 suggested that activity levels for budgets would be based on, but not equivalent to 2003/04 levels, the PCT being unable to set a deficit budget or devolve resources exceeding overall resource availability.

Proposal 4 would involve the sharing of activity and resource utilisation data at practice level across all budget headings, which would not be classed as a formal part of the scheme unless expressly agreed by formal resolution by the PCT PEC and Board. This proposal would effectively "block back" non included items to the PCT.

After discussion, it was agreed that these proposals should be considered in greater detail at the next Informal PEC meeting on 8 February 2005.

ZI, PM

Proposal 1
Proposal 2
Proposal 3
Proposal 4
All
PEC (04) 193 PCT PERFORMANCE REPORT

Members considered a summary report of PCT performance against CHAI’s nine key performance targets during November 2004, as used in preparation for the Star Ratings process for 2005/06.

It was noted that the targets for Inpatient waiting times had not been met in October and were a consistent problem. Other areas for concern were targets for outpatient services and Early Intervention services for mental health and cancer waits (which had shown much greater improvement since October).

The Director of Finance & Performance reported that the newly appointed Head of Health Improvement would produce reports on targets causing concern, for discussion at PEC meetings.

PEC (04) 194 WHITE PAPER ON PUBLIC HEALTH: CHOOSING HEALTH — MAKING HEALTHY CHOICES EASIER

Members considered a report on the recent White paper on Public Health. This was an important document, marking a "sea change" in emphasis within the Department of Health, moving from treating illness to improving people’s health.

Key priorities were
Reducing the number of people who smoke
Reducing obesity and improving diet and nutrition
Increasing exercise
Encouraging and supporting sensible drinking
Improving sexual health
Improving mental health

Health improvement was to become part of mainstream systems for incentives, performance management, regulation and inspection and the Government was to publish a delivery plan early in 2005.

Key implications for the PCT were highlighted as follows:

Financial Resources:
Funding opportunities from the Department of Health and other sources needed to be anticipated and all existing resources available to the PCT identified to support the implementation of the White Paper.

Planning & Modernisation:
Improving health was one of the four national priorities for the LDP in 2005-2008 and the PCT needed to demonstrate engagement with all local partners through the County Local Strategic Partnerships (LSP) and the two Local Authority LSPs and associated theme groups.
Capacity and Capability:
Further development of managed specialist public health networks was needed, including an increase in School Health Advisers and an increase in capacity in sexual health services and occupational health.

A PEC sub group was to be set up to lead on the White Paper, including leading on reducing health inequalities.

Further discussion of this report was to take place at the Informal PEC meeting on 8 February 2005 and there was also to be a seminar on the White Paper on 21 February 2005 from 2:15-4:15pm in the Boardroom, Mellor House.

PEC (04) 195 NEW COMMUNITY PHARMACY CONTRACT

Members considered a report summarising the new Community Pharmacy Contract, which was to be implemented in October 2005.

A steering group had been set up to implement the new contract, based on a national format and meeting on a monthly basis. A forum was also to be held in February for all stakeholders and a fortnightly newsletter was to commence in January 2005.

As Community Pharmacies were to take part in up to six health promotion initiatives within a twelve month period, these were to be discussed at the next Informal PEC meeting on 8 February 2005. The issue of repeat dispensing would also be considered at this meeting.

PEC (04) 196 GP OUT OF HOURS UPDATE

Members considered a paper outlining progress to date with regard to the new Out of Hours Service, introduced in line with the new GMS contract.

The PCT had been awarded £50k capital as an incentive scheme payment, due to the successful implementation of the OOH service.

There were problems in establishing technical links between Staffordshire Ambulance Service and NHS Direct and the link was due to be tested again for a "go live" date around 12 January 2005. The Department of Health had confirmed that a second tranche of incentive scheme funding of £50k would not be affected as long as "go live" was completed by mid January.

A recent survey of patients attending the Out of Hours Centre at North Walls had revealed a high degree of patient satisfaction and the results of the survey were to be shared in more detail with the OOH sub group.
It was suggested that obtaining feedback from practices using the OOH service would help in ironing out initial problems and could be discussed at the OOH sub group meetings. The PEC Chair also agreed to take any concerns to forthcoming PCT meetings with the Ambulance Service.

With regard to opt in practices, the PCT was continuing to work with two practices - in Bilbrook and Brewood - who were providing their own OOH service, in order to ensure that the required quality standards were reached.

PEC (04) 197  SHARED CARE PRESCRIBING OF DRUGS

Members considered a report outlining changes relating to shared care prescribing of drugs as a result of the new GP Contract.

Currently drugs were categorised into green, amber and red in relation to whether prescribing and continuity of care took place in secondary or primary care, or both. As a result of categorisation, an approved Essential Care Agreement was set up, defining the responsibilities of each of the parties sharing patient care.

Discussions had taken place with practices, in consultation with the South Western Staffordshire GP Subgroup of the LMC, in order to obtain a consensus view on shared care prescribing. As a result a new list had been drawn up in relation to drugs and the appropriate prescribing source.

Members noted the results of the consultation, formally encouraged the development and operational use of Essential Care Agreements and supported the PCT commissioning of shared care prescribing and monitoring of drugs as per the report.

PEC (04) 198  CLINICAL GOVERNANCE COMMITTEE REVISED TERMS OF REFERENCE

Members considered a report outlining proposals to revise terms of reference of the Clinical Governance Committee. As a result of a recent Away Day, the role and function of the Clinical Governance committee had been re-examined.

It was proposed that the Committee was split into a core group (who would meet monthly, being responsible for day-to-day co-ordination, delivery and monitoring of the PCT Clinical Governance agenda) and a wider main group (meeting bi-monthly and taking overall responsibility for co-ordination and steering PCT clinical governance activity).

After discussion, it was agreed that this proposal should also be taken to the next Board Meeting, to be held on 27 January 2005.
PEC (04) 199  GMS/PMS IT UPDATE

Members noted a report outlining the investment in IM&T in General Practice inline with the PCT IT investment policy and the new GMS contract.

All 25 practices were reported to have benefited from IT investment and by the end of the financial year all practices would be able to link to the QMAS system and have the ability to run the new GMS Contract.

However, it was noted that a significant amount of equipment was in need of upgrade over the next 12-24 months, due to age or incompatibility for modern IT communications.

The PCT was to commence a rolling programme of replacing GP IT equipment from 2005/06.

PEC (04) 200  SUMMARY OF CLINICAL INCIDENTS

Members noted a summary report of clinical incidents received by the PCT since the meeting of 16 November 2004.

These related mainly to poor discharge of patients from hospital and the issuing of flu vaccinations in the community. There was also a reported problem in accessing Out of Hours services for a terminally ill patient.

PEC (04) 201  CHD CHOICE AT POINT OF REFERRAL BY THE CARDIOLOGIST

Members noted a report detailing arrangements which were to be put in place in relation to patients requiring a coronary artery bypass graft, angioplasty or heart valve operation at the point of referral by the cardiologist. A choice of 4-5 alternatives was to be made available by December 2005.

PEC (04) 202  SUMMARY REPORTS OF SUB COMMITTEE MEETINGS

Members noted a summary report of the Prison Partnership Board Meeting of 23 November 2004.

PEC (04) 203  ACTIVE LIVING STRATEGY – ACTION PLAN

Members noted a draft Active Living Action Plan which had been updated following the Governments White Paper Choosing Health. A strategy implementation group was to be set up to oversee delivery of the plan.

With regard to funding, the Physical Activity Promotion Fund formed part of the White Paper strategy, but it was not presently know how much would be invested in this. It was therefore expected that the PCT would have to seek other sources to fully implement the plan.
PEC (04) 204 NATIONAL SERVICE FRAMEWORK FOR CHILDREN, YOUNG PEOPLE & MATERNITY SERVICES

Members noted a summary report of the above, which was a ten year programme, produced jointly by the Department for Education and Skills and the Department of Health. It was to form a key part of the Government's Change for Children reforms to tackle child poverty, disability and mental health.

The NSF had been discussed at the Children's PEC Sub Group, which would be leading the PCT’s response to developing a local action plan.

PEC (04) 205 ADULT LIFESTYLE SURVEY

Members noted a draft of the Adult Lifestyle Survey, which was to be published in January as the Annual Report of the Director of Public Health for 2005.

The survey reported the results of a large-scale postal survey on the lifestyle behaviours of adults registered with a GP in South Western Staffordshire PCT and would provide a baseline for targeting initiatives, thereby enabling progress to be measured.

In summary, findings were a prevalence of sunburn, very low consumption of fruit and vegetables, inadequate exercise and an upward trend in excessive alcohol consumption.

PEC (04) 206 DRAFT RESPONSE TO PUBLIC CONSULTATION DOCUMENT – THE DEVELOPMENT OF DENTAL TRAINING & SPECIALIST DENTISTRY

Members noted a draft response to proposals regarding future undergraduate dental training and provision of specialist care for the West Midlands area. These were a result of consultation by South Birmingham, Coventry and South Stoke PCTs and four options were given with regard to proposed changes.

In summary the PCT response supported Option 3, which was the provision of Outreach Centres. This was considered to offer the greatest benefit to the area and be the most sustainable option for maintaining dental training in the West Midlands. Support was also given to the proposal that outreach centres were developed to a different timetable to those in Birmingham. The development of strategic partnerships with local universities was also part of the PCT response, in order to maintain teaching facilities for students and research links.

PEC (04) 207 ACCESS BOOKING & CHOICE UPDATE

Members noted an update report on the work of the Access Booking and Choice team.
All targets for Choice at Six Months had been achieved to date for patients waiting for elective care.

Activity to the value of £173,931 had been scheduled at local Nuffield Hospitals for Orthopaedic and General Surgical procedures, and this was to take place by the end of February 2005.

Sub groups had been set up for Choose and Book in all partner organisations, to coordinate local delivery. The Choice Team were working closely with Patient & Public Involvement groups and had produced information to support patients in making their choice.

PEC (04) 208 HEALTHCARE COMMISSION ASSESSMENT FOR IMPROVEMENT – CONSULTATION DOCUMENTS

Members noted a report on consultation taking place by the Healthcare Commission. This was in relation to a new approach to assessing the performance of healthcare organisations in England.

The draft consultation documents had been circulated to members of the Clinical Governance Committee for comment by 20 January 2005. The committee was to collate and discuss comments prior to feedback to the Healthcare Commission by 21 February 2005.

Members noted and supported the proposed system for consultation via the Clinical Governance Committee.

PEC (04) 209 DATE OF NEXT MEETING

Informal:
8 February 2005 at 12:30 hrs at Perton Civic Centre

Formal:
1 March 2005 at 12:30 hrs in the Boardroom, Mellor House

PEC (04) 210 EXCLUSION OF THE PRESS AND PUBLIC

It was resolved to exclude the press and public from the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

Signed ........................................ Date ........................................

Dr Roger Beal
Professional Executive Committee Chair
South Western Staffordshire Primary Care Trust
THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP8 [ ] to the Witness Statement of William Price

Witness Name: William Price
Statement No: First
Exhibits: WP1 – WP17
Dated:
Minutes of a meeting held on 1 March 2005 at 12:30pm in the Boardroom, Mellor House, Corporation Street, Stafford.

Present: Dr Roger Beal (Chair)
William Price (Chief Executive)
Susan Fisher (Director of Finance & Performance)
Jack Nunn (Therapist Member)
Jan Warren (Director of Primary Care & Professional Development)
Jane Brown (Therapist Member)
Dr Zafar Iqbal (Director of Public Health & Partnership)
Dr Eddie Fong Lee (GP member)
Elaine Tinkler (Nurse Member)
Dr John Hearn (GP Member)
Dr Peter Maidment (GP Member)
Dr Mark Bland (GP Member)
Frances Sutherland (Nurse Member)
Dr Stuart Lloyd (GP Member)

In Attendance: Julie Phillips (Associate Director of Corporate Affairs), Glyn Ravenscroft (Non Executive Director Representative), Sheilah Blackwell (Nurse Consultant, Palliative Care), Cathy Riley (Head of Medicines Management), Nicky Hodson (Head of Primary Care) and Jennie Thomas (Secretary to the Board & PEC).

PEC (04) 211 APOLOGIES
Apologies for absence were received from Carolyn Parker, Bernard Bester and Andrew Morrison.

PEC (04) 212 MINUTES
The minutes of the meeting held on 18 January 2005 were approved as a true and accurate record.

PEC (04) 213 MATTERS ARISING
PEC (04) 191: Modernisation Projects Update

Gastroenterology
The Director of Public Health and Partnerships was looking into the issue of patients incurring charges for investigative tests and confirmed that he would report back his findings to the PEC. This was due to the Medical Director of Mid Staffordshire General Hospitals recommending that H Pylori tests were made available on prescription. It was noted by members that local pharmacists were currently having difficulty in obtaining supplies.
PEC (04)192: Practice Based Commissioning

A lunchtime meeting to discuss Practice Based Commissioning had taken place and there was to be a further meeting at 9am on 8 March 2005 at Cannock Cricket & Hockey Club.

Members noted that proposals put forward with regard to Practice Based Commissioning had not been discussed at the most recent Informal PEC meeting, as originally planned.

PEC (04) 194: White Paper on Public Health: Choosing Health – Making Healthy Choices Easier

Capacity & Capability

The Director of Public Health & Partnerships reported that the first meeting of the PEC White Paper Subgroup had taken place and that there was PEC representation within the membership.

PEC (04) 214  NURSE VERIFICATION OF EXPECTED DEATH

Members considered a proposed policy for nurses to verify expected death. This had previously been agreed by the Palliative Care Sub Group of the PEC.

The policy incorporated appropriate education, training and competence assessment, and differentiated between expected and unexpected death recognition. Out of Hours nursing staff had requested to undertake this procedure and the policy was to be evaluated prior to being fully instigated.

Members agreed the policy and supported its implementation.

PEC (04) 215  OUT OF HOURS – OPT IN PRACTICES

Dr Peter Maidment’s interest was declared for this item.

At the PEC meeting of 18 January an Out of Hours update was presented. The quality standards for two practices wishing to Opt in to providing their own services had not, at that time, been ratified. Subsequently it had been established that these practices were achieving a high percentage of the standards and had plans in place to meet the remaining standards.

Members therefore agreed the approval of the Bilbrook Medical Centre and the Surgery, Brewood to provide their own OOH care.

PEC (04) 216  MODERNISING NHS DENTISTRY: A PROGRESS REPORT

Members considered a summary report of the progress of the Dental Action Plan. This had been submitted to the National Dental Support Team and was to be presented to the PCT Board in March 2005.
The PCT had been successful in securing £400,000 recurrent funding for the next three years. Full implementation of local commissioning for NHS Dentistry had been put back from October 2005 to April 2006, but as one practice was currently operating under a PDS contract and another two were to “go live” in March 2005, the PCT was on course to meet the national targets for NHS dentistry.

South Western Staffordshire PCT had been working with the Department of Health to recruit overseas dentists from Poland, two of whom were to start work in March 2005 and a further one in June 2005 in practices within Stafford and Stone.

Members noted that due to financial constraints, it was possible that full PCT implementation would be re-phased towards 2006/07.

PEC (04) 217  PREScribing BudgEt Settings 2005/06

Members noted a report summarising the issues involved in the setting of GP Drugs Budgets and the methodology proposed for the financial year 2005/06.

The needs based capitation formula used in allocating prescribing budgets was reported to be capable of explaining only 62% of variation in prescribing expenditure at practice level, despite being robust when applied to populations at a PCT level. It was thus proposed, taking into account local knowledge as per guidance, to move further towards a more capitation based drug budget for practices, also taking into account the number of nursing and residential home patient numbers at practice level.

The 2003/04 and 2004/05 budgets had been based on a 70:30 historic:capitation split and it was agreed to accept the proposal recommended by the Head of Medicines Management for a 60:40 split for the financial year 2005/06.

The PCT adjustment to Uplift was to be reduced to 1.1%. This was based on an assumed growth trend of 9% with adjustments of 4% for generic drugs, 3.2% for the Pharmaceutical Prescribing Retail Scheme and 0.7% for Sept 04 generic. The Director of Finance & Performance reported that most PCTs were working to this figure or below.

A summary of the key figures is to be produced for practices and the Board and PEC.

The reduction in uplift combined with the drive to reduce GP referrals was noted as an area of risk by members.

PEC (04) 218  PREScribing incEntivE SCHEME 2005/06
Members considered a report outlining the proposed Prescribing Incentive Scheme for 2005/06. This was complimentary to the Quality & Outcomes Framework and supported cost and clinically effective prescribing.

The scheme was to apply to all practices, whether or not they chose to manage their entire indicative unified budget during 2005/06. For those however who did, any additional savings on the prescribing budget were to be considered alongside proposals for practice based commissioning (subject to the rules on how savings could be spent in the practice-based commissioning guidance).

Members agreed the proposed scheme.

PEC (04) 219  MEDICINES MANAGEMENT STRATEGY 2005-08

Members considered a report summarising the Medicines Management Strategy and action plan for 2005-08.

This was an updated strategy in line with the Local Delivery Plan, developing further the planning for particular core areas such as Supplementary Prescribing and Medicines Management in community pharmacy and prisons.

Targets in the action plan included:

- Ensuring that prescribing expenditure fell within budget,
- The establishment of PCT Prescribing and Mental Health Formularies,
- The development and monitoring of 3-year practice specific prescribing strategies,
- The development of a medicines management section of the PCT website
- Medication reviews and schemes to help older people in using their medicines, as per the NSF Older People target
- Making available to all practices technical support or a Practice Pharmacist
- The inclusion of medicines management forms in the PCT Clinical Audit Programme
- Ensuring effective liaison with secondary care on interface prescribing/medicines management issues
- An investigation of cost-effective methods of procuring medicines and the development of a service level agreement with the acute trust for supply of medicines to community staff

It was noted that Prisons Medicines Management was still at a very basic stage, not yet being computerised, but that more robust data would begin to be available in due course.

Members also noted the importance of Patient Care Directives with regard to Intermediate Care prescribing and this was to be
incorporated into the strategy. Members agreed the Medicines Management Strategy and action plan.

PEC (04) 220 HEALTH INEQUALITIES

Members considered and discussed a report outlining a multi-agency approach to tackling health inequalities in the Stafford Borough Area.

As a result of the Wanless Report and the Public Health White Paper "Choosing Health", it was recognised that plans to improve health would need to concentrate on disadvantaged groups and areas in order to close the health gap.

It was proposed therefore to concentrate efforts on the Highfields and Silkmore areas of the PCT within Stafford Borough, partnerships having already been forged with the Stafford Borough Local Strategic Partnership, Police and Social Services and agreement reached with regard to a way forward. The subsequent aim was to apply lessons learned from this initiative to other populations and areas of the PCT with deprivation.

Members discussed the importance of equity across the whole PCT area, with the use of the health equity audit to ascertain the most appropriate area to target. It was therefore agreed to endorse the approach taken to tackle health inequalities, but across the PCT wide area, rather than just the Stafford Borough.

PEC (04) 221 PCT PERFORMANCE REPORT

Members considered a report outlining PCT performance during December 2004 against the nine CHAI key performance targets used to determine Star Ratings.

Key areas of concern with regard to missed targets continued to be:

- Cancer waits - including urgent GP referrals, patients starting treatment within 31 days of diagnosis and those starting treatment within 31 to 62 days of diagnosis.
- Mental Health Assertive Outreach services
- More than a 3% increase in GP written referrals
- The number of patients waiting more than 13 weeks for an outpatient appointment

Daycase and outpatient booking services had narrowly missed the targets for December; with 99.5% of daycases and 73% out of 75% of outpatients being booked.

However, access to Primary Care and A&E services and Emergency Readmissions continued to meet targets as in previous months and the annual national targets for smoking
cessation had already been reached. The Director of Finance and Performance confirmed that Jane Chapman, Head of Performance Improvement was working on GP referral data, and that monthly reports were to be provided as part of the GP Commissioning project.

PEC (04) 222 QUALITY & OUTCOMES FRAMEWORK

Members considered an update report on the progress of the Quality and Outcomes Framework.

Prior to the commencement of the new GP Contract, all practices had identified the services they would agree to provide, and these had been recorded in the form of aspiration points within the Quality and Outcomes Framework.

The framework had been assessed, according to DoH guidelines, with practice visits, which had taken place between October 2004 and January 2005. An assessment team (consisting of a PCT management representative, a clinician and a patient representative) had met with all practices and summary reports had been produced and signed off by the Chief Executive.

The Quality and Outcomes Framework lead was now to work alongside Clinical Governance to assess all evidence provided by the practices, and establish a full audit trail demonstrating PCT ratification of the Practice points achieved. It was noted that the timescale for this was extremely marginal as practices were not obliged to provide evidence until 31 March 2005 and the PCT were required to verify and initiate payment in April 2005.

Based on evidence received to date, the assessment team were confident that the aspiration points indicated by practices were achievable and accurate. It was therefore proposed to make payments to practices in April, with the caveat that payments be recouped early in the financial year, should serious discrepancies be identified.

During discussion, members noted that the system of aspiration points was essentially based on trust and that data currently being gathered would over a period of time clarify the true patterns of compliance. It was reported that from next year, PCTs achieving less than 750 points were likely to receive less Allocation, with increased funding being given to those PCTs which exceeded their aspiration points.

The Chief Executive expressed thanks to all those who had been involved, at practice and PCT level, in successfully establishing the Quality and Outcomes Framework.

PEC (04) 223 PPI SUB COMMITTEE TERMS OF REFERENCE
Members considered a report summarising the Terms of Reference for the Patient and Public Involvement sub committee. Key terms of reference were as follows:

- To meet quarterly and oversee the implementation of all local and national consultation exercises.
- To develop mechanisms and procedures for patients and the wider community to be effectively engaged in determining priorities, plans and investment decisions of the PCT.
- To act in an advisory capacity to all internal groups and committees to ensure that new services reflected the patient experience.
- To oversee the work of the Patient Advice and Liaison Service (PALS), monitoring quarterly reports.
- To oversee the production and distribution of the leaflet “Your Guide to Health Services”
- To monitor the delivery of the Expert Patient Programme.
- To monitor the interface between the PCT and The PPI Forum and Health Overview and Scrutiny Committees to ensure the maintenance of effective joint working.
- To oversee an annual conference to review patient and public involvement activity over the previous year and monitor progress.

PEC (04) 224  Palliative Care Progress Report Related to NICE Guidance

Members considered a report presented by Sheilah Blackwell, Nurse Consultant in Palliative Care, which summarised the progress to date of palliative care services in relation to NICE guidance.

The twenty recommendations in the Guidance had been used to benchmark the PCT’s service provision and commissioning arrangements relating to palliative care and specialist palliative care. These were linked to the updated Quality and Outcomes Framework.

Issues of note were as follows:

**Inter-professional communication within teams**
Problems had been reported with regard to current out of hours arrangements provided by Staffordshire Ambulance Services for palliative care patients. It was noted that a clearer differentiation of care provision was required in relation to palliative and terminal care. However, it was noted that SAS were developing a system for GPs to “flag up” palliative care patients via a pro-forma, for out of hours purposes.

**Availability of records to patients**
Guidelines required that patients should be offered a
permanent record of important points relating to their consultation. This did not currently happen, but was in the process of being instigated at the local Trust.

**Psychological Support Services**
These were recognised as being of national concern and at a local level the provision of clinical psychology services had cost implications.

However, areas of good practice included the provision of a discharge planning team, a breast care support group, the production of patient leaflets for self help, the availability of Hospital and Hospice Chaplains and the Hospice at Home service - including 24 hour nursing and medical provision. A draft palliative care education strategy had also been developed and was awaiting ratification.

**PEC (04) 225 MODERNISATION UPDATE**

Members considered a briefing paper drawn up by the Chief Executive after the January Board Meeting, consisting of update reports of the individual modernisation projects.

**Rehabilitation**
The Board had agreed a proposal to increase the staffing of the Stafford Intermediate Care Team and to commission 6 nursing home beds to replace a rehabilitation service currently provided at Coppice Ward in Cannock.

**Chronic Disease Management**
The team in the North was to be refocused to enable the team to receive referrals for Chronic Obstructive Pulmonary Disease from GPs.

An Evening and Night service was to be created in the South and the existing Intermediate Care Teams expanded.

**Muscular Skeletal**
The Board received a proposal to introduce a Muscular-skeletal clinical assessment service, designed to reduce the number of outpatient Consultant appointments and provide more appropriate treatment pathways for patients.

The Board delegated authority to the Modernisation/Recovery Plan Project Board to commit expenditure on establishing the service.

**Ophthalmology**
Three local optometrists had completed training to work as Community Optometrists with Specialist Interests. It was planned that they would co-manage Glaucoma patients, provide ongoing care for stable Glaucoma patients, receive referrals and diagnose Glaucoma patients requiring treatment, ocular hypertension requiring monitoring or other eye
problems requiring monitoring or re-referral. A second proposal for a triage service was also being considered.

Palliative Care
The Board agreed to conduct a high level viability study to assess the development of a cost effective community based service for Heart Failure. A similar service for Stroke patients was also being considered.

Heart Failure
National Opportunities Funding had been secured, along with Cannock Chase PCT and Mid Staffordshire Hospital to set up a specialist heart failure nursing service, to identify patients requiring multiple admissions and manage their care in the community. The team had already started taking patients onto their books.

GP Referral Project
An action plan had been proposed which included routine feedback of GP referral costs data to practices and the introduction of Open Access investigations for GPs in the south.

Practice Based Commissioning
A proposal was being developed aimed at engaging all practices in the practice based commissioning process.

The Chief Executive, PEC Chair and Director of Finance & Performance were to visit practices over the next couple of months to discuss this and other Modernisation projects in more detail.

PEC (04) 226 SUMMARY OF CLINICAL INCIDENTS
Members noted a summary report of ten clinical incidents received by the PCT since the last PEC meeting on 18 January 2005.

These included an inappropriate community referral, poor discharge, the prescribing of incorrect medication, the provision of insufficient information when referring and incorrect calculations (with the use of the wrong paperwork) in relation to wound care.

PEC (04) 227 MEDICINES MANAGEMENT POLICY
Members noted a summary report of the PCT Medicines Management Policy. This was to apply to all staff employed by the PCT and was developed in order to effectively manage risks relating to prescribing, dispensing, storing, administration and disposal of medicines.

The policy has been developed through the Medicines Management Policy sub-group and the Professional Advisory
PEC (04) 228

SUMMARIES OF SUB COMMITTEE MINUTES

Members noted summaries from the following PEC Sub Committee meetings:
Premises Meeting of 13 January 2005
Out of Hours Meeting of 19 January 2005
Mid Staffs CHD Lit Meeting of 27 January 2005
Pharmacy Contract Implementation Meeting of 1 February 2005
Clinical Governance Meeting of 7 February 2005

PEC (04) 229

SCREENING INFORMATION ON NEWBORN

Members noted a summary report of the newborn hearing screening programme, which was a national programme, being gradually rolled out across the country in phases. South Western Staffordshire PCT was in the last wave of funding for the programme and had a target to implement the screening programme by October 2005.

Funding had been offered to cover the costs in 2005/06 and 2006/07 and the PCT was required to pick up the funding thereafter, which was likely to equate to approximately £47,000-£57,000 per year.

PEC (04) 230

CHILDREN'S FUND

Members noted a report summarising the Children's Fund Plan. All PCTs were being asked to sign up to the plan and the PCT Children's PEC sub committee had supported this.

Part of the plan involved a commitment that £600k (recurrent for 3 years) be divided between the six PCTs in Staffordshire. Each PCT would be asked to identify its priorities for preventative work with children aged 5-13 year in line with national and local objectives and the Children's NSF. The Children's PEC sub group was therefore to work with the Children's Fund Unit to identify priorities and projects and would report back to the PEC at a later date with an update of developments.

PEC (04) 231

ALCOHOL HARM REDUCTION STRATEGY FOR ENGLAND

Members noted the Alcohol Harm Reduction Strategy for England, which set out the Government's approach to tackling the harm and cost of alcohol misuse in England.

The local Crime & Disorder Partnerships (Responsible Authorities Group) and the local Crime and Disorder strategies were identified as the ideal avenues to take the strategy.
PEC (04) 232  ANY OTHER BUSINESS

Book & Choose:
It was reported that a booking management service was not now required, as an electronic version was to be made available. This would free up non recurring monies, especially in relation to IT and would help practices to be appropriately equipped to achieve NPfIT.

Practice Based Commissioning:
Members discussed the proposals set out for Practice Based Commissioning, especially proposals 1 and 2.

The PEC Chair suggested that the PCT consider providing a system of shadowing to practices, giving appropriate management support, which could perhaps be on a collaborative, rather than practice basis.

It was agreed that a set of principles should be established with regard to devolved rights and responsibilities and the Chief Executive and Director of Finance & Performance were to incorporate this into a report to aid those who would be involved in Practice Based Commissioning.

PEC (04) 233  DATE OF NEXT MEETING

Informal:
22 March 2005 at 12:30 hrs at Perton Civic Centre

Formal:
12 April 2005 at 12:30 hrs in the Boardroom, Mellor House

PEC (04) 234  EXCLUSION OF THE PRESS AND PUBLIC

It was resolved to exclude the press and public from the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

Signed .................................................... Date ..........................................................

Dr Roger Beal
Professional Executive Committee Chair
South Western Staffordshire Primary Care Trust
THE MID Staffordshire NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP9 [ ] to the Witness Statement of William Price
South Western Staffordshire Primary Care Trust

Minutes of a meeting held on Thursday 28 April 2005 at 12:30pm in the Boardroom, Mellor House, Corporation Street, Stafford.

Present:
Jenny Cornes (Chair)
Glyn Ravenscroft (Non Executive Director)
William Price (Chief Executive)
Jan Warren (Director of Primary Care & Professional Development)
Susan Fisher (Director of Finance & Performance)
Dr Zafar Iqbal (Director of Public Health & Partnership)
Dr Roger Beal (Chair of Professional Executive Committee)
Carol Hurley (Non Executive Director)
Maureen Compton (Non Executive Director)
Frances Sutherland (PEC Nurse Representative)
Brian Holland (Non Executive Director)
Dr Stuart Lloyd (GP Representative)

In Attendance
Jane Chapman (Head of Performance Improvement), Julie Phillips (Associate Director of Corporate Affairs) and Jennie Thomas (Administrator/Secretary to the Board & PEC).

PCT (05) 01 APOLOGIES

Apologies were received from Mike Washburn.

PCT (05) 02 MINUTES

The minutes of the meeting held on 31 March 2005 were amended as follows:

PCT (04) 159 Modernisation Update
Performance Management and Monitoring of Modernisation Projects:
The Director of Finance & Performance confirmed that the target figure for savings resulting from Modernisation projects was approximately £3.4m, which would be used to partly offset the projected 2005/06 recurrent deficit.

PCT (04) 187 Items Arising from the PEC
Prescribing Uplift:
PEC members had agreed to a reduced prescribing uplift of 1.1% for 2005/06.
PCT (04) 188 PCT Financial Performance Report
The Director of Finance & Performance reported that cash brokerage of £1.5m had been received and expressed her thanks to local PCTs.

PCT (04) 189 Payroll Services
Members discussed details surrounding the tendering of payroll services, including the suggested timetable and selection criteria. Members noted that the Strategic Health Authority were leading on this project.

PCT (04) 191 PCT Performance Report
Members noted that the Healthcare Commission was now responsible for producing the key targets for star ratings, against which the PCT would be measured for 2005/06.

With these amendments the minutes were approved as a true and accurate record and signed by the Chair.

PCT (05) 03

CHIEF EXECUTIVE’S REPORT

Team Brief:

A Team Brief had recently been circulated, summarising papers discussed at the PEC meeting of 1 March 2005.

The Chief Executive reported that distribution had been amended, as the Brief was still not reaching all members of the wider team. Managers were now being sent the report in the first instance for cascading to their teams.

Due to these problems, the PEC nurse vacancy for the South of the patch had been delayed, and in the meantime, Elaine Tinkler had proffered her resignation, due to an opportunity for further study at the University of Warwick. Those expressing interest for these two posts had been asked to contact the Chief Executive by no later than 8 April 2005.

Out of Hours Services:

It was noted that both Bilbrook and Brewood practices had now expressed a desire to exercise their right to opt-out of providing Out of Hours services. Both practices had agreed a three month notice period to this effect.

PCT (05) 04

PEC CHAIR’S REPORT OF MEETING OF 12 APRIL 2005

Resignations:
Two recent resignations from the PEC were reported – those of Elaine Tinkler (as recorded above) and also Dr Eddie Fong Lee, who had resigned due to increasing involvement with a bid for Technology Status at his local High School. Formal thanks were expressed to them both on behalf of the Board, for their commitment and hard work.
Performance Monitoring of GMS/PMS Contracts:
An approach had been agreed by the PEC based on national guidelines.

Prescribing Support Technicians:
The PEC had supported a proposal for selective top slicing to support practices not currently using support arrangements (i.e. those who had not done everything possible).

Aesthetic Surgery:
The PEC had supported guidelines in relation to secondary care.

Modernisation:
At the PEC meeting there had been detailed discussions on many issues, including Orthopaedic Triage. This was to be written up, taking account of issues raised.

The PEC Chair reported that the current round of practice visits had confirmed support for ideas such as peer review and referral advice and that no objections had been raised for work taking place at other practices.

Choose and Book:
This had been approved in principle, but issues such as NHS Direct funding had not been clear at the time of discussion. However, these issues had now been resolved.

Other papers discussed at PEC were agenda items at today's meeting.

PCT (05) 05 BUDGET BOOK

Members considered a summary report of the Financial Plan, showing a non recurrent deficit of £4.2m within the context of the PCT's statutory duty to remain within resource and cash limit.

The Executive Management Team had identified a non recurrent figure of £700,000 for repayment and members considered and agreed a detailed draft plan being prepared for submission to the Strategic Health Authority. The exercise was to be ongoing, in order to reduce the projected non recurrent element of the deficit as much as possible.

The need for robust risk management was identified and reporting arrangements were to be reviewed, especially in relation to Payment by Results and Prescribing, which were considered to be amongst the highest risks.

Members approved the proposal that the budget was brought into balance based on a combination of PCT specific cost reduction proposals together with pursuing brokerage

Exec Team
requirements from the Strategic Health Authority.

MODERNISATION PLAN – PERFORMANCE REPORT

Members considered a performance monitoring report, identifying progress against individual project plans and financial targets.

Some projects were currently failing to hit their process and/or financial milestones. These included:

- Intermediate Care – North, due to likely peaks and troughs in service use,
- Open Access Diagnostics, for which a contract had not yet been successfully placed due to relatively small activity levels.
- A Falls Prevention project, which had been scoped but had proved unlikely to release savings in the timetable of the recovery plan.
- HQ/Non Pay Projects, including Lease Cars. This project was on track to make savings, which would not be released until October, at the point of renewal of the insurance policy.
- Development of Outpatient services in Primary Care – this was to be completed as part of the Service Level Agreement and therefore the timescale would prove to be outside the control of the PCT.

Members agreed that a system should be developed for the closure of projects that were deemed to be unsuccessful, after an appropriate period of time.

A draft monthly summary report was presented to members for discussion. The format of the report was agreed – with the addition of a section for actual savings made against target.

Verbal thanks were expressed to the Head of Performance Improvement and her team for the work undertaken to date.

PCT (05) 07

PCT PERFORMANCE REPORT

Members considered a report summarising PCT performance against key targets set by the Healthcare Commission to establish the Star Ratings for 2005/06.

Areas of continuing concern were:

- emergency re-admissions, where for non elective admissions there had been growth of more than 1% at year to date by all main providers.
- An increase of more than 3% from the PCT target for GP referrals to outpatients.
- 341 patients waiting more than 13 weeks for an outpatient appointment, against a local target in February of 325.

However, the Director of Finance & Performance confirmed
that all national targets had been achieved.

PCT (05) 08  STRATEGIC SERVICES DEVELOPMENT PLAN

Members considered a report outlining the proposed direction of travel resulting from the Strategic Services Development Plan. This had previously been shared with the Board and PEC as well as a wider audience, which had included, amongst others, practices, the Local Medical Committee and Social Services.

The plan underpinned the strategy to take the PCT modernisation agenda forward, through the development of capacity within Primary Care.

Practice needs had been reviewed by the PCT Premises Committee on a geographical basis, to ascertain developments currently planned or agreed and to ensure that these fitted into the modernisation agenda and could deliver the plans for primary care.

Members noted the importance of local partnership working and the presentation of a quality business case to the Strategic Health Authority. The above direction of travel was therefore agreed, provided that plans were outlined in greater detail with regard to processes and assessment criteria relating to individual projects.

PCT (05) 09  HUMAN RESOURCES REPORT

Members noted a report outlining:

Sickness absence and turnover information
The overall sickness rate continued to be in excess of 6%. Members noted that this was being closely monitored by HR, with the maintenance of regular contact with absentees.

The PCT was working with other PCTs across the West Midlands to test and benchmark both sickness and turnover levels, in order to check whether experienced levels were a cause for ongoing concern.

Improving Working Lives
Validation for Improving Working Lives was to take place during the week commencing 19 December 2005. A request was to be made for IWL to be a standing agenda item for all future team meetings and a second newsletter was to be produced. Focus groups were also to be set up to discuss issues relating to IWL and the outcomes of the Staff Opinion Survey.

Agenda for Change
Nationally, the PCT continued to make good progress in matching jobs and assimilating staff onto the new paybands.
As at 13 April, 482 posts had been matched and only 10 staff had requested a review of the decision on their payband. 100 posts were awaiting the publication of new nationally agreed profiles and profiles were also awaited for jobs in Public Health, HR and Dental Services. 11 posts required the completion of a Job Analysis Questionnaire.

Staff Opinion Survey
The results of the Survey had been considered by the PCT Joint Staff Partnership. Issues noted were significant improvements and good overall PCT performance in comparison to others nationally. An Action Plan was to be produced by the HR/OD groups and issues arising from the Survey were to be discussed at the planned IWLU Focus Groups.

E-recruitment
This had now been implemented across the PCT and training sessions had begun to take place. The effectiveness of the NHS Jobs website was to be assessed in the future to decide on future recruitment methods.

The following HR Policies and Procedures were agreed by members:
- Smoke Free Environment Policy
- Cross Organisational Redeployment Policy
- Recruitment and Selection Policy

The Induction Policy did not include SFI and was therefore to be resubmitted.

PCT (05) 10 RISK SHARE HOSPICES
Members considered a report outlining current funding of hospices by SWS PCT. The options for altering the funding were discussed. These included:
- Current funding
- Collaborative commissioning based on contract prices
- Collaborative commissioning based on a standardised weighting
- Non collaborative commissioning

Members agreed that there was no advantage to withdrawing from current arrangements and that therefore these should continue for a further year, with risk sharing arrangements being reviewed at that time. However, it was also agreed that the issue of a reduced contribution to St Giles Hospice should be discussed with the other three Staffordshire PCTs in the very near future.

PCT (05) 11 DRAFT BUSINESS CYCLE
Members considered a proposed calendar of meetings which would form a framework for the PCT's core business. This was approved, subject to the addition of a Special Board Meeting on 21 July 2005, in order to consider the final accounts, which would be due for submission by 22 July 2005.

**PCT (05) 12 PRISON HEALTH**

Members considered a report summarising progress to date with regard to the transfer of commissioning prison health services.

The transfer of commissioning responsibility had occurred on 1 April 2005 and the PCT had agreed to take on responsibility for managing the prison Area Pharmacy Service (APS) at a future date to be agreed. The APS was to become smaller as an independent prison pharmacy was to be established in HMP Birmingham, servicing both the Birmingham and Worcester prisons.

The TUPE transfer of prison nursing staff had been postponed from 1 April until 1 June 2005. This was due to further work being required on agreeing the terms and conditions of transfer – in particular Grievance, Disciplinary and Disputes -with staff side representatives. Meetings had been arranged for 14 April and 6 May to take these issues forward.

A preliminary risk assessment had been undertaken relating to clinical and operational issues. Identified risks related to the nature of the client group, pharmacy, finance and operational processes. A revised prison health group structure was being considered to take forward risk monitoring and the implementation of corrective action plans.

The prison health funding allocation for 2005/06 had been announced, which demonstrated 24.3% growth in resources from the 2004/05 allocation. Requests for investment were to be presented as a business case to the Prisons Working Group before being passed to the Partnership Board, who would have responsibility for prioritising and authorising all investments.

Opportunities for service and workforce redesign had been identified at a recent Prison Health Development Day and these were to be prioritised by the Working Group for inclusion in a prison health action plan, which was to be drafted by the end of June 2005.

**PCT (05) 13 PALS/COMPLAINTS QUARTERLY REPORT**

Members considered a summary report of PALS enquiries and complaints dealt with during the period 1 January to 31 March 2005. Compliments were also recorded, relating to community dental services, the PALS service and general nursing services.
The overall trend in the report was of a reduced number of complaints and an increased number of PALS enquiries, confirming that the PALS service was resolving issues before they became complaints.

PCT (05) 14 ANY OTHER BUSINESS

The following questions in relation to Drugs and Alcohol were put to the Executive Team:

- What was the target for the number of people who it was aimed to get into drug treatment?
- What was the time limit between requesting and receiving treatment?
- Were the PCT meeting targets?
- What was the impact of drug testing orders?
- What was the number of people who waited longer than 12 months to receive treatment?

PCT (05) 15 DATE AND TIME OF NEXT MEETING

Date & time of next meetings:

INFORMAL – 26 May 2005, Committee Room 1, South Staffordshire Council Offices, Codsall.

FORMAL - 23 June 2005, Boardroom and Room 3, Mellor House, Corporation Street, Stafford.

PCT (05) 16 EXCLUSION OF PRESS AND PUBLIC

It was resolved to exclude the press and public from the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

Signed .................................................... Dated ........................................

Jenny Cornes
Chair
South Western Staffordshire Primary Care Trust
THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP10 [ ] to the Witness Statement of William Price
MID STAFFS COMMISSIONING MEETING  
WEDNESDAY 15 JUNE 2005, 12:30PM  
ROOM 6, PGMC

Present:-

Phil Coates Clinical Lead – NICE Implementation, MSGH
Helen Pernen Head of Patient Access, MSGH
Andrew Crawshaw Director of Partnerships and Service Development, MSGH
John Smith Commissioning Manager, CC PCT
Tom Travers Director of Finance, CC PCT
John Newsham Director of Finance and Planning, MSGH
Lynne Deavin Commissioning Manager, SWS PCT
Lizions Director of Nursing and Operational Services, CC PCT
Jane Chapman Head of Service Improvement, MSGH
Susan Fisher Director of Finance, SWS PCT
Karen Bray Modernisation Support Manager, MSGH
William Price Chief Executive, MSGH

1. Apologies

   Were received from Andi Selvam, General Practitioner, CC PCT, John-
   Pierre Parsons, Chief Executive, CC PCT and Jan Harry, Director of
   Clinical standards, MSGH

2. Minutes of the previous meeting held 18 May 2005

   The minutes were accepted as a true and correct record.

3. Matters arising not appearing on the agenda

   None.


   Dr Summers stated that there had been 108 inappropriate referrals in May
   - she was unable to categorise these due to time restraints. At the moment
   patients are not being transferred back to primary care. Letters have been
   re-sent to GPs reinforcing the guidelines by SWS PCT, CC PCT to check –
   John Smith.

   From Monday referrals will start being recorded for 2 weeks then sent back
   through the PEC chairs. A discussion took place regarding the guidelines
   and Andrew Crawshaw believes that they are correct, the criteria has not
   changed, yet inappropriate referrals are still coming through.

   JS

   AC

5. MSGH financial recovery plan

   Susan Fisher believes that clinical changes need explaining in greater
   detail before the plan is signed off. Jan Harry to arrange.

   JH

6. Catheter Lab – confirmation of funding

   Julie Whittingham has emailed confirmation of what activity is coming to
   MSGH. Lynne Deavin to discuss detail re Stone patients that would go to
   UHNS. John Smith, Lynne Deavin and Andrew Crawshaw met with
   Michael Brooks to discuss this, a spreadsheet was presented showing the
   money coming into MSGH, but not the money coming out of UHNS; this

   LD
needs to be looked at in a separate meeting. Susan Fisher requested a simple summary. John Smith to discuss with Michele Brooks.

John Smith is to seek assurance from Michael Brooks of a zero net impact and after the full assessment of the UNHS shift in activity had been taken into account. This will be reported back to the group.

Andrew Crawshaw reported that the Cath Lab will open on 18th July and that patients would be phased up to 5 per session.

7. A&E waiting time targets

In May A&E hit 95.2%. June has been a pressure month with an increased number of breaches over 2 days. There are a high number of medical patients coming through. Other trusts are in a similar position.

There are no 9-month or 17-week breaches. Targets set for the directorates meet the October timeframe.

There is concern in outpatients for 4 specialties including neurology, dermatology, gastroenterology and oral surgery. MSGH are an outlier nationally against the balanced score card. The hospital is looking at scheduling for 13 weeks for October and is undertaking considerable work in the problem areas.

Lynne Deavin reported that the gastro protocol has been sent out.

Lynne Deavin requested the dermatology drop off rate is shared via Millar Bowness.

Andrew Crawshaw stated that there is still an underlying problem in dermatology. Liz Onions said that it was her objective to revisit the dermatology work, and questioned whether it should be put under IPH. Liz Onions to set up a meeting - SWS agreed that this needs to be fast tracked.

John Newsham said that work in oral surgery is in hand with UHNS. MSGH have a high reference cost which needs to be looked at.

Phil Coates said that there will be an inevitable increase in emergency admissions due to the ageing population, plus the impact of the GP contract.

Jane Chapman said that the economy group are considering the front door for patients as a priority. Services will be looked at to match the patients needs by autumn. Jane Chapman is awaiting comments on the terms of reference for the economy group which includes relocating the Out of Hours Service.

Phil Coates said that intermediate care teams will not prevent the main causes of admissions into secondary care.

John Newsham questioned whether intermediate care beds are being used - SWS said they were being used for step down.

8. Revised waiting list targets

John Smith stated that he would be agreeing the returns following a meeting with John Newsham.
John Newsham said that we should take the opportunity to use free activity for MRI scans. This needs to be looked into including where a mobile unit could be plugged in. John went on to say that this does not have to be on the hospital site.

Lynne Deavin and John Smith to discuss and take forward.

9. Terms of reference

Susan Fisher, Lynne Deavin, John Smith and Karen Bray to pull together a first draft and share this with the group.

10. PCT practice based commissioning and impact

Susan Fisher believes that this needs to be tailored to each PCT. Phil Coates has been invited to a meeting this pm to ensure that secondary care is involved from the outset. In SWS PCT - several practices have taken direct services. CC PCT - practices have shown some interest.

A lot of work needs to be done in both PCTs. In the future practices will develop direct relationships with acute trusts. Susan Fisher stated that all practices have to move towards practice based commissioning within 3 years.

Andrew Crawshaw questioned the future role of PCTs, William Price said that PCTs would work with GPs re reconfiguration, be responsible for monitoring targets and to performance manage financial balance.

11. Any other business

John Newsham presented a list of mental health drugs following an FOI application by John-Pierre Parsons for details of mental health drugs dispensed by MSGH pharmacy – to be picked up by PCTs. There is a significant amount of money that can be saved.

South Staffs Healthcare have placed an advert for a pharmacist, the post holder will be responsible for devising a formulary. To take forward at the next SSRC commissioning meeting by Susan Fisher and Kathy Riley.

Anticoagulation cards have been received by the hospital from practices in Rugeley for hospital staff to dose patients – no warning was given. CC PCT to take back.

12. Date and time of next meeting

Wednesday 20 July 2005, 12:45, Room 1, PGMC.
THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP11 [ ] to the Witness Statement of William Price
With regard to increased referrals, where are these coming from? I am advised ours are roughly on line. Can you please provide detailed information for tomorrow's meeting. J-PP

----Original Message----
From: BOWNASS MILLAR (RJD) MSGH-TR
Sent: 20 September 2005 12:01
To: Price William (5MN) SOUTH WESTERN STAFFORDSHIRE PCT; Parsons Jean-Pierre (5MM) CANNOCK CHASE PCT (E-mail); Travers Tom (5MM); Fisher Susan (5MN) SOUTH WESTERN STAFFORDSHIRE PCT; YEATES MARTIN (RJD); Harris Martin (Q26) SHROPSHIRE AND STAFFORDSHIRE HA; Williams Sylvester (5MN); McCourt Liz (5MN) SOUTH WESTERN STAFFORDSHIRE PCT; CRAWSHAW ANDREW (RJD) MSGH-TR; PLANT COLIN (RJD) MSGH-TR; DURRANS DAVID (RJD) MSGH-TR; HARRY JAN (RJD) MSGH-TR; GIBSON JOHN (RJD) MSGH-TR; NEWSHAM JOHN (RJD) MSGH-TR; BONNASS MILLAR (RJD) MSGH-TR; SADLER NORMA (RJD) MSGH-TR; YEATES MARTIN (RJD)
Subject: Waiting List Management. OCTOBER TARGETS
Importance: High

William - you have written to Martin Yeates expressing your concerns about the number of potential breaches of the 13wk/6mth targets that we still have on our waiting lists projecting forward to the end of October. As you return from your leave (hoping you had a good time) I am able to update you as follows:

As you will be aware we already run a weekly waiting list meeting (9am Tuesdays) to which PCT and STAs are invited. Sylvester Williams for Cannock and Liz McCourt for South Western always attend and Karen Monez from STAs was able to join us last week. They are all also included in our twice weekly data update reports.

These targets have been, and continue to be, a major challenge to the Trust. It is worth pointing out that what has, and is, being achieved is in the face of increased referral rates and activity, beyond the assumptions built into the commissioning models. This you may wish to take into account at your meeting tomorrow (21st).

I am enclosing the latest traffic light progress report generated from this morning's meeting from which you will see that concerted effort is going into those parts of the waiting list that have not yet been fully resolved, solutions are in sight and some specialties have already achieved the target. Over the last month we have cleared 75% of the outpatient list (down from 3200 to 867) and 50% of the inpatient list (down from almost 1000 to 493). I am confident that we will release the additional capacity needed to complete the task.

It remains this Trust's firm commitment to achieve both the inpatient and the outpatient targets by the end of October. The Trust Board (non-executive directors and executive

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directors), the Clinical Directors and Chairman of Medical Staff Committee have expressed their resolve and have been instrumental in bringing the whole consultant body on board and releasing the additional capacity and changes in working practices necessary. Martin Yeates re-emphasised this to the Senior Managers Meeting yesterday which I echoed at Waiting List Meeting this morning.

I hope that you are reassured that everything that can be done is being done and that we will achieve the targets. For my part my attention is also drawn to the sustainability of our position for the future and the national December target in particular.

<<Inpatient Waiting List Action Plan v1 20sep05.doc>>

Kind Regards
Millar Bownass
Director of Patient Access
THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP12 [ ] to the Witness Statement of William Price
MY / MM

22nd September 2005

TO:
Ms Karen Morrey – Delivery Team Manager: South Staffordshire
Mr Jean-Pierre Parsons – Chief Executive: Cannock Chase PCT
Mr William Price – Chief Executive: South Western Staffs. PCT
Mr John Newsham – Director of Finance & Planning: MSGH Trust

Dear Colleague,

Health Economy Finance Steering Group

Many thanks for your various communications regarding the Steering Group, which were received whilst I was on holiday. You will now be aware that the inaugural meeting has been convened for Tuesday 11th October at 3.00 pm in Room 7, Postgraduate Medical Centre, Staffordshire General Hospital. My particular thanks to all of the PA’s involved, who worked hard to find a date that was suitable to all of our diaries.

I attach an agenda for the meeting, but felt that it would also be helpful to comment on one or two of the communications that I have received.

Firstly, with regard to William’s letter dated 31st August, there were a number of very helpful issues raised, and just answering them in turn:

1. I believe we should at this stage deal with those issues related to non-mental health primary care and secondary care, rather than to include other non-acute services such as Mental Health. The group may choose to do this later, but initially I would like to focus on our particular set of circumstances.

2. I agree that the group looking at the detailed PbR issues should continue. However the Steering Group should look at the high-level impact and strategy issues coming out of PbR.

3. Whilst I accept the view that any thoughts of development proposals should not be encouraged, I do not believe that all developments have a cost implication, and I certainly support the view that we should be considering “invest to save” and/or “disinvestments” proposals.

4. I believe it is appropriate to raise the concern that we might be too focussed on financial solutions rather than service solutions, based upon the current title of the group. However, I think the Terms of Reference do cover the opportunity to consider issues outside of the pure financial discussion, and I expect that we inevitably will discuss service issues in order to arrive at financial solutions.

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Integrated Service Improvement Plan (ISIP). I believe this will be picked up as part of the debate with the wider South Staffs. Chief Executives Forum agreed on 22nd September.

I would rather keep the meeting to a tight membership initially, but would certainly not discount the opportunity for co-opting other clinical and/or modernisation staff onto the group if we feel it is going to be helpful in due course.

I believe the discussion surrounding the future of PCT provider functions will be discussed in many forum. However, on the basis that we are looking at development, “invest to save” and “disinvestments” solutions, there are inevitably opportunities for rationalisation across acute and community services. In order to move care closer to home and reduce the size of the acute and secondary care sector it is inevitable that the discussion about provider services in the community will form part of our discussions.

I would under no circumstances wish to see any duplication of effort, particularly from Chief Executives, and therefore we need to agree early on where the other forums link in with this meeting, not least of all the commissioning meetings that you refer to, but also the newly formed South Staffs. Programme Board, and perhaps we could clarify that at our first meeting.

Moving to the communication from Jean-Pierre Parsons, I have agreed that in order for us to make sensible decisions, information will be required for the meeting. I have asked that John Newsham ensures that the pack of information is circulated one week in advance of our meeting in order for us to consider the current position of the PCTs and the Acute Trust.

Once again, my thanks to all of you for agreeing to join the meeting, and I look forward to seeing you on 11th October.

Kindest Regards.

Yours sincerely,

Martin Yeates
Chief Executive

cc. Mr Phil Taylor – Director of Performance and Finance : Shropshire & Staffordshire Strategic Health Authority
Mrs Susan Fisher – Director of Finance : South Western Staffs PCT
Mr Tom Travers – Director of Finance : Cannock Chase PCT
Mr Simon Stevens - KPMG

PCT00280003654
Witness Name: William Price
Statement No: First
Exhibits: WP1 – WP17
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP13 [ ] to the Witness Statement of
William Price
South Western Staffordshire NHS

South Western Staffordshire Primary Care Trust

Minutes of a meeting held on Thursday 29 September 2005 at 2pm in the Council Chamber, South Staffordshire Council Offices, Codsall.

Present:  
Jenny Comes (Chair)  
Glyn Ravenscroft (Non Executive Director)  
Maureen Compton (Non Executive Director)  
Brian Holland (Non Executive Director)  
Carol Hurley (Non Executive Director)  
William Price (Chief Executive)  
Jan Warren (Director of Primary Care & Professional Development)  
Susan Fisher (Director of Finance & Performance)  
Dr Zafar Iqbal (Director of Public Health & Partnership)  
Dr Roger Beal (Chair of Professional Executive Committee)

In Attendance  
Jayne Deaville (Director of Finance & Performance, South Staffordshire Healthcare NHS Trust), Steve Grange (Project Director for Foundation Trust/Deputy Director for Strategic Development, South Staffordshire Healthcare NHS Trust), Councillor Kathleen Perry (Staffordshire Health Scrutiny Committee Member, Staffordshire County Council), Jane Chapman (Deputy Director of Performance), Julie Phillips (Associate Director of Corporate Affairs) and Jennie Thomas (Administrator/Secretary to the Board & PEC),

PCT (05) 68  
APOLOGIES

Apologies were received from Mike Washburn and Dr Stuart Lloyd.

PCT (05) 69  
MINUTES OF THE MEETING OF 28 JULY 2005

The minutes of the meeting held on 28 July 2005 were amended as follows:

Apologies were recorded from Councillor Kathleen Perry (Staffordshire Health Scrutiny Committee Member, Staffordshire County Council).

PCT (05) 48 Chief Executive’s Report – Healthcare Commission Star Ratings:

Members noted that the Chief Executive, rather than the Director of Finance and Performance, was to undertake a
review of decision making processes around the recent appointment of a Learning Disability Co-ordinator.

With this amendment the minutes were approved as a true and accurate record and signed by the Chair.

PCT (05) 70  CHIEF EXECUTIVE’S REPORT

Members considered a report by the Chief Executive, covering a recent Choosing Health Seminar, a recent paper about a “Patient Led NHS” and the Integrated Improvement Plan.

**Patient Led NHS**

The Strategic Health Authority was today considering options to be submitted by them to the Department of Health regarding reconfiguration of PCTs. These included a single Staffordshire wide PCT, incorporating the current six PCTs, with North and South Stoke PCTs possibly merging into a single organisation. The merger of Telford & Wrekin and Shropshire County PCTs was also being considered.

It was also proposed that the Strategic Health Authority merge with both West Midlands South and Birmingham and the Black Country Strategic Health Authorities to create one West Midlands-wide organisation.

It was envisaged that Chief Executives for new Health Authorities would be in post by December 2005, followed by those for PCTs in February or March 2006. Newly structured PCTs were therefore likely to be in place by May 2006.

**Integrated Service Improvement Plan (ISIPs)**

This plan was to be a replacement of the NPIIT project, and had been designed to ensure integration of major change programmes within each local health economy and to identify and quantify benefits to be maximised.

Members agreed that the plan should be discussed at an Informal Board meeting, prior to final submission.

PCT (05) 71  PEC CHAIR’S REPORT OF MEETING 13 SEPTEMBER 2005

**Specialised Services**

A presentation had been given by Dr Jonathan Howell, (Consultant in Public Health Medicine to the Shropshire and Staffordshire Specialised Commissioning Group) on Specialised Services.

**Primary Health Care Facilitator for Learning Disabilities**

A draft job description for a Primary Health Care Facilitator for Learning Disabilities had been amended to include case management of clients.
Oral Health in Children
Members supported recommendations, amongst others, for ongoing discussions with South Staffordshire Water about fluoridation of water supplies in Stafford and Stone, as fluoridation had been proven to help eradicate dental caries in children.

Quality & Outcomes Framework for 2005/06
This was approved by the PEC - lay assessor were not to be part of visiting teams for 2005/06, but would be involved instead via Patient Groups, where these were in existence.

Home Oxygen supplies
Possible problems relating to this service were noted, due to an imminent change of supplier and also an increase in the number of health care professionals who would be able to refer.

Feedback Forms
A form designed to improve communication between referring GP and discharging hospital consultants was approved.

Practice Modernisation Visits
The PEC noted issues arising from recent practice modernisation visits, which were in the process of being addressed. Overall, it was felt that these visits had been beneficial, having served to strengthen communication between GPs and the PCT.

Long Term Conditions
Members had adopted a model of care template that had been developed by the Improving Hospital Partnership project for Long Term Conditions.

Musculoskeletal Service
Members had received a verbal update of this service, noting that it had commenced in the Stafford area on 18 July 2005 and was to be rolled out to the South from October 2005.

Cancer Plan
Members noted a report of national and local progress with regard to the ten year NHS Cancer Plan of September 2000.

Mental Health Services
Members noted a paper re the above, particularly in relation to prison services and pilot schemes within practices.

Individual Patient Treatments
The PEC had agreed options 1-3 relating to funding considerations of the above, but not option 4. This paper was to be discussed later on the Board agenda.

Other papers noted by members included the following:
NSFs for Children & Young People's Services, Older People, Long Term Conditions, Stroke and Coronary Heart Disease Cancer Plan
Diabetes Care
Summaries of Clinical Incidents
Summaries of Sub Committee Minutes
Health Inequalities Update

PCT (05) 72
PRESENTATION FROM SOUTH STAFFORDSHIRE HEALTHCARE NHS TRUST REGARDING FOUNDATION TRUST BID
South Staffordshire Healthcare were in the midst of an application to become a Foundation Trust and a brief presentation was given by Jayne Deaville (Head of Finance & Performance) and Steve Grange (Project Director for Foundation Trust/Deputy Director for Strategic Development, South Staffordshire Healthcare NHS Trust).

Preparations involved looking at freedoms and benefits which would be achieved for clients, users and purchasers. Becoming a Foundation Trust would give staff the opportunity to get involved in how services were run and therefore influence them and would also provide the opportunity to consider service innovations, to ensure good quality local services.

15000 members, from both public and staff, were to be recruited over a three year period, and it was hoped that the first 5000 would be secured by December 2005.

Questions were taken from Board members and these included the definition of key criteria linked to the application, the issue of risk management, retention of core community service provision, Mental Health services for children and provision of shared services in the new climate of Commissioning a Patient Led NHS.

Information packs on the Public Consultation being undertaken regarding Foundation Trust status were distributed to members and a further presentation offered if required. Members also noted that up to date information was available from the South Staffs Healthcare web site.

PCT (05) 73
ANNUAL REPORT 2004/05

Members noted the Annual Report, which had been received at the Annual General Meeting preceding the Board Meeting.

Formal thanks were given by the Chief Executive to Mrs Pam Page (Corporate Affairs Administrator) for her hard work in putting the report together.
PCT (05) 74  ANNUAL HEALTH CHECK/STANDARDS FOR BETTER HEALTH

Members considered a report outlining progress made to date on the Annual Health Check, along with key related messages from the Healthcare Commission.

Updated information and guidance had been issued for assessing core standards, as well as for the draft declaration for 2005/06. Members noted these, and agreed the definitions of "reasonable assurance" and "significant lapse" in relation to core standards assessment. Members also approved the time scale in relation to making the draft declaration available to members of the public.

Formal thanks were given to the Associate Director of Corporate Affairs, Jane Brown, Community Nutrition & Dietetics Services Manager and other members of the Steering Group for their contribution to the project.

PCT (05) 75  PCT FINANCIAL PERFORMANCE REPORT

Members considered a report outlining PCT performance against financial targets as at August 2005. This showed a net overspend of £584k for the year to date and a forecast outturn of £2.054m deficit at year end.

The Director of Finance & Performance outlined the main risks. These could increase the deficit to £3.5 to £4m. The serious cash position was also discussed.

The Director of Finance & Performance had met recently with PCT colleagues within Shropshire and Staffordshire, who had agreed to share details of their individual cash positions in order to develop a robust plan.

The Modernisation projects were not delivering savings as originally anticipated, there being a current shortfall of approximately £1m.

A meeting had recently taken place between the Strategic Health Authority and the PCT Chair and Chief Executive about the current financial position. It had been emphasised that the organisation must break even financially and continue to focus on both finance and targets.

Members discussed alternatives for achieving financial balance. The Chief Executive outlined the tough alternatives that were being considered and costed by the Executive team in order to identify areas where expenditure could be stopped immediately. These included redundancies, withdrawal of service provision (e.g. for clients considered to be borderline in their need), the sale of premises and associated cost effective
relocations, savings on prescribing, mergers and alternative means of funding staff.

PCT (05) 76  PCT PERFORMANCE REPORT

Members considered a report outlining the PCTs performance against key targets set by the Healthcare Commission, which had been used to produce Star Ratings.

Areas of concern, based on available July data were as follows:

**Outpatient target** – 202 patients had waited more than 13 weeks for a first outpatient appointment as a result of a GP referral (the target set was 145).

**Inpatient and day case target** – 118 patients had waited more than six months for a first inpatient appointment as a result of a GP referral (target set was 87).

**Emergency Re-admissions**
There had been more than 1% increase in activity (target) compared to the plan.

**Cancer Targets**
All providers had been asked to submit action plans to ensure that they would meet cancer targets. The Director of Primary Care & Professional Development agreed to look at the overall figures, as Cancer Lead for the PCT.

Mid Staffordshire General Hospital now had (short term funded) trackers in to trace their data. However, data had not been available from Royal Wolverhampton NHS Trust for a period of three months. The Director of Finance & Performance agreed to seek clarity re their position.

Members noted the current performance against Key targets and the close monitoring required of cancer targets.

PCT (05) 77  QUALITY AND OUTCOMES FRAMEWORK 2005/06

The PEC had recently agreed the Quality & Outcomes process for 2005/06. This was a voluntary framework for practices to follow in order to raise organisational and patient experience.

As a result of analysis of the process undertaken last year, various changes had been agreed for 2005/06 in order to ensure that visits had a more robust structure. As a means of cost reduction it had been agreed not to include a lay assessor in the visiting team, but their involvement was to continue via patient groups where these were in existence. Members considered the option of a Non Executive Director taking the place of the lay assessor, within their current role. Due to the
necessity of clinical input, members supported the continuation of payments relating to GPs on the visiting teams.

PCT (05) 78

COMMUNICATIONS STRATEGY

Members considered the PCT Communications Strategy, which had been in draft form for some time and required ratification by the Board.

The strategy incorporated policies on Media, Major Incidents and Publications with the aim of developing the following key communication areas for staff and external audiences:

- Proactive and reactive media and public relations
- Engaging the public
- Health promotion/education
- Links across the organisation and with partners
- Patient advice and liaison services

Members ratified the PCT Communication Strategy.

PCT (05) 79

INDIVIDUAL PATIENT TREATMENT REQUESTS PROCESS

Members considered a report of the process agreed at a recent PEC meeting for responding to individual patient treatment requests.

The principles on which decisions were to be based had been incorporated into a template for use in every case. These had recently been amended to include human rights and were:

1. Quality of clinical care
2. Quality of life
3. Health gain
4. View of stakeholders
5. Equity
6. Value for money
7. Human rights

In order to manage costs, the PCT needed also to consider affordability and the PEC had agreed the following options to be used:

To only fund life saving interventions or those interventions which avert serious disability (eg blindness).

Where treatment met the seven principles and where deferral of treatment would not affect the health outcome significantly, funding should be deferred until April 2006.

On occasions, Trusts sought funding for Individual Patients in year when in reality this constituted unplanned development of a new service. For some of these requests it would have been reasonable for the PCT to expect the Trust to present and agree a business case with the Commissioners before
contracts were signed. It was proposed that in such circumstances funding requests from Trusts should be refused or the Trust asked to risk share, even if the individual patient request met the criteria as above. Members approved the above process for considering individual patient requests for treatment.

PCT (05) 80 MODERNISATION PLAN – PERFORMANCE REPORT

Members considered and discussed a report outlining progress to date on PCT Modernisation projects, with particular emphasis on savings achieved.

Currently these were in the region of £500,000, which was considerably below original projections. However, the Vice Chairman commended the work of community and management teams in establishing significant improvements to care pathways for patients affected by a number of projects. Members also noted that new projects were being scoped and considered for inclusion in the plan, such as the transfer of diabetes care from the acute sector into the community.

As the PCT had been challenged by the Strategic Health Authority to maintain financial balance at year-end, a serious overview was required of individual projects and the way forward. It was agreed that the Executive Team would consider appropriate measures at their meeting on Tuesday 4 October. These were to be reported back to the Non Executive Directors at their Briefing on Wednesday 5 October, reflecting on discussions which had taken place at today’s meeting.

PCT (05) 81 RISK MANAGEMENT REPORT (INCLUDING ANNUAL REPORT 2005)

Members considered the Risk Management Annual Report for 2005, which gave details of achievements over the last twelve months as well as information on incidents, complaints and claims.

Notably, the PCT had achieved Level 1B of the National Health Service Litigation Authority Risk Management Standards for PCTs. A maximum score had been obtained for clinical care, competence and communication and the PCT Policy for Consent to Examination and Treatment was noted to “provide a very good level of detail for local arrangements”. The PCT was also noted to be “clearly committed to the provision of risk management training” and to “have produced good guidance in the management of complaints”.

Members also noted the Risk Register/Assurance Framework (Strategic Risks).
PCT (05) 82  CHILD PROTECTION QUARTERLY UPDATE

Members considered the Child Protection Quarterly Update.

Child Protection remained an area of high risk for the PCT. The post of named doctor remained outstanding, although members noted that the Director of Public Health & Partnership was responsible for identifying an appointee in individual cases if necessary, the role passing to him by default if there was no-one available.

A nurse support role to the named doctor was delivering training and liaising with GP practices. Uptake for this training had been high.

Members noted that a final report was expected relating to the first of two recent serious child protection cases. As a result of this, an action plan was to be drawn up and presented to both Board and PEC for approval.

PCT child protection statistics and case note audit results were noted by members.

PCT (05) 83  HUMAN RESOURCES REPORT

Members considered the latest Human Resources Report, for September 2005.

Workforce Information & Profile
There was a downward trend for sickness absence rates from a peak of 6.96% in January down to 5.62% in July. Staff turnover was in line with the levels experienced by PCTs within the West Midlands at 10.23%.

A workforce plan had been produced and submitted to the Workforce Development Confederation.

Revised HR Strategy
At the Board meeting of June 2005 members had considered a draft HR Strategy. This had subsequently been revised, as it did not reflect the position and plans of the PCT in relation to modernisation and the financial position. Members considered this further draft and agreed to its adoption and implementation.

Improving Working Lives
Work was ongoing in preparation for Validation during week commencing 19 December 2005.

Agenda for Change
The PCT continued to make good progress in matching jobs and assimilating staff onto new pay bands. At the end of August over 94% of posts had been matched, against a September target of 95%. 71% of staff had been assimilated
to new pay bands and 40 of these were requesting a subsequent review.

**Joint Staff Partnership (JSP)**
Draft Health & Safety policies - on Lone Working and Handling Non Physical Assault and Aggression - had been considered at the September meeting of the JSP. Final versions were to be presented to the Board at a future date for agreement.

Revised Guidelines for Managers and Staff on the management of ill health and sickness absence were also agreed, and these were to be implemented across the PCT, supported by a programme of briefing sessions for managers and staff side representatives.

**Staff Opinion Survey**
This was to be distributed by week commencing 3 October at the latest, to all staff. The survey was this time to include core questions only, in order to allow for comparisons with last year.

**Commissioning a Patient Led NHS**
This had two major strands – PCT reconfiguration and the transfer of directly provided services to alternative providers. Members noted that the impact of both these changes would require significant leadership support and input from Human Resources.

**PCT (05) 84 MINUTES OF SUB COMMITTEE MEETINGS**

Members noted minutes from the following sub committees:

- HR & OD of 29 June 2005
- Risk Management of 14 July 2005
- Clinical Governance of 1 August 2005

**PCT (05) 85 IMPROVING WORKING LIVES – PRACTICE PLUS ASSESSMENT**

The first draft Improving Working Lives self-assessment had recently been completed and circulated. It was the result of a large amount of work undertaken by PCT staff and formal thanks were given by Carol Hurley, Non Executive Director, on behalf of the Board.

**PCT (05) 86 NATIONAL PATIENT SURVEY 2005**

The National Patients Survey for 2005 had been undertaken by Patient Dynamics, and comparing the results with last year's national average response rates, the PCT had scored better overall, with no areas of major concern needing to be addressed.
This information had been presented to the PEC at their meeting in July and it had been agreed that no further action was required. A response to the survey findings was to be drawn up for the local press.

Members noted information relating to those areas where questions and response rates fell below the national average, which included:

- an increase in the number of patients not having received medication checks by their GP within the last twelve months,
- an increase in the number of patients who smoked cigarettes,
- an increase in those patients who had not been offered a flu jab within the last twelve months,
- patients having difficulty in making GP appointments more than 3 working days in advance,
- patients not receiving copies of letters sent between the hospital and their family doctor.

PCT (05) 87 LOCAL DELIVERY PLAN

Members formally received the Local Delivery Plan.

PCT (05) 88 DATE AND TIME OF NEXT MEETING

INFORMAL – 27 October 2005, Boardroom, Mellor House, Corporation Street, Stafford

FORMAL - 24 November 2005, Committee Room 1, South Staffs Council Offices, Codsall

PCT (05) 89 EXCLUSION OF PRESS AND PUBLIC

It was resolved to exclude the press and public from the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

Signed .......................... Dated ..........................

Jenny Cornes
Chair
South Western Staffordshire Primary Care Trust
8th November 2005

Mr. William Price
Chief Executive
South Western Staffordshire PCT
Mellor House
Corporation Street
Stafford
ST16 3SR

Dear William

Re: Strategic Direction

I am currently working with our staff internally but also with external stakeholders in an attempt to develop a Strategic Direction for our Organisation. This coincidentally has worked extremely well in terms of the timetable with the Foundation Diagnostic.

My plan is to develop the principles for the Strategic Direction by Christmas and then to work closely with the Clinical Directorates to ensure that they have a sustainable future, both financially and clinically in the light of those principles which I hope to have agreed by the Board at its meeting on the 8th January 2006.

In developing the Strategic Direction, I am particularly keen to ensure that the Primary Care Trust are engaged both in terms of reflecting their perception of the Trust as it currently stands but perhaps more importantly to ensure that our Strategic Direction is consistent with the strategic intentions of the Local Commissioning Organisations.

Perhaps when you have had time to reflect upon this plan, you could discuss with me the most appropriate way in ensuring that we achieve this objective of involving your PCT in our development.
I look forward to speaking to you in the near future but would be grateful for an early response as I intend to have a draft Strategic Direction available for consultation in early December.

Kindest regards

Yours sincerely

Martin Yeates
Chief Executive
Witness Name: William Price
Statement No: First
Exhibits: WP1 – WP17
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP15 [ ] to the Witness Statement of William Price
South Western Staffordshire Primary Care Trust

Minutes of a meeting held on 27 April 2006 at 12.30 p.m. in the Boardroom, Mellor House, Corporation Street, Stafford.

Present:  
Jenny Cornes (Chair)  
Maureen Compton (Non Executive Director)  
Jan Warren (Director of Primary Care & Professional Development)  
Susan Fisher (Director of Finance & Performance)  
Carol Hurley (Non Executive Director)  
Dr Roger Beal (Chair of Professional Executive Committee)  
Glyn Ravenscroft (Non Executive Director)  
Mike Washburn (Non Executive Director)  
Dr Zafar Iqbal (Director of Public Health & Partnership)

In Attendance:  
Julie Phillips (Associate Director of Corporate Affairs), Councillor Kathleen Perry (Staffordshire Health Scrutiny Committee) and Vanessa Ridout (PA/Office Manager, Finance Directorate).

The Chair welcomed Jon Crockett, Chief Executive of Wolverhampton Primary Care Trust to the meeting.

PCT (06) 01 APOLOGIES

Apologies were received from Dr Stuart Lloyd, William Price and Brian Holland.

PCT (06) 02 MINUTES OF THE MEETING HELD ON 30 MARCH 2006

The minutes of the meeting were amended as follows:

PCT (05) 154: Financial Plan 2006/07 – It was agreed that there would be no new investments or uplifts on internal budgets. The legal status of the new Directly Enhanced Services was statutory. With regard to the prescribing budget it was agreed, following finance panel, that there would be no uplift on the outturn.

With these amendments the minutes were approved as a true and accurate record and signed by the Chair.

PCT (06) 03 MATTERS ARISING

PCT (05) 170: Risk and Risk Management in Prison Healthcare

Members noted that the Prisons were also represented at the
Improving Working Lives Core Group.

PCT (06) 04 CHIEF EXECUTIVE’S REPORT

Commissioning a Patient Led NHS (CPLNHS)
The Secretary of State had announced the reconfiguration of Strategic Health Authorities in line with the consultation document i.e. a single West Midlands Strategic Health Authority.

No announcement had been made on the Ambulance or PCT configurations although the Strategic Health Authority had recommended the merger of six Staffordshire PCTs into one. This announcement was due on 8 May 2006.

PCT Support
The Chair introduced Jon Crockett who briefed the board on his role in supporting the PCT on resolving the financial challenges it was facing. He highlighted that problems faced by the PCT were in the context of an inherited financial problem, a difficult financial year and also that the organisation would not be around in six months time. He also identified the pressures affecting the PCT as being finance, contracts and service delivery. Additional support was to be available from David Alcock, Director of Finance from North Warwickshire Primary Care Trust and he was looking to identify commissioning expertise.

PCT (06) 05 PEC CHAIR’S REPORT OF MEETING OF 11 APRIL 2006

GP Referrals Project Update
A paper was to be presented to the next PEC giving an update on practice action plans and processes for 2006/07.

Policy on low priority treatments
These included small hernias, gallstones etc. which were to be considered in the context of reducing the numbers commissioned. Further work would be required prior to implementation.

Benchmarking of Primary Care
It was noted PMS was generally more expensive than GMS.

Staffordshire County Council - Ageing with Opportunity in Staffordshire
Comments and feedback relating to this were required by the end of May.

PCT (06) 06 PCT PERFORMANCE REPORT

Members considered a report summarising PCT performance against targets set by the Healthcare Commission.

The report had recently been presented at Finance Panel and
members noted that targets around cancer waits and A&E had been missed. Clarification had been sought from the Trust who confirmed that the cancer target was missed in January and related to two patients. This was due to a delay in the diagnostic test for one patient and secondly because of a complex diagnostic pathway. It was confirmed that the target had been achieved prior to and since January.

The A&E target was also showing as red and this was due to a large number of staff being off sick.

**PCT (06) 07 REVISED TERMS OF REFERENCE FOR AUDIT COMMITTEE**

The draft terms of reference for the audit committee had been revised in order to reflect the particular nature of Audit Committees in the NHS and their growing role in developing integrated governance arrangements and providing assurance that NHS bodies were well managed across the whole range of their activities.

Following the new integrated governance arrangements it was proposed to combine the Risk Management and Clinical Governance committees into one and a paper focussing on the accountability framework would be brought back to the next Board meeting. KPMG had endorsed the proposal.

Members ratified the terms of reference.

**PCT (06) 08 ANNUAL HEALTH CHECK DECLARATION 2005/06**

Members considered the Annual Health Check Declaration for 2005/06, which was about to be for submitted to the Healthcare Commission. Two areas had been revised to show compliance and these were cleanliness in Prisons and NICE guidance. Prior to sign off, comments had been sought from the Strategic Health Authority and the Staffordshire Health Scrutiny Committee and these were expected that day. The Audit Committee had reviewed and ratified the PCT Annual Health Check declaration 2005/06 prior to submission for approval to the PCT Board.

The Chair of the Board thanked all staff involved for their work in preparing the report.

Members ratified the PCT Annual Health Check Declaration on compliance with core standards.

**PCT (06) 09 FINANCIAL PLAN UPDATE**

Members considered an update report on the Financial Plan 2006/07, which had been submitted to the Strategic Health Authority on 12 April. This showed improvement from the plan previously discussed at Board, resulting from the following:
- Review of planned investments closing the gap by £2.5m
- A worsening of the position as a result of the potential increased deficit reported for 2005/06

The Strategic Health Authority had asked that the PCT resubmit milestones to achieve waiting times. The Board agreed that the plan should be resubmitted and members noted that the deficit would increase to £5.9m if this could not be mitigated and the PCT would need further plans to achieve financial balance.

The Modernisation Board was to continue looking at the savings targets and other options were to include Choosing Health and Palliative Care.

An action plan was to be presented to the next Finance Panel meeting on 25 May 2006.

PCT (06) 10 MODERNISATION

Members considered a progress report of the Modernisation Plan projects, detailing financial performance and projected savings at the end of the financial year.

Orthopaedic triage services had been implemented and the report showed a good number of patients having been seen by the service, rather than by consultants. The Service Level Agreement with the acute sector had been revised to take this into account.

The Intermediate Care Team Action Plan showed that all sections were progressing well. Although actions relating to the targets were not yet complete, they were well underway. Teams in both the North and South were focusing on admission avoidance, which was anticipated to generate £600k of savings.

Streamlining Emergency Care work was ongoing, with a focus on Older People and was being led by Liz Sargeant, Project Director for Service Reconfiguration.

It was agreed to refocus on admission avoidance and members noted its importance as a way of partnership working with Trusts for service redesign.

PCT (06) 11 HUMAN RESOURCES REPORT

Members considered a report containing key performance data and current human resource information.

Members noted the achievement of head count reduction and agreed the revised Special Leave Policy.
PCT (06) 12  INEQUALITIES PROGRESS REPORT

Members considered the Inequalities Progress Report. The PCT had organised a conference on behalf of Stafford Together and Stafford Borough Local Strategic partnership, to look at the commitment of key organisations and the voluntary sector in working together to tackle health inequalities and to agree to move forward in partnership. Stafford Together had produced a series of short and medium term projects and an action plan was being developed.

Stafford Borough Council had offered the Highfields Neighbourhood Office to the Primary Care Trust for use in acting on plans that emerge from the work. A business case was being prepared with partners, to enable the facility to open in the autumn of 2006. A whole range of agencies were to have access to the building with the costs dependent on the business case and some organisations being in a position to pay for the use of the building. The PCT was not committing any resources to this facility.

The Director and Deputy Director of Public Health had visited head teachers in the area to gain their perspective on health needs and wider health inequalities and the findings were appended to the report.

Members felt that the report currently did not contain sufficient detail to support further commitment at this stage.

PCT (06) 13  CHILDREN & THE STRATEGIC PLAN

Members considered a report of the Children’s Trust and the Strategic Plan.

It was agreed that the plan would need to include the following -

- links to organisational responsibilities
- implementation plan
- detail on the financial consequences for the PCT and would support invest to save options

PCT (06) 14  COMPACT WITH THE VOLUNTARY AND COMMUNITY SECTOR IN SOUTH STAFFORDSHIRE

Members considered a report on the Compact with the Voluntary and Community Sector in South Staffordshire.

It was felt that detailed discussions were required before signing up to the Compact and that a covering letter should be issued stating that due to the financial position of the PCT no new investments would be made.

A discussion took place around the need to keep the voluntary
sector involved when developing/cutting services and that all opportunities should be looked at regarding services.

PCT (06) 15 UPDATE ON LOCAL AREA AGREEMENTS

Members had previously received a report outlining the rationale behind Local Area Agreements (LAA) and considered an update on the LAA to date. Further guidance on timescales had been made available from Government Office West Midlands and Staffordshire County Council had responsibility for developing the LAA with its partners. Information sharing sessions had already taken place and the PCT had had representation at a number of events. Staffordshire LAA would cover the 4 blocks:

- Children and Young People
- Healthier Communities and Older People
- Stronger and Safer Communities
- Economic Development and Enterprise.

Two further blocks had also been agreed

- Sustainable Communities and
- Collaboration

Leads had been agreed for all the blocks and members noted that timescales were tight, as Staffordshire County Council were coordinating with 6 PCTs and 8 local authorities.

Members noted the proposed governance arrangements and timescale for agreeing LAAs and the need to participate in influencing the development of the LAAs through County based processes. Members also considered the implications for the PCT.

PCT (06) 16 MINUTES OF SUB COMMITTEE MEETINGS

Members noted the sub committee minutes from the following:

- Audit committee meeting of 12 January 2006

- Clinical Governance Committee meeting of 6 February 2006

PCT (06) 17 DENTAL UPDATE

Members noted the update on the outcome of the new contractual arrangements for NHS dentistry and the position in South Western Staffordshire. The paper also provided a brief overview of the new patient charges system that had come into force on 1 April and introduced the new Out of Hours arrangements for patients requiring emergency or urgent dental care.
PCT (06) 18 EVIDENCE BASED PRACTICE AND CLINICAL RISK – CLINICAL POLICY REVIEWS

Members noted a report on the role of the Evidence-based Practice/Clinical Risk Group in facilitating the development and review of clinical policies and best practice guidelines and the coordination of clinical risk management. The report highlighted the progress with updating existing clinical policies and the process of development of new clinical policies/guidelines.

PCT (06) 19 CHILD PROTECTION QUARTERLY UPDATE

Members noted an update report on child protection issues. The final version of the revised document 'Working Together to Safeguard Children' was still awaited, which had closed the consultation period in October 2005. The chapter on Local Safeguarding Children’s Boards had been agreed and the first meeting of the Staffordshire Safeguarding Children had taken place in March. The Director of Primary Care was the PCT representative for the South Staffordshire Primary Care Trusts.

PCT (06) 20 OUT OF HOURS SERVICES

Members noted an update on the planned relocation of Out of Hours services from Stafford Central Clinical to Stafford General Hospital along with future developments.

PCT (06) 21 HEALTH FRAMEWORK FOR LOCAL COUNCILS

Members considered a report on the progress in developing Local Councils health frameworks. Stafford Borough Council and South Staffordshire District Council had agreed to develop a health framework in conjunction with the Director of Public Health. The process for developing the framework had yet to be finalised but was likely to involve the following:

- Mapping of current councils’ initiatives which impacted on health
- Examining the key functions of the councils
- Assessment of what further could be done to impact on health
- Assessment on how the health of the employees of the Councils could be improved
- Establish mechanisms to ensure public health was considered in developing policy
- Opportunities for joint working particularly in agreeing and delivery of Local Area Agreements

It was envisaged that health frameworks would be agreed by August 2006.
PCT (06) 22 2004/05 PROGRAMME BUDGETING FINANCIAL RETURN

Members noted a report on the breakdown of 2004/05 programme budgeting across the 23 categories for all of the Primary Care Trusts in the Strategic Health Authority. The Director of Finance and Performance was a member of the Strategic Health Authority Benchmarking group. A separate analysis of maternity costs for which the PT appeared to be an outlier was to be reported at a future PEC meeting.

PCT (06) 23 DATE AND TIME OF NEXT MEETING

Date and time of next meetings

INFORMAL – 25 May 2006, Committee Room 1, South Staffs Council Offices, Codsall


PCT (06) 24 EXCLUSION OF PRESS AND PUBLIC

It was resolved to exclude the press and public from the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

Signed .........................................................., Dated ........................................

Jenny Comes
Chair
South Western Staffordshire Primary Care Trust
THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP16 [ ] to the Witness Statement of William Price
Recovery Plan
2006/07 to 2007/08

June 2006

Endorsed by: William Price, Chief Executive

Date: 26 June 2006
Recovery Plan 2006/07 to 2007/08

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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>A4C</td>
<td>Agenda for Change</td>
</tr>
<tr>
<td>B</td>
<td>Benchmarking</td>
</tr>
<tr>
<td>BLT</td>
<td>Burntwood, Lichfield and Tamworth</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Children and Mental Health Services</td>
</tr>
<tr>
<td>CIP</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>DN</td>
<td>District Nurse</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
</tr>
<tr>
<td>EP</td>
<td>Existing Project</td>
</tr>
<tr>
<td>ERT</td>
<td>Enzyme Replacement Therapy</td>
</tr>
<tr>
<td>FFCE</td>
<td>First Finished Consultant Episode</td>
</tr>
<tr>
<td>FNC</td>
<td>Free Nursing Care</td>
</tr>
<tr>
<td>FOA</td>
<td>First Outpatient Attendance</td>
</tr>
<tr>
<td>FYE</td>
<td>Full Year Effect</td>
</tr>
<tr>
<td>GMS</td>
<td>General Medical Services</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HCHS</td>
<td>Hospital and Community Health Services</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Informatics Service</td>
</tr>
<tr>
<td>HQ</td>
<td>Headquarters</td>
</tr>
<tr>
<td>IAT</td>
<td>Inter Authority Transfers</td>
</tr>
<tr>
<td>ICT</td>
<td>Intermediate Care Team</td>
</tr>
<tr>
<td>IMST</td>
<td>Information Management &amp; Technology</td>
</tr>
<tr>
<td>LDDF</td>
<td>Learning Disability Development Fund</td>
</tr>
<tr>
<td>LDP</td>
<td>Local Delivery Plan</td>
</tr>
<tr>
<td>MSGH</td>
<td>Mid Staffordshire General Hospital</td>
</tr>
<tr>
<td>NGDS</td>
<td>New General Dental Service</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NR</td>
<td>Non-Recurring (One off commitment)</td>
</tr>
<tr>
<td>NSCAG</td>
<td>National Specialist Commissioning Advisory Group</td>
</tr>
<tr>
<td>OLS</td>
<td>Old Long Stay</td>
</tr>
<tr>
<td>OOH</td>
<td>Out Of Hours</td>
</tr>
<tr>
<td>OP</td>
<td>Out Patient</td>
</tr>
<tr>
<td>PAU</td>
<td>Paediatric Assessment Unit</td>
</tr>
<tr>
<td>PBR</td>
<td>Payment By Results</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PID</td>
<td>Project Initiation Document</td>
</tr>
<tr>
<td>PIS</td>
<td>Prescribing Incentive Scheme</td>
</tr>
<tr>
<td>PMS</td>
<td>Personal Medical Services</td>
</tr>
<tr>
<td>PPA</td>
<td>Prescription Pricing Authority</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality Outcome Framework</td>
</tr>
<tr>
<td>R</td>
<td>Recurring (Ongoing commitment)</td>
</tr>
<tr>
<td>R &amp; M</td>
<td>Repair and Maintenance</td>
</tr>
<tr>
<td>SAS</td>
<td>Staffordshire Ambulance Service</td>
</tr>
<tr>
<td>SaS&amp;HA</td>
<td>Shropshire and Staffordshire Health Authority</td>
</tr>
<tr>
<td>SLA</td>
<td>Service Level Agreement</td>
</tr>
<tr>
<td>SIHA</td>
<td>Strategic Health Authority</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>SWS</td>
<td>South Western Staffordshire</td>
</tr>
<tr>
<td>T&amp;O</td>
<td>Trauma and Orthopaedic</td>
</tr>
<tr>
<td>VFM</td>
<td>Value For Money</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole Time Equivalent</td>
</tr>
<tr>
<td>WP</td>
<td>Weighted Population</td>
</tr>
</tbody>
</table>
South Western Staffordshire PCT – Recovery Plan 2006/7 to 2007/8

1.0 Introduction

South Western Staffordshire PCT embarked on an ambitious Recovery process during 2004/05 following the identification of an underlying deficit towards the end of 2003/04, which was mitigated that year through national resource limit and local balance sheet flexibility.

The PCT overspent by £3.75m in 2004/05 and a further £1.15m in 2005/06, giving a cumulative deficit of £4.9m to recover.

Whilst the 2005/06 position is a further breach of duties it also represents a significant improvement in the overall recurring position of the PCT and a reduction in the rate of in year overspend. This was achieved through specific savings initiatives and a programme of Modernisation, which was managed through a Modernisation Board.

During the latter stages of planning for 2006/07 all PCTs have been required to pick up the impact of funding the NHS Bank (net contribution £2.54m) and the impact of the Purchaser Parity Adjustment (£1.44m in 2006/07). The net impact of these changes given the challenging agenda already faced by the PCT necessitates a reassessment of the overall approach and deliverability of the PCTs financial strategy.

2.0 Financial Recovery Board: Process, Structure and Governance Arrangements

The process for achieving financial recovery will now be managed through a Financial Recovery Board, chaired by a Non Executive Director of the PCT. The Terms of reference for the Financial Recovery Board are given at Appendix 1.

The Financial Recovery Board and PCT Board will receive monthly performance reports, the format of which is to be agreed, but is likely to include current actions, tracking resources released and monitoring process against key performance indicators and milestones. A formal report will be submitted to each Board meeting and the financial consequences will be incorporated in the Finance Panel report.

All projects covered by the Recovery Plan process will be required to produce a Project Initiation Document (PID) and a detailed Action Plan, which include key milestones to ensure performance is measurable. Each project will have its own project arrangements and the Lead Director will be responsible for the submission made by the Lead Officer who is responsible for the project management of his/her own specific project. The Financial Recovery Board will be supported by a full time Project Manager who will monitor progress against plans and be directly accountable to the Chief Executive, Recovery Board and Intervention Team.
The Financial Recovery Board will identify key communication issues including matters for consultation around proposed service changes. A Financial Recovery Board newsletter will also be produced.

3.0 Financial Position

3.1 Financial Strategy 2004/5 to 2005/06

Having projected a deficit of £3.75m for 2004/05 a financial strategy was produced early in 2004/05 to recover the underlying position, based on:
- Improved financial governance and reporting
- Sound balance sheet management
- Recurrent balance by the end of 2005/06
- Repayment of 2004/05 deficit in 2006/07
- Delivery of recurrent savings

3.2 Outturn 2005/06

The outturn position for 2005/06 is summarised in Table 1 below:

<table>
<thead>
<tr>
<th>Table 1 – Outturn 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repayment of 2004/05 deficit</td>
</tr>
<tr>
<td>MSGH brokerages withdrawn re: 2003/04</td>
</tr>
<tr>
<td>Prior Year Issues</td>
</tr>
<tr>
<td>In year savings (Appendix 2)</td>
</tr>
<tr>
<td>PBR pressures</td>
</tr>
<tr>
<td>In year pressures</td>
</tr>
<tr>
<td>In year deficit</td>
</tr>
<tr>
<td>Outturn 2005/06</td>
</tr>
</tbody>
</table>

It is to be noted that in order to contain the position, particularly pressures arising from a move towards full PBR in 2005/06 substantial additional savings of £3.35m have been delivered by the PCT. A more detailed breakdown of these in-year savings is given at Appendix 2.

The above has been achieved with some considerable effort by managers and staff within the PCT and external partners e.g. prescribing.

3.3 2006/07 Plan Submission

The plan submitted to the Health Authority for 2006/07 is summarised in Table 2 overleaf (A more detailed breakdown of the submission is given at Appendix 3):
Table 2 – 2006/07 Plan Submission

<table>
<thead>
<tr>
<th></th>
<th>Rec</th>
<th>Non Rec</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allocations Gross of Purchaser Parity Adjustment</strong></td>
<td>200,456</td>
<td>15,888</td>
<td>216,344</td>
</tr>
<tr>
<td><strong>Commitments (including Redundancy Costs)</strong></td>
<td>197,928</td>
<td>16,140</td>
<td>214,068</td>
</tr>
<tr>
<td><strong>PCT Initial Start point Surplus/(Deficit)</strong></td>
<td>2,526</td>
<td>(252)</td>
<td>2,276</td>
</tr>
<tr>
<td><strong>Repayment of Prior Year Deficit</strong></td>
<td>(4,911)</td>
<td>(4,911)</td>
<td></td>
</tr>
<tr>
<td><strong>Modernisation Savings</strong></td>
<td>1,600</td>
<td></td>
<td>1,600</td>
</tr>
<tr>
<td><strong>Original Recovery Plan</strong></td>
<td>4,128</td>
<td>(5,163)</td>
<td>(1,035)</td>
</tr>
<tr>
<td><strong>West Midlands Bank Contribution</strong></td>
<td>(5,506)</td>
<td></td>
<td>(5,506)</td>
</tr>
<tr>
<td><strong>West Midlands Bank Loan/Interest</strong></td>
<td>2,963</td>
<td></td>
<td>2,963</td>
</tr>
<tr>
<td><strong>Purchaser Parity Adjustment</strong></td>
<td>1,440</td>
<td></td>
<td>1,440</td>
</tr>
<tr>
<td><strong>Surplus/(Deficit)</strong></td>
<td>2,688</td>
<td>(7,706)</td>
<td>(5,018)</td>
</tr>
</tbody>
</table>

In line with the PCTs financial strategy the Plan shows a recurring surplus at the initial start point of £2.528m (Ref. 1) and an overall surplus of £2.276m. Taking account of the repayment of the PCTs brought forward cumulative deficit of £4.911m (Ref. 2) there remains a shortfall of £2.635m to achieve the objective of repayment of the deficit in 2006/07. It had been anticipated that modernisation projects from 2005/06 would have a further benefit of £1.6m in 2006/07, which would have reduced the overall gap at this stage to £1.035m (Ref. 3). Given that this residual sum is of a non-recurring nature this would have been containable within normal parameters and processes.

A review of the overall modernisation and recovery process and the revised scale of the challenge given the requirement to contribute to the NHS Bank and pick up the impact of the Purchaser Parity Adjustment would now indicate that it is not appropriate to assume that the balance of £1.6m will be delivered in isolation and this should be added back to the overall savings target required. This will then be offset by the reassessed impact of projects and savings plans within the overall figures rather than as an item in isolation.

In the light of the above the overall requirement for savings is given at Table 3 below:

Table 3 – Overall Savings Requirement

<table>
<thead>
<tr>
<th></th>
<th>Rec</th>
<th>Non Rec</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Modernisation schemes in original plan</strong></td>
<td>1,600</td>
<td></td>
<td>1,600</td>
</tr>
<tr>
<td><strong>Net deficit submitted to SiHA</strong> (per table 2 Ref. 4)</td>
<td>(2,688)</td>
<td>7,706</td>
<td>5,018</td>
</tr>
<tr>
<td><strong>Total savings to Identify</strong></td>
<td>(1,088)</td>
<td>7,706</td>
<td>6,618</td>
</tr>
</tbody>
</table>

3.4 Financial Risks

Appendix 4 shows a financial risk analysis for 2006/07. On this basis and an assessment of the position at this point a potential increased deficit of £0.9m exists. The most significant risks apart from savings remain as PBR and Prescribing. These risks will be managed in year within the PCT. The PCT
has a strong history of managing a challenging prescribing budget. In addition more robust SLAs exist to achieve capacity targets. On this basis these potential risks have not been included in the total savings target.

### 4.0 Existing Modernisation Schemes

A number of modernisation schemes that were initiated in 2005/06 will have an impact on maintaining the financial position in 2006/07 onwards. A brief resume of the schemes is given below:

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Description</th>
<th>SLA Assumption</th>
<th>Measures</th>
<th>Lead Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Care Team (ICT) admission avoidance (Ref: EP1)</td>
<td>ICT take referrals directly from GPs SAS and A&amp;E to treat patients in their home or nursing home</td>
<td>840 admission avoided (695k)</td>
<td>Actual against historical</td>
<td>Jan Warren</td>
</tr>
<tr>
<td>Obstetric Outpatients (Ref: EP2)</td>
<td>Converted N12 at MSGH with zero length of stay to ward attenders</td>
<td></td>
<td>$420K</td>
<td>*Contact monitoring</td>
</tr>
<tr>
<td>Excess bed days (Ref: EP3)</td>
<td>ICT focus on supporting the discharge of patients post trim point</td>
<td>Reduction between 2004/05 and 2005/06 of c. $420k</td>
<td>*Contract monitoring</td>
<td>Jan Warren</td>
</tr>
<tr>
<td>Orthopaedic Triage (Ref: EP4)</td>
<td>All GP referrals triages and streamlined to the most appropriate service – primarily community based Physiotherapy</td>
<td>Reduction of 1st OP appts by 1,298 (€187k)</td>
<td>Triage service activity data and HIS referral data</td>
<td>Jan Warren</td>
</tr>
<tr>
<td>Ophthalmology Triage (Ref: EP 5)</td>
<td>Optometrists triage and treat referrals of defined conditions in line with a pathway.</td>
<td>Reduction of 1st OP appts by 330 (€33 gross)</td>
<td>* Activity reports and ophthalmology report</td>
<td>Zafar Iqbal</td>
</tr>
<tr>
<td>New follow up ratio (Ref: EP6)</td>
<td>Working towards upper quartile performance at all providers</td>
<td>7 months @ upper quartile MSGH, 5% reduction Dudley, RWH Ibc Total c.€827k</td>
<td>*Contract monitoring</td>
<td>Susan Fisher</td>
</tr>
<tr>
<td>Consultant to consultant referrals (Ref: EP7)</td>
<td>In 05/06 the consultant to consultant referrals rose significantly above the rates for other activity. For 06/07 they were capped at the 04/05 rate</td>
<td>Represents a reduction of approximately 20% on 04/05</td>
<td>*Contract monitoring</td>
<td>Susan Fisher</td>
</tr>
<tr>
<td>Prescribing (Ref: EP8)</td>
<td>Containment of the uplift to 0% on outturn (initially 4%)</td>
<td>£1.1m</td>
<td>Monthly PPA data</td>
<td>Jan Warren</td>
</tr>
<tr>
<td>Stone Rehabilitation Centre (EP9)</td>
<td>Sale of Stone Rehabilitation Centre</td>
<td>£300k (non-recurrent)</td>
<td>Sale of premises</td>
<td>Julie Phillips</td>
</tr>
<tr>
<td>Vacancy Freeze (EP10)</td>
<td>The PCT has a vacancy freeze which is managed on an exception basis via a control process.</td>
<td>N/A</td>
<td>Prism wte and FMR wte</td>
<td>Jan Warren</td>
</tr>
</tbody>
</table>

* Within contract or core business therefore no specific PID

A full list of existing and new schemes can be found in Appendix 5
5.0 Expenditure Review 2006/07

Control of expenditure is normally exercised through the scheme of delegation and the normal budgetary control process. The PCTs financial position has however necessitated the introduction of more rigorous controls in some areas over the last year. The following section highlights the current process for vacancy control and summarises a process of Expenditure reviews.

5.1 Vacancy Freeze

The PCT has a vacancy freeze which is managed on an exception basis via a control process. Following the completion of an approval form, completed and signed by the line manager, finance and the Director each vacancy is risk assessed and approval is by exception via the vacancy control panel. The vacancy control panel consists of the three Executive Directors. Criteria for agreeing recruitment is based on a risk assessment – including clinical risk, service provision, contribution to modernisation. New posts also require the approval of the Chief Executive.

Posts are only advertised when this process is complete and each new starter form will be reconciled back to an agreed and completed vacancy control form. Administrative, Managerial, Health Visiting and School Nurse posts have already been frozen for the last 12 months and will continue to be so as part of the overall freeze. This is reflective of the agenda set by “Commissioning a Patient Lead NHS” and in accordance with a current review of roles.

5.2 Headcount Reduction

The PCT has been set a target headcount reduction of 12.0 for 2006/07 and this is a key indicator for monthly Performance reports.

5.3 Expenditure Reviews

The Executive Team has been tasked with reviewing all budget heads to assess whether or not these can be reduced using a standard checklist identifying risks, impact and achievability of reducing baseline spend.

5.4 Headquarters Expenditure Review

A review led by the Chief Executive has resulted in the reduction of start budgets for 2006/07 of £400,000. This is in addition to withholding inflationary uplifts to budgets, which was already accounted for in the plan. The main areas of reduction include removing vacant posts from the structure and some anticipation of staff movements (10.5 posts removed in total) together with a stringent approach to other discretionary non-pay items. The final figures have been corporately agreed by the Executive Team. Some of the above will impact on the Headcount reduction required by the SIHA although some will not as the posts were vacant at the end of 2005/06.
Table 4 – Financial Plans 2006/07 to 2007/08

<table>
<thead>
<tr>
<th></th>
<th>R £000</th>
<th>NR £000</th>
<th>Total £000</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>Savings target</td>
<td>1,088</td>
<td>(7,706)</td>
<td>(6,618)</td>
<td>Table 3 above</td>
</tr>
<tr>
<td>Byre Existing projects</td>
<td></td>
<td></td>
<td>0</td>
<td>Already included in SLAs etc Appendix 5</td>
</tr>
<tr>
<td>New projects</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discretionary</td>
<td>642</td>
<td>400</td>
<td>642</td>
<td>Appx 5 Headquarters</td>
</tr>
<tr>
<td>spend reductions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assumed allocations</td>
<td>200</td>
<td></td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Redundancy costs</td>
<td>429</td>
<td></td>
<td>429</td>
<td>Now assumed in 2007/08</td>
</tr>
<tr>
<td>delayed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revised Total</td>
<td>2,130</td>
<td>(7,077)</td>
<td>(4,947)</td>
<td>Ref 5</td>
</tr>
<tr>
<td>2006/07 Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recurring start 2007/08  
2,130 2,130 From above

2006/07 deficit  
(4,947) (4,947) From above (Ref 6)

2007/08 uplift/additional funding  
18,059 15,034 33,093 Per Appendix 3.2

In year commitments (including inflation & PPA)  
(16,836) (15,246) (31,882) Per Appendix 3.2

Additional savings  
3,301 3,301 Per Appendix 5

Redundancy Costs  
(429) (429) Originally assumed in 2006/07

Revised Total  
6,854 (5,588) 1,266

2007/08 Plan

The above table has not assumed any return of resource from the Bank in 2007/08. The definitive rules are imminent on the repayment of bank loans but early indications are that these will be repaid over a 3 year period. This position will need updating on receipt of the final rules.

The reductions of spend on acute services clearly represent large proportions off the above plan, but represent relatively modest percentage movements and have assumed some costs to provide alternatives.

The impact of moving towards mental health benchmarking is only partly included with a further improvement possible in 2008/9.
7.2 **Risks**

All new project lead officers have already identified high-level risks. A formal risk management process will be adopted (draft 1, Appendix 7) as part of the overall project management of the recovery plan. This will cover financial, clinical and organisation risks and reports will be provided to the Recovery Board at agreed intervals.

8.0 **Conclusion**

The PCT recognises the significant non-recurring nature of the issues it faces. However the plan is based on achieving a recurring surplus in accordance with the NHS operating framework and to recognise benchmark data indicates high relative costs in some areas.

Further many of the schemes are transferable across the new reconfigured PCT and could therefore deliver further savings on a wider population.

This plan is based on a 2-year recovery period and on this basis the PCT requires £4.947m (Table 4 Ref. 5) brokerage in 2006/7 (largely as a result of the historic deficit of £4.9m), which would be repaid in 2007/8 (Table 4 Ref. 6).
APPENDIX 1

SOUTH WESTERN STAFFORDSHIRE PRIMARY CARE TRUST

FINANCIAL RECOVERY BOARD

MEMBERSHIP AND TERMS OF REFERENCE

1. STATUS AND REPORTING ARRANGEMENTS

The Financial Recovery Board is a sub committee of the Board and reports to the Board and the Finance Panel on a monthly basis. There will be a 48 hour turnaround of draft minutes.

2. MEMBERSHIP

Non-Executive Director (Chair) – deputising arrangements will apply
Chief Executive
Director of Finance and Performance
Director of Public Health and Partnerships
Director of Primary Care and Professional Development
Associate Director of Corporate Affairs
Project Manager
Head of Provider Services
Professional Executive Committee Chair
GP from Practice Based Commissioning Groups x 2
Projects Leads to be co-opted as and when required
Strategic Health Authority (nominated member)
KPMG (nominated member)
Intervention Team
  - Chief Executive, Wolverhampton PCT
  - Director of Finance, North Warwickshire PCT
  - Director of Service Improvement, Shropshire and Staffordshire Strategic Health Authority
Practice Managers x 2 (nominations - representative of Practice Populations)
3. TERMS OF REFERENCE

a) To deliver (on behalf of the Board) the overall financial recovery plan, including:

   To agree the financial total which needs to be recovered.

   To agree the schemes identified and their contribution, including timescales.

   To identify and deliver schemes.

   To agree responsibility for delivery.

   To identify additional support required.

The outcomes of the above will be reported to the PCT Board for adoption.

b) To ensure robust clinical engagement occurs in support of recovery plan delivery.

c) To monitor progress, performance manage delivery, agree corrective action against the recovery plan and report to the Board as necessary.

d) Is responsible for ensuring appropriate communication including consultation issues.

4. FREQUENCY OF MEETINGS

The Financial Recovery Board will meet monthly.

5. QUORUM

A third of the membership will represent a quorum providing one Executive Director and one Non Executive Director is present. In relation to the Chair role deputising arrangements will apply.
Witness Name: William Price
Statement No: First
Exhibits: WP1 – WP17
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit WP17 [ ] to the Witness Statement of William Price
Price William (5MN)

From: Thomas Jennie (5MN)  
Sent: 08 September 2006 14:33  
To: ’stuart.poynor’  
Cc: Price William (5MN)  
Subject: Continuity Issues

SENT ON BEHALF OF WILLIAM PRICE:

Stuart - following our discussion last week I have itemized below the issues, as discussed:

PCT Recovery Board Continuity: This has been a subject of our earlier emails. Assuming Mike Washburn agrees to be a NED for the new PCT for a few months or so (per Project Board proposal) then I would assume that this resolves the issue of the NED Chair of the SW5 Recovery Board. (Note: Mike was unable to make a NEDs meeting this week so not aware yet of his response to the proposal). The Clinical lead role will I assume be dependent upon the sort of arrangement the PEC chairs propose;

Specialised Services: I think you wanted to discuss this (including the email I have sent to the residual Chief Exec re. revised LSCG constitution; quoracy; membership; voting rights etc)? Happy to pick up after my leave;

Out of Hours tender: On the basis of the conversation with yourself and J-PP on 1 Sept I am working on the basis of the tender going ahead. (The risks specifically for SW5 relate to the reliance on GPs in manning the OOH centre and their sign-up or otherwise to any revised arrangements. The process is also complicated by having entirely different arrangements in the South of the PCT. My more generic concern was therefore whether or not we could cope with the complexity of this at a time of such significant organizational change);

Child Protection: SW5 has identified Zafar as our Named Doctor. If we have an incident his role is to find an appropriate doctor to deal with it. If he cannot, then he has to fulfill the role. This is not a common practice but pragmatic and acceptable bearing in mind Zafar is still a registered GP. Given that the new PCT will have to have a named doctor etc it would probably be good to be able to remove this role from Zafar in the future;

IT: Noted on 1 Sept that Paula is picking up this work-stream. She may wish to consider bringing Information functions together as an early win;

Scheme of Delegation: Chris Riley is working on this as part of the Governance arrangements. Not sure if Susan has picked it up with you but Chris needs to see you to sort what you want delegated, to who, how etc. Appreciate you are asking Directors to do what they have always done but it will probably need some fixing around the edges still to accommodate the Lead Directors for each locality etc. I will ask Chris to make arrangements to see you after your week in America;

Board dates: Understand from newsletter that these have not been set yet. I think I have been asked because of the above;

On-Call arrangements: These probably need tweaking in terms of reflecting who is / is not around post 1 Oct?

Provider services costings: This is perhaps slightly longer term but we have wondered locally about the impact of a revised provider management arrangement on the overhead of any provider function. (Will for example a session of a Physio in Cannock cost the same as a Physio in Burton?).

PCT management costs: Similar to above, presumably there will be a knock on impact of revising the management structures on all overhead absorption. Looking at this from scratch would remove any anomalies which may be in the system now. Not sure about timing but if for example we move on shared services or any other key driver then it has to be looked at;

(Both of the above issues potentially impact on budgets for and costs to PBC)

Management cost savings: Noted the need to save from shared services e.g payroll and estates given that they are in our current overhead. Given there will be less organizations to deal with there is an argument that the providing trusts could make a quick gain in terms of administering less systems/control accounts etc. Not sure if anyone has this on a project list;

Joint Recovery projects: Is there scope for the new PCT to rationalise the management of some recovery type projects which more than 1 PCT is currently undertaking?

Continuity (Vanessa Barrett email): Sorry I could do with clarity about your preferred way of handling this (I wondered if
This is a duplication some of the work already being done in the Governance work-stream in particular.

Hope the above makes sense. If you wish to discuss, please let me know.

Thanks Wm.

Jennie Thomas
Administrator/Secretary to the Board and PEC
Chief Executive's Directorate
South Western Staffordshire Primary Care Trust
Our ref: WP/BP/Poynor

Mr S Poynor
Chief Executive Designate
South Staffordshire PCT
C/o Mellor House
Corporation Street
Stafford
ST16 3SR

28 September 2006

Dear Stuart

Handover Reports

Please find attached a report which was represented to our final Board meeting of 28 September 2006. The report also includes at Attachment 1 a paper that went to our 12 September PEC which gives an Update on the main PEC Workstreams. I hope you will find these documents helpful.

I would like to draw the two Tender processes to your attention as follows:-

- Prison Pharmacy Tender – this will need to be presented to the South Staffordshire PCT Board in October or November (Jan Warren is the contact/lead).
- Agree for the tender for the pressure relief service to be presented to the PCT Board in October/November.
- Kinver practice tender – this is “on-hold” pending legal clarification of any revised requirements resulting from a similar exercise in Derby. When this is clarified an amended timetable will be drawn up (Jan Warren is the contact/lead) which will include a proposed date for Board consideration.
- You will note that the report does not cover the Out of Hours tender as this was not specific to SWS PCT alone. I have however written to you under separate cover in relation to this.

I trust you will find this helpful.

Yours sincerely

Willam Price
Chief Executive

CC J Warren
S Fisher

G:\Chief Executive Directorate\Chief Executive\Correspondence\Correspondence 601-700\673 Poynor 290906.doc
For Consideration

Subject: End of Term Report

Key Issues:

The purpose of this report is to highlight specific areas of work which need to be brought to the attention of the new PCT.

Recommendation(s):

2.1 The following specific issues need agreeing:-

- agree the presentation of the outcome of the tenders for the prison pharmacy to the PCT Board in October/November.

- agree presentation of the tender evaluation for the Kinver General Practice Tender to the PCT Board for approval in December/January and to note this process has been delayed due to a recent court case

- confirm the highest priority for development is Rising Brook, subject to the agreement of functional content.

- agree that the Shared Financial Services Board continues in the short term as a Working Group based on the locality structures. In the longer term a review of Shared Services across Staffordshire and Shropshire may be required to achieve management cost savings.

- agree for the tender for the pressure relief service to be presented to the PCT Board in October/November

2.2 The remainder of the report is for noting
<table>
<thead>
<tr>
<th>Standards for Better Health</th>
<th>Issues</th>
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<tbody>
<tr>
<td>Safety</td>
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<tr>
<td>Clinical and Cost Effectiveness</td>
<td></td>
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<tr>
<td>Governance</td>
<td></td>
</tr>
<tr>
<td>Patient Focus</td>
<td>The standards underpins all areas of the PCT activities. This report is a position statement and comments on the individual standards not directly relevant for this report.</td>
</tr>
<tr>
<td>Accessible and responsive care</td>
<td></td>
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<tr>
<td>Care Environment &amp; Amenities</td>
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<td>Public Health</td>
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South Western Staffordshire NHS
Primary Care Trust

"End of Term Report"
September 2006
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<td>Occupational Therapy/Stone Rehabilitation Services</td>
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<td>Physiotherapy Service</td>
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<td>Nutrition and Dietetic Services</td>
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<td>Annual Health Check/Improvement Reviews</td>
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<td>3.10</td>
<td>Research Governance</td>
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<tr>
<td>4.</td>
<td>Local Area Agreement</td>
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<td>5.</td>
<td>Community Chest</td>
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<tr>
<td>6.</td>
<td>Recommendations</td>
</tr>
</tbody>
</table>
"End of Term report" September 2006

1. **Background**

The purpose of this report is to highlight specific areas of work which need to be brought to the attention of the new PCT. The report is not intended to include all generic issues, these will be picked up across the new PCT as a matter of course e.g. arrangements for Emergency Planning.

A separate report has been prepared for the PEC in relation to current issues for each of the PEC sub groups. This report is given at ATTACHMENT 1.

2. **Key Issues**

The following section covers work areas where it is considered that specific areas pertinent to the handover to the new PCT need to be identified.

2.1 **Prison Pharmacy**

The PCT is leading, in conjunction with Lifesource Procurement Hub, the tender process for the Prison Area Pharmacy Service (APS). The APS, and consequently the tender process, covers 10 prisons and 5 PCT's in total. (SWS PCT, Burntwood, Lichfield and Tamworth PCT, Redditch and Bromsgrove PCT, Shropshire County PCT and South Derbyshire PCT).

The evaluation panel at SWS PCT consists of Cathy Riley, Jacky Punch, Mark Axcell and Sarah Forrest.

A final series of tender evaluation meetings are currently being arranged across the 5 PCT's and it is anticipated that evaluations will be completed by early October 2006. The recommendation from the evaluation panels regarding the preferred provider will need to be presented to a meeting of the new PCT Board in October or November 2006 for approval.

APS staff are Prison Service employees and will go through a three-month TUPE consultation period before service implementation can commence. It is unlikely therefore that the new service will be in place before the end of the financial year.

**Recommendation**

To agree the presentation of the outcome of the tenders to the PCT Board in October/November.

2.2 **Kinver General Practice Tender**

The PCT is currently mid way through a process to tender for the provision of a General Practice in Kinver, the service currently being provided by staff (including GP's) who have transferred to the PCT under TUPE arrangements following the resignation of the previous GP.

Legal advice is being sought following the recent ruling in North Eastern Derbyshire PCT, which will delay the original timescale.
If the PCT receives confirmation that no additional processes are required the recommendation of the evaluation panel will be presented to a meeting of the PCT Board in December. If further consultation is required the timescale will be delayed and the Board decision will be in January.

The assessment panel consists of

<table>
<thead>
<tr>
<th>GP Rep</th>
<th>Ian Wilson</th>
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<tbody>
<tr>
<td>PPI rep</td>
<td>(Non Executive Director)</td>
</tr>
<tr>
<td>Primary Care rep</td>
<td>Lynne Deavin</td>
</tr>
<tr>
<td>Independent rep /Practice Manager</td>
<td>Quentin Hill (East Staffs Practice Manager)</td>
</tr>
<tr>
<td>Finance rep</td>
<td>Mark Axcell</td>
</tr>
<tr>
<td>Panel Co-ordinator (only)</td>
<td>Sarah Forrest</td>
</tr>
</tbody>
</table>

**Recommendations**
- To agree presentation of the tender evaluation to the PCT Board for approval in December/January.
- Note this process has been delayed due to a recent court case.

2.3 Inequalities
Both the Stafford Inequalities Project (Penkside, Manor, Highfields and Western Downs Wards) and the Wombourne Inequalities Project (Wombourne South West Ward) are reported in the Agenda Item 2.4 Choosing Health Priorities for 2007/08.

**Recommendation**
To note the above.

2.4 Premises
A detailed report has been completed by Strategic Health Care Planning (independent consultants) as part of the recovery plan project. This included the use and condition of PCT owned and leased premises. The work consisted of three parts
- To assess estate utilisation;
- To assess opportunities for revenue savings;
- To assess opportunities for Asset Disposal and/or Capital gains.

The above exercise has been carried out in the context of the PCT’s Strategic Services Development Plan (SSDP), which includes a requirement to improve capacity in primary care.

A number of opportunities exist for moving staff to other premises in order to achieve a more rational distribution of services and effective use of premises.

The Board has previously considered an outline Business Case for Rising Brook Health Centre. The project has re-affirmed that the case for renewal of these premises is justified in terms of the overall state of the building. The report recommends that this project be pursued as a priority; however further detail needs to be worked through in relation to functional content in the context of Payment By Results and Practice Based Commissioning.

There are risks in relation to financial viability due to impairment. Opportunities are currently being considered for a transfer of the asset to another NHS organisation rather than a private sale as was originally proposed for consideration.
Recommendations
To confirm the highest priority for development is Rising Brook, subject to the agreement of functional content.

2.5 Prisons
A report on prison service issues is included in the PEC report.

Recommendations
To note the content of the PEC report.

2.6 Board Sub Committees
Minutes of Sub committee meetings that have not been previously received by the Board are included elsewhere in these Board papers (Section 4.1).

2.6.1 Human Resources (Full HR report at item 4.4 refers)
There is one outstanding Employment Tribunal. One appeal and one disciplinary are due to be heard before the end of September. There are two ongoing investigations. Service managers are dealing with several cases of staff on long-term sick leave with support from the Human Resource department. Other issues are evidenced in the sub committee minutes.

2.6.2 Audit Committee
The audit committee minutes evidence all ongoing key issues.

2.6.3 Remuneration Committee
No outstanding issues.

2.6.4 Clinical Governance
The Clinical Governance Annual Report and Development Plan was presented to the July Board and September PEC.

Recommendation
To note the above.

2.7 Shared Services
The PCT provides shared Financial and Primary Care registration services to the existing South Staffs PCTs. The service is governed by a Shared Financial Services Board which is chaired by a Non Executive Director of the PCT with membership including the Directors of Finance of each of the PCTs. It is proposed this Board continues in the short term as a Working Group based on the locality structures. In the longer term a review of Shared Services across Staffordshire and Shropshire may be required to achieve management cost savings.

Recommendation
To propose that the Shared Financial Services Board continues in the short term as a Working Group based on the locality structures. In the longer term a review of Shared Services across Staffordshire and Shropshire may be required to achieve management cost savings.
2.8 Child Protection
All PCTs are required to identify individuals who can fulfil specific roles in terms of Child Protection. The arrangements for this PCT are as follows:

- Named Doctor: Dr Zafar Iqbal with other medical support as required. There is also ongoing Health Visiting support to the role.
- Designated Doctor: Dr Gunjan Patel. This has been vacant with limited cover for the past year, but Dr Patel will now move into the post (and will backfill his current clinical work).
- Designated Nurse: Heather Widdowson
- Named Nurse: Jean Arbon

With the exception of the named Doctor the service is commissioned from South Staffordshire Healthcare Foundation Trust (SSHCT) and covers South Staffordshire.

The above situation is not ideal and given the high importance of Child Protection it is considered vital that the new PCT identifies revised arrangements with immediate effect. The SLA will be reviewed with the Trust and a draft business plan produced on behalf of all PCT’s.

- JIV represents South Staffordshire PCT on new Staffordshire Local Safeguarding Board.
- Partners In Paediatrics are still working up regional wide child sexual abuse (particularly out of hours) proposal.

The PCT has had two serious case reviews. Executive summaries of the former Area Child Protection Committee reports are included as part of the Child Protection Annual Report. (Agenda item 2.7).

Recommendation
Note the outstanding issues and the need to ensure service continuity.

2.9 Transfer of Liabilities – Legal Claims
The PCT will transfer two employer liability cases and one public liability case to the new PCT. These are accrued for in the accounts.

Recommendation
To note the above.

2.10 Choosing Health
There is a detailed paper on implementing choosing health on the Agenda as item 2.3 Choosing Health Priorities for 2007/08.

Recommendation
To note the above.

2.11 Infection Control
The previous SLA for providing an Infection Control Service for all South Staffordshire PCTs was discontinued in 2006/07. As a temporary measure specialist infection control support was secured but now a substantive post has been advertised to provide specialist nursing support. A formal approach has been made to all local Trusts to provide the appropriate microbiological support. If the microbiological support issue is not resolved then the PCT may have to report non-compliance in the infection control area in Standards for Better Health.

Recommendations
Note the risk to non-compliance in relation to Standards For Better Health.
3. **Provider Services**

3.1 **Dental Care Services**

3.1.1 **School Dental Screening**
The school dental screening service, which is part of epidemiology programme, is currently suspended as further guidance is awaited from the Department of Health regarding patient consent to undertake screening. During the suspension staff who would have been involved have been re-directed to reducing the current backlog with special needs treatment.

3.1.2 **Dental General Anaesthetic, Burton**
There are historical problems with the provision of general anesthetics at Queens Hospital Burton, i.e. lack of theatre time and lack of consultant time. The service has recently improved, but ongoing monitoring is necessary.

3.1.3 **Dental Nurse Registration**
As from 2008 all dental nurses will need to be registered with the General Dental Council. The PCT currently working with WDD and Further Education establishments to identify training available to dental practices, including the community dental service. The PCT also needs to scope the preparedness of the community service and that of general practice.

**Recommendation**
To note the above.

3.2 **24 Hour Nurse Cover – South Locality**
24 hour District Nursing will commence in October to further develop admission avoidance and equity of service. This is in addition to the current day and evening services and to replace the on call arrangements.

The team is to be relocated to the Social Care and Health's Residential Home in Bilbrook, this will help to address the lone worker issues previously encountered and give support to Health and Social Care staff.

**Recommendation**
To note the above.

3.3 **Community Matrons**
The PCT has not specifically appointed to Community Matron posts. Some District Nurses have undertaken the training. The PEC agreed the PCT should review the pilot work in the South before any firm decisions were made. The new PCT may wish to reassess the approach of no new investment in the light of the fact that the PCT will miss the national and local target with the Local Delivery Plan (LDP).

**Recommendation**
To note the above.

3.4 **Occupational Therapy/Stone Rehabilitation Service**
The Pressure Relief Service is currently out to tender and will need evaluating. This will need to be presented to the new PCT Board in October / November
Integrated Equipment Service – the PCT is working with Social Care and Health on integrating its provision of community equipment.

Recommendations
To note the content of the report identifying the tender for the pressure relief service to be presented to the PCT Board in October/November.

3.5 Physiotherapy Service
In addition to providing manual handling for the four existing South Staffordshire PCTs, the service is supported by external income from a contract with Social Services which is likely to be re-tendered in 2007.

Recommendation
To note the content of the report identifying the Physiotherapy contract with Social Services that will require re-tendering for.

3.6 Nutrition and Dietetic Services
3.6.1 Big Lottery Fund bid (Staffordshire-wide)
The Dietetic element to a Big Lottery Fund bid has been submitted; the initial project proposal met with a favourable response. The final outcome is due November 2007.

3.6.2 Eating Disorders Dietetic Team
The PCT provides a dietetic support service to SSHCT via an SLA for the eating disorders inpatient unit (Kinver Clinic)

There is a planned expansion of the inpatient ward, with an additional 0.5wte Band 6 Dietician requested. This would support nasogastric feeding and there are also plans in progress for training and guideline development to support the service.

The proposed merger of service with the Shropshire Eating Distress Service requires the service model to be agreed.

Recommendation
To note the above.

3.7 Health Visiting
Following a review of Health Visiting it is proposed that the balance should be altered to reflect the PCT population.

Health visitors are currently working across the health economy to introduce new care pathways for the treatment of eczema, bowel care and breathing difficulties. This is part of the service redesign aligned to the recovery plan.

Recommendation
To note the above.

3.8 Complex cases
Two complex case packages have previously been agreed by the Board. Both cases will need to be reconsidered by the Board in the future due to change of circumstances.

Recommendation
To note the above.
3.9 Annual Health Check / Improvement Reviews
The Improvement Review for Diabetes Services is expected in Autumn 2006 but it may possibly be delayed due to problems with the national diabetes patient survey, and concerns raised by General Practitioners about confidentiality.

A mid year review of compliance with the core standards has been undertaken.

Recommendations
To note that a mid year review has been undertaken.

3.10 Research Governance
3.10.1 Research Management and Governance Processes
SWS PCT currently hosts the process which is in place covering the four South Staffordshire PCTs. This is in line with national requirements. Discussions are in progress with the four North Staffordshire PCTs to streamline (and amalgamate where appropriate) processes across Staffordshire. The funding is allocated by Department of Health. A staged reduction is planned over the next 2 years as part of proposals to centralise processes in some areas.

Research governance processes currently being aligned with PCT/Department of Health requirements.

Recommendations
To note the content of the report.

4. Local Area Agreement
The Local Area Agreement process is being led by the Health and Social Care Board. High-level outcome indicators have been submitted. Further work needs to be done on negotiating targets and agreeing action plans to meet targets.

The actual targets and plans may not reflect needs of the PCT locality. Once a target at County level has been agreed with Government Office targets at District level will need to be negotiated.

South Staffordshire LSP have established a group to input into the LAA. Tilly Flanagan and Dr Iqbal will continue to provide the PCT input.

Stafford Borough LSP are initially asking the Stafford Governance to provide input into the LAA process. Dr Iqbal will continue to provide relevant input.

Recommendation
Note the process for PCT involvement.
Community Chest

A series of Community Chest Projects were agreed in 2005/06 costing £24,580.

The Projects include:
- A Healthy Cooking Group at Silkmore Primary School.
- A Home Start Stafford and District Healthy Living Project.
- A GO5 Exercise Referral Project for Mental Health.
- A Mental Health Support Group in Wombourne, Penkridge and Stafford.
- A Carers Support and Drop In Service for South Staffordshire.
- Supporting the Stafford Borough Council's Walking for Health Programme.
- Exercise Classes for Special Populations in South Staffordshire.
- Stafford Hospital Eye Clinic Outpatient Department's Information and Help Desk.

Evaluations are due at the end of October 2006 and no major problems are anticipated with the outcomes.

No additional projects have been agreed for 2006/07.

Recommendation
Note that no additional projects are planned for 2006/07.

6. Financial Position

The PCT Board has developed and the SHA has approved a Financial Recovery Plan which is based on a £4.9m year end deficit. Under the rules for in-year PCT reconfiguration it is understood that the new PCT will be responsible for the production of a set of mid-year accounts. These accounts - under the guidance - will be expected to show a break-even position. This would be achieved by matching the resource limit to spend at that point. The break-even would be inconsistent with the year-end projection.

7. Recommendations

6.1 The following specific issues need agreeing:-

- agree the presentation of the outcome of the tenders for the prison pharmacy to the PCT Board in October/November.

- agree presentation of the tender evaluation for the Kinver General Practice Tender to the PCT Board for approval in December/January and to note this process has been delayed due to a recent court case

- confirm the highest priority for development is Rising Brook, subject to the agreement of functional content.

- Agree the Shared Financial Services Board continues in the short term as a Working Group based on the locality structures. In the longer term a review of Shared Services across Staffordshire and Shropshire may be required to achieve management cost savings.
• Agree for the tender for the pressure relief service to be presented to the PCT Board in October/November

6.2 The remainder of the report is for noting
For Consideration

PROFESSIONAL EXECUTIVE COMMITTEE

Subject: South Western Staffordshire PCT – Workstream Updates

Key Issues:

The attached updates summarise the work of the PEC sub-groups prior to the dissolution of South Western Staffordshire PCT at 30 September 2006. The reports are intended to show the current position in relation to each of the work streams and any key issues, which are considered appropriate.

These updates are to ensure that the new PCT understands the progress and proposed direction of travel for these work areas.

It is to be noted that the Clinical Governance Annual Report 2005/06 and Development Plan 2006/07 appear separately on this agenda.

Recommendation:

The PEC is asked to:

- Consider the attached updates
INDEX

- Mental Health
- Drugs & Alcohol
- Practice Based Commissioning (PBC)
- IT
- Commissioning
- Cancer
- Palliative Care
- Managed Diabetes Care Network
- Children & Young People
- Community Pharmacy
- Out of Hours
- Modernising Dentistry
- NSF Older People
- Medicines Management
- CHD
- Stroke
- PALS/Patient and Public Involvement
- Smoking Cessation Service
- Choosing Health
- Prison Healthcare
- Sexual Health
South Western Staffordshire NHS Primary Care Trust

PEC WORKSTREAM UPDATE

TITLE: Mental Health

Lead Director: William Price  
Lead Officer: Sue Wardle

1. Key Issues

- The PEC has agreed a mental health strategy built around the 'stepped care model'. This model requires the enhancement of services in primary care and the PCT has agreed a range of interventions to support patients presenting in primary care with mild to moderate mental health problems which will prevent referral to secondary mental health services. An action plan has been developed – the main issues to be carried over to the new PCT are:-
  - Appointment of Primary Care Mental Health Workers to agreed job description and model as agreed at the Mental Health PEC Sub Group. The model involves setting up a management board to oversee the strategic direction and outcomes.
  - Pilot of Computerised Cognitive Behavioral therapy services for one year to agreed plan as agreed at the Mental Health PEC Sub Group.
  - These developments to address unmet needs in primary care, both on an individual face to face and group basis and to include the mental health needs of patients with chronic illnesses and needs arising from QOF screening for depression. Links will be made to the Intermediate Care teams.

- Prison Mental Health – a mental health needs assessment has been undertaken and the results should be used to inform future development of prison mental health services.

2. Contingencies for handover to new PCT

- Until suitable arrangements are in place it is proposed that the mental health sub group (which includes primary care representation) continue to oversee the implementation of the action plan.
- It is also proposed to continue the prison mental health in reach commissioning meeting until other arrangements are in place.
- The PCT has representation on the Staffordshire wide Mental Health LIT and Standard Leads meetings

3. Risk Implications

Loss of PCT locality agenda (which has sign up from local primary and secondary care clinicians and voluntary sector) to a wider Staffordshire/South Staffordshire model.
PEC WORKSTREAM UPDATE

TITLE: Drugs & Alcohol

Lead Director: William Price  Lead Officer: Tilly Flanagan

The main issue is the current restructure of DAAT and as a result a number of key posts are not in place. Major problem for the DAAT is the cut in the expected uplift. This has resulted in £0.5 million deficit to deliver both Young Peoples and Adult Treatment Plans. Funding for alcohol treatment services again has been highlighted. Adult treatment funding is primarily for drug treatment not alcohol. Funding for alcohol treatment should come from the PCT; however, there is a shortfall in PCT contributions to cover alcohol treatment costs. The DAAT is currently writing an alcohol strategy.

A Locally Enhanced Service is operating in 6 practices. There may be issues for the future as to whether drugs and alcohol services are covered by tariff.

Integrated Drug Treatment System for Prisons

Featherstone and Stafford have been funded to develop an Integrated Drug Treatment System (IDTS). The PCT will need to work closely with the DAAT to develop commissioning plans. This could potentially require the pooling of associated funding e.g DIP, CARATS. In the process of agreeing a mechanism with the DAAT to develop plans.

Locality Substance Misuse Group

This is working across Local Authority Districts: Cannock, South Staffs and Stafford. The group has focused on mapping current work relating to prevention and enforcement issues. This group will continue and will be directly linked into the DAAT structure.

Responsible Authorities Group

It is a statutory requirement that the PCT will provide representation on the RAGs. This will need to continue. This PCT has not paid full financial contributions as a partner over the last two years. There is an expectation that this will be fulfilled in future. (£3k for South Staffordshire and £5k for Stafford).

Contingencies for handover

1. LES payments based on activity. Monitoring will be needed and payments made. Need to identify process.
2. Locality Substance Misuse Group will continue, could share PCT rep with Cannock Chase.
3. RAGs are a statutory body and will continue. PCT representation is a statutory requirement.

Risks

The main risk is around alcohol provision. The DAAT could decide to stop alcohol treatment for users who do not have a drug problem. Choosing Health funding in 2007/2008 identifies £60k funding for alcohol. This could be provided to DAAT to offset alcohol treatment costs – subject to overall agreement of the Choosing Health proposals.
Practice Based Commissioning (PBC)

The PCT has two local authorities which have been broadly used to define former PCG’s and localities within the current PCT (South Staffordshire and Stafford).

Variations are:
- Claverley included in PCT South locality (this practice is in Shropshire)
- Penkridge is South Staffordshire Council but Stafford locality
- Cheslyn Hay and Great Wyrley are Cannock Chase PCT but covered by South Staffordshire Council.

In the context of PBC
- The Peninsula locality (South Staffordshire) covers 10 practices, but at this point 2 practices have not opted to be part of the formal locality governance structure and are working as a cluster.
- This locality is First Wave Improvement Foundation for PBC and GP’s formally attend programmes.
- Governance agreed between 8 practices
- Programme of work includes non elective admission at RWHT/Dudley and links to OOH’s service
- This locality is supported by Susan Fisher
- Liz McCourt is part time project manager for if first wave.

- Stafford and Surrounds cover 14 practices, but of this 4 practices have not opted to be part of the formal locality
- Formal Governance across 10 practices
- Programmed work includes reviewing 7 key areas e.g. Community Nursing, Diabetes.
- This locality is supported by Jan Warren, Chris Riley, Jane Chapman

Other achievements
- Information support package developed e.g. Activity (SOLLIS) by practice and all DES data.
- Almost 100% DES sign off (progressing the remaining 5).
- Full budget booklet available and all PCT resources identified by practice
- Draft Memorandum of Agreement
- Formal process for business cases being developed
- Formal monthly Local Improvement Team operating
- Monthly established learning forums – clinical and non clinical
Challenges

In the context of the financial position, to agree criteria for "savings". Formal infrastructure support to localities.
The Lorenzo community system is working - in the context of the national issues (e.g. no Child Health System). Training time is also proving a challenge. This is all dealt with across the new PCT via appropriate HIS processes. (PCT leads are Oliver Bennett and Frances Sutherland).

- The lack of a business continuity plan for all systems and organisations across South Staffordshire features in Audits. As lead, Susan Fisher has agreed the relevant systems with the HIS and continuity risks (particularly due to Shared Financial Services - SFS) but the HIS Board needs to agree an infrastructure solution. (Susan Fisher liaises with Bob Weaver of HIS).

- Codsall Office has no back up facilities and links are difficult on this non-NHS site (South Staffordshire Council Offices). This needs investment or a review of what work is essential at Codsall if the location continues.

- GMS IT – significant pressures exist on the historic IT budget. The PCT has a prioritisation checklist but this is often raised at LMC as a high profile issue in SWS PCT.
5.5 Provider Services Review

These budgets have had no inflationary uplift, which represents a significant challenge to manage in 2006/07 particularly bearing in mind the incremental nature of the revised Agenda for Change pay scales. An assessment by the Directors of Primary Care and Finance of the challenge and any discretionary expenditure flexibility has led to the conclusion that there is not further scope to reduce these budgets. There is however potential scope for utilising workforce differently, which could help to deliver the rest of the Recovery Programme.

5.6 Commissioned Services

The vast majority of expenditure is via Service Level Agreements for Acute and Mental Health Secondary Care services. These issues are covered later in section 6 of this report.

5.7 Other Baseline Services

Other budgets in this category include for example, expenditure with the Voluntary Sector, Specialised Services, Out of County Placements, NHS Direct. Many of these are commissioned collectively by all four PCTs within South Staffordshire. A review of all baseline expenditure and a balance sheet review was undertaken prior to the formulation of the recovery plan. A further review will be undertaken with the support of the Intervention Team to identify any proposed changes in these areas which need multi-PCT agreement in order to improve chances of success.

At this stage there is no assumed saving in 2006/7 or 2007/8 plans from this area.

5.8 Reconfiguration

This Recovery Plan has been produced at a time when PCTs will be going through a reconfiguration mid way through 2006/07.

Although savings are required to be made through reconfiguration, these have not been assessed in the Recovery Plan and have not been financially quantified. This view has been taken on the basis that resources released are required to be spent on improved patient care (e.g. increased palliative care spend) and in recognition of there being some likelihood of redundancy costs which will offset savings in the early year(s).

6.0 Recovery Programme 2006/07 to 2007/08

The programme of additional projects for Financial Recovery has been derived from a top down and a bottom up approach. The former has involved Benchmarking the PCT against others within Shropshire and Staffordshire and or nationally whereas the latter is built on ideas and issues which have come up and/or been suggested. In general the latter will effectively contribute to the former and there needs to be consideration of the possibility of double counting in terms of aiming towards a norm in general whilst also targeting
specific initiatives (both new initiatives this year and pursuing full year effects from last).

All projects proposed within this document are supported by a Project Initiation Document (PID). At this stage some detail needs to be finalised in these PIDs – this process being planned for completion by the end of June 2006. This should not however impact on the validity of the overall assumptions and should be more around ensuring full completion of detailed documentation and allowing appropriate consideration by the Recovery Board of the issues.

6.1 Benchmarking

The PCT has a registered patient population of approximately 192,000 but the national weighting formula allocates funding for a population of 149,000. The DoH weighted capitation formula determines PCT’s target shares of available resources to enable them to commission similar levels of healthcare for populations with similar healthcare need, based on age distribution of the population, additional need and unavoidable geographical variations in the cost of providing services. This PCT’s current funding is seen to be £2m above that required by a weighted population of 149,000. As such, the PCT has to deliver its responsibilities at a reduced cost per head of the population it serves.

6.1.1 Demography & socio economic profile

South Western Staffordshire PCT has a predominantly elderly population compared to the national average, i.e. a greater proportion in age groups over the age of 40. The PCT has particularly higher than national averages for the age groups 55 to 59, 60 to 64 and 65 to 69. Currently 17.4% of the population are over 65 and 8% are over 75. This is expected to increase to 20.2% by 2011 in the over 65s and 9% in the over 75s as the ‘post war baby boomers’ age through the population. An older population profile leads to a higher demand on health services.

Correspondingly the PCT has fewer of its population in the younger age groups.

Although overall the PCT is relatively affluent there are pockets of deprivation within more affluent wards and rural deprivation and access remains an issue. Three practices have over 10% of their population in low income categories as defined by being exempt from prescription charges.

6.1.2 Mortality and morbidity

The PCT has approximately 5% lower mortality than national averages for the major causes of death, i.e. cancers, and CHD, but is 5% higher than average for stroke (although this is not statistically significant).

The PCT has higher recorded prevalence for 7 of the 12 QOF indicators. These are: CHD (+7%); stroke (+5%); LVD (+6%); hypertension (+4%); epilepsy (+23%); hypothyroidism (+13%) and cancer (+17%).
In Summary, the PCT morbidity and mortality data does not justify the extent of the reduced funding via the weighted capitation formula. The PCT will be highlighting this with policy makers.

6.1.3 **Acute Services**

Benchmarking data shows this PCT to be a high user of secondary care services relative to its capitation weighted formula – although unweighted data is more at the average level (This is particularly pertinent as the unweighted PCT population stands at around 192,000 whereas the weighted population is around 149,000).

Benchmark data for Elective referrals, inpatients and first and follow-up outpatients, shows that if the PCT moved a third of the way towards the England average referral rate this would result in a reduction in expenditure of around £3.0m. Some movement has been made towards these figures as the PCT has already negotiated a reduction in follow-up rates and introduced a new protocol for consultant-to-consultant referrals, for example. Access levels to different hospitals across the PCT do appear to show significant variability with higher levels at Stafford Hospital. Taking the above into account it is considered reasonable to aim for some movement towards the England average rate in 2007/08 and recognising that it could incur some costs to implement, a figure of £1m (net of additional costs) is assumed in 2007/8 plans.

Benchmarking non-electives would indicate that the PCT has the highest non-elective activity and costs across the Shropshire and Staffordshire Strategic Health Authority. (Further information on the benchmarks can be found in Appendix 6). Whilst precise details need to be worked through and it is recognised that some gains will be made in existing specific projects – such as Paediatric Assessment – it seems reasonable to assume that some gain can be made in this area. Again this may incur some costs – for example to set up alternative provision for patients who are “off legs” where there is no existing alternative to hospitalisation. The recovery plan is based on whole systems redesign and will include further work with Out of Hours Providers and the Ambulance Services.

Recognising that moving towards benchmarks could incur some costs to implement, including the possibility of incentivising change, the following assumptions have been made:

- £1m net of additional costs in 2007/8 plans for Electives;
- £1m net of additional costs in 2007/8 plans for Non-Electives
6.1.4 Mental Health Services

A comparison of local costs to national Reference costs indicates that the local mental health trust is relatively expensive. Reducing to the national average cost has the potential to save £2.7m. It is recognised that these reference costs are based on 2004/05 and should be updated in the coming months for 2005/06. Given that the Trust is proposing further rationalisation and reconfiguration with Shropshire this presents an opportunity to reduce overheads and work towards achieving national norms. It is also proposed that the trust carry out a comprehensive costing and charging review to ensure that all commissioners are charged at equivalent rates. Given the diverse nature of SWs PCT it is envisaged that there are some opportunities for competitive tendering of some parts or all of the services in order to ensure appropriate value for money.

The Recovery plan assumes a part year implementation of £750k in 2007/8 based on any necessary notice being assessed and served during 2006/07.

6.1.5 Primary Care

The PCT is seen as high cost when benchmarked against others in Shropshire and Staffordshire although comparisons are difficult without further support due to definitional issues.

The plan assumes gains already made in 2006/07 and is limited in 2007/8 to opportunities that exist. In general it is deemed to not be possible to renegotiate existing contracts for primary care solely on the basis of value for money and cost.

6.2 Other New Projects

A list of all other new Projects is given at below.

<table>
<thead>
<tr>
<th>Project Name:</th>
<th>Understanding Mental Health Costs and Activity – Are We Getting Value for Money?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To examine available comparative information on activity and costs and to seek value for money from Providers.</td>
</tr>
<tr>
<td>Ref:</td>
<td>B1</td>
</tr>
<tr>
<td>Lead Director:</td>
<td>William Price</td>
</tr>
<tr>
<td>Lead Officer:</td>
<td>Sue Wardle</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Name:</th>
<th>Primary Care Value for Money</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To understand, assess and address the benchmarking position in relation to primary care GMS and PMS expenditure</td>
</tr>
<tr>
<td>Ref:</td>
<td>B2</td>
</tr>
<tr>
<td>Lead Director:</td>
<td>Jan Warren</td>
</tr>
<tr>
<td>Lead Officer:</td>
<td>Lynne Deavin</td>
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</tbody>
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PCT00180014607

WS0000016313
<table>
<thead>
<tr>
<th>Project Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning Strategy for Elective Activity</td>
<td>Establish a health economy agreed target to reduce elective activity</td>
</tr>
<tr>
<td>ENT</td>
<td>Offer a triage service for ENT referrals to reduce activity in secondary care and direct flow of a proportion of triaged patients to a community based ENT service for out-patient procedures</td>
</tr>
<tr>
<td>Dyspepsia shift to primary care</td>
<td>Explore possibility of redesign dyspepsia pathway in order to reduce endoscopies</td>
</tr>
<tr>
<td>Carpeltunnel</td>
<td>For patients requiring surgery the service is being developed in primary care below tariff</td>
</tr>
<tr>
<td>Decommission low priority procedures</td>
<td>Release resources by decommissioning low priority procedures across all providers</td>
</tr>
<tr>
<td>Trial Without Catheter</td>
<td>To reduce the number of patients being admitted to secondary care for an over night stay in order to have an indwelling catheter removed</td>
</tr>
</tbody>
</table>
Project Name: Discharge with no procedure
There are a significant number of patients who are coded to
discharge procedure not carried out. While this may be clinically
appropriate for many patients this project will identify whether this
can be brought down.
Ref: E7
Lead Director: Susan Fisher
Lead Officer: Sue Wardle

Project Name: Rheumatology
To contain Rheumatology drug expenditure and to assess the
viability of the Rheumatology nursing service to Mid Staffs
General Hospital
Ref: E8
Lead Director: Susan Fisher
Lead Officer: Cathy Riley

Project Name: Primary Care Incentive Scheme
To provide incentives for primary care to deliver reduced
secondary care spend
Ref: E9
Lead Director: Susan Fisher
Lead Officer: Jane Chapman

Project Name: Paediatric assessment
To reduce PAU attendances and to ensure all paediatric
attendances are clinically and cost effective
Ref: NE1
Lead Director: Jan Warren
Lead Officer: Gill Landon, MSGH  Glenda Dixon, SWS

Project Name: Benchmarking – Non-elective
There is evidence that the access rates for non-elective
admissions are higher than the England average at MSGH.
Ref: NE2
Lead Director: Susan Fisher
Lead Officer: Jane Chapman

Project Name: Streamlining Emergency Care (Older People)
Improve the flow of older patients into community based services
and provide an alternative pathway, developing a quality service
which represents better VFM
Ref: NE3
Lead Director: Jean Pierre-Parsons/ Jan Warren
Lead Officer: Jane Chapman
<table>
<thead>
<tr>
<th>Project Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Visiting</td>
<td>Improving the match between health needs and delivery</td>
</tr>
<tr>
<td>Ref: NE4</td>
<td>Lead Director: Jan Warren</td>
</tr>
<tr>
<td></td>
<td>Lead Officer: Glenda Dixon</td>
</tr>
<tr>
<td>Out of Hours - Benchmarking</td>
<td>To ensure clinical and cost effective OOH Services and to ensure contracts are appropriate and services not duplicated</td>
</tr>
<tr>
<td>Ref: NE5</td>
<td>Lead Director: Jan Warren</td>
</tr>
<tr>
<td></td>
<td>Lead Officer: Lynne Deavin</td>
</tr>
<tr>
<td>Relocation of OOH</td>
<td>This is a project to co-locate the SWS OOHs service with A&amp;E to facilitate the transfer of patients between the two services via an appointment process.</td>
</tr>
<tr>
<td>Ref: NE6</td>
<td>Lead Director: Jan Warren</td>
</tr>
<tr>
<td></td>
<td>Lead Officer: Lynne Deavin</td>
</tr>
<tr>
<td>Long Term Conditions</td>
<td>Effective management of long-term conditions is a key component of the PCT LDP.</td>
</tr>
<tr>
<td>Ref: NE7</td>
<td>Lead Director: Jan Warren</td>
</tr>
<tr>
<td></td>
<td>Lead Officer: Carol Adams</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>To develop and co-ordinate an appropriate 'composite' model of care delivery, for those with palliative and terminal care needs particularly out of hours.</td>
</tr>
<tr>
<td>Ref: NE8</td>
<td>Lead Director: Jan Warren</td>
</tr>
<tr>
<td></td>
<td>Lead Officer: Carol Adams/Lynne Deavin</td>
</tr>
<tr>
<td>COPD</td>
<td>Identify sponsorship for a SWS team to complement and work in partnership with the team being established in Cannock chase PCT</td>
</tr>
<tr>
<td>Ref: NE9</td>
<td>Lead Director: Jan Warren</td>
</tr>
<tr>
<td></td>
<td>Lead Officer: Darren Gibbons</td>
</tr>
<tr>
<td>Mental Health Section 12 claims</td>
<td>To reduce spend on section 12 claims.</td>
</tr>
<tr>
<td>Ref: O1</td>
<td>Lead Director: Susan Fisher</td>
</tr>
<tr>
<td></td>
<td>Lead Officer: Ann Fereday</td>
</tr>
</tbody>
</table>
7.0 **Impact on Financial Plans 2006/7 to 2007/8**

7.1 Schemes planned to impact in 2006/07 and 2007/08 together with other one-off cost saving reviews are anticipated to impact on the overall savings requirement as shown at Table 4 overleaf:
South Western Staffordshire
Primary Care Trust

PEC WORKSTREAM UPDATE

TITLE: Commissioning

Lead Director: Susan Fisher
Lead Officer: Jane Chapman

SLA deliverables
There are several key modernisation projects under development to ensure the delivery of the existing SLAs.
- Reducing the follow-up to new ratio - at MSGH to upper quartile. The work is also being undertaken at other provider trusts but is not as critical to the delivery of the SLA.
- Consultant to consultant referral rates at MSGH to be reduced to level of 2004/05 out-turn.
- Intermediate care team need to deliver admission avoidance for key conditions
These projects are all being monitored through the Recovery Board.

Therapy charges
The PCT is pursuing recovery of £350k for the provision of therapy out patients which we consider to be covered in the tariff. STfA involved in this issue. This is a Financial Recovery Plan project.

Beta-Interferon
The PCT, along with PCTs in North Staffs and the UHNS has operated a demand management process for the use of Beta-interferon. Following a challenge from the MS Society it would seem that we can no longer operate this which would give us a cost pressure of approx £30k in 2006/07 and recurrently £65k.

Wheelchair Services
The PCT has benchmarked its wheelchair service with that in East Staffs and BLT and the results are being shared with Mid Staffordshire General Hospitals Trust.

Implanon
Currently 65 devices are implanted through a Locally Enhanced Service (LES) by 12 practices. The service is inequitable. There are also difficulties when a patient moves into the area to arrange removal. As an interim arrangement the PCT plans to fund Dr Kundu to undertake a small number of procedures following clinical prioritisation. The VFM of the LES needs to be reviewed.

Ambulance Service (South Western Staffordshire PCT Lead)
The PCT has experienced considerable difficulty accessing data from the SAS. We particularly wish to pursue charging arrangements for when multiple vehicles are dispatched to a scene and amend the basis of the SLA charging.

Mental Health
See separate report.

Learning Difficulties (Cannock Chase PCT Lead)
SSHIC have served notice on the Learning Difficulty Services.

Continuing Care
This is managed on the PCTs behalf be CC PCT

Choose & Book
The PCT has an issue on access to year 3 funding but this should be generic across South Staffordshire.
Specialised Services

Access to RWHT Heart and Lung Centre remains an issue. The PCT is working with MSGH to retain preferred referral route to UHNST for tertiary care. The Catheter Lab at MSGH is performing to agreed levels but further capacity exists.
PEC WORKSTREAM UPDATE

TITLE: Cancer Services Sub-Group
(Local Implementation Team)

Lead Director: Jan Warren
Lead Officer: Lynne Deavin

Key issues:

The Cancer Services Sub-Group is Chaired by Lynne Deavin, Head of Primary Care, South Western Staffordshire PCT; it consists of representatives of South Western Staffordshire PCT, Cannock Chase PCT, Mid Staffordshire NHS Trust and the voluntary sector.

The Group is recognised by the Statutory Boards/PEC/Acute Trust and the North West Midland Cancer Network and maintains links with the Birmingham and Black Country Network.

The Group is responsible for co-ordination and consistency of Cancer Policies across the locality and has corporate responsibility for overseeing the modernisation of service change in the local health economy to meet local needs and National. The key issues are to

- Implement the recommendation in line with the Improving Outcome Guidance of the site specific group specifically head and neck.
- Monitor waiting times, i.e. 31 day and 62 day targets for treatment.
- Implement bowel screening
  - Royal Wolverhampton Hospital NHS Trust went live in July 2006
  - South Western Staffordshire PCT residents from the GP Practices in the South of the PCT should commence screening at beginning of 2007 at this Trust
  - University Hospital of North data not yet known due to slippage
PEC WORKSTREAM UPDATE

TITLE: Palliative Care Sub-Group

Lead Director: Jan Warren  Lead Officer: Lynne Deavin

Key Issues:

The Palliative Care Sub-Group is responsible for the development of an integrated comprehensive service for Palliative Care Services that is in line with relevant National Guidance and the assessment of local need.

The Sub-Group consists of South Western Staffordshire PCT, Mid Staffordshire NHS Trust, the voluntary sector and the Network.

The PCT is currently working with Practices to implement the End of Life Pathway, an initiative that is supported by a national allocation. This will support patients in enabling them to die at home.

The PCT has also developed a Model for the Integration of Palliative Care Services with existing community based teams which would enable the Care Manager to plan, based on the needs of the patient and the skills available within the team. This will also involve Social Services (Age Concern), Marie Curie and the voluntary sector.

This model should ensure a holistic and seamless service to enable the Patient if medically stable to remain at home.

The timescale for implementation of the new model is December 2006.

Katharine House Hospice funding has not been resolved to the satisfaction of the Hospice. The Hospice view is that this PCT is funding Hospices outside the area at the expense of Katharine House.

Public Health have agreed to review Hospice/Palliative Care utilisation by the end of December 2006.
PEC WORKSTREAM UPDATE

TITLE: Managed Diabetes Care Network

Lead Director: Jan Warren  Lead Officer: Lynne Deavin

Key Issues:

The Managed Diabetes Care Network is chaired by Jane Brown of South Western Staffordshire PCT. It consists of representatives from South Western Staffordshire PCT, Cannock Chase PCT, Mid Staffordshire General Hospital Trust and Diabetes UK.

The aim of the Group is to improve the quality of diabetes care for the local health economy, whilst implementing the National Service Framework.

Current issues being addressed are

- Implementation of the Diabetic Foot Care Guidance
- Development of a user group in conjunction with Diabetes UK
- Implementation of an Educational Package

The PCT have been actively involved in the implementation of the Diabetic Retinopathy Screening Service and hosts this new service on behalf of all PCTs in Staffordshire. This service is on schedule to meet the NSF target of “a minimum of 80% of patients with diabetes offered screening for the early detection of diabetic retinopathy by January 2006, as part of a systematic programme that meets national standards. Rising to 100% coverage of those at risk by the end of 2007”.

As a result of a stakeholder event the PCT are currently working with Mid Staffordshire General Hospitals Trust on service re-design, which should result in the transfer of resources from secondary to primary care.

Both PCTs are also in the process of implementing the Foot Care and Obesity Strategy that was resourced with £15K from the National Diabetes Team in 2004 and are currently developing proposals for the use of the £15K, which we were successful in securing this year.

These proposals will address Education and the development of a User group.
South Western Staffordshire
Primary Care Trust

PEC WORKSTREAM UPDATE

TITLE: Children & Young People

Lead Director: Jan Warren
Lead Officer: Sue Wardle

1. Key Issues

The agenda for children and young people is a large and complex one – at a strategic level this is being driven by the Staffordshire Children's Trust. The main components of this agenda are:

- Setting up Children's Trust Locality Boards
- Community Learning Partnerships
- Healthy Schools Partnerships
- Establishment of Local Safeguarding Board to replace Area Child Protection Committee
- Local review of child protection SLA needed
- The Children and Young People's block of the Local Area Agreement
- Child and Adolescent Mental Health Services
- Stafford Children's Center
- Implementation of Common Assessment Framework
- Recovery project on Paediatric Assessment Unit

2. Contingencies for handover to new PCT

The PCT has strong representation on the main bodies that are driving the strategic agenda, ie

- Integrated Strategy Group of the Children's Trust Board – rep Sue Wardle
  - This group oversees the whole children's services agenda and is the driving force behind the Children’s Trust.

- South Staffordshire Children’s Locality Board – reps Glenda Dixon and Tilly Flanagan
  - This group is responsible for the implementation at local level including Community Learning Partnerships

- Healthy Schools Partnership – rep Tilly Flanagan/Sue Wardle
  - This group oversees the healthy schools partnership and has links to other areas of the agenda eg CLPs

- Local Safeguarding Board – rep for health economy Jan Warren
  - This group will be leading the child protection agenda for the future

- South Staffordshire Children’s Leads meetings – rep Sue Wardle
  - Until other arrangements are established, this group will continue to meet to share information and approaches and to ensure a coherent approach to policy. The group has been charged with producing a briefing document for the new PCT.

Also, in the interim, until suitable local arrangements are established, (most likely through Locality Children's Boards) it is proposed that the Children's PEC Sub Group will continue to meet to provide the link between strategic and operational services.

Sue Wardle is a member of the group established to develop an approach to Children's Services across the new PCT.

3. Risk Implications

- Engagement of PBC locality groups – arrangements to involve PBC groups are still to be established
- Establishment of a Stafford Borough Locality Children's Board has been very slow and has not yet had its first meeting. This is needed to reflect locality issues.
- The review of the Child Protection SLA needs to address local risks
PEC WORKSTREAM UPDATE

TITLE: Community Pharmacy Sub-Group

Lead Director: Jan Warren
Lead Officer: Lynne Deavin

Key issues:-

The Pharmacy Sub-Group consists of representatives from the PCT and community pharmacy. The subgroup is responsible for overseeing the implementation of the new contractual framework for community pharmacy, which included the ongoing development of services, particularly Essential and Advanced services in the new framework.

The current issues are: -

- A constitution for a new Local Pharmaceutical Committee has been agreed and the new LPC will be configured in line with the boundaries of the new South Staffordshire PCT. A new committee is in the process of being selected.

- Community Pharmacies are currently preparing for the implementation of the ETP service, which the PCT is providing a supporting role. The PCT has issued a Smartcard to all pharmacists that have applied, ready for electronic prescribing.

- Work will still need to be carried out on the monitoring of the new Pharmacy Contract.

- A proposal for the delivery of a Medicines Use Review service within community services, i.e. district nursing and/or intermediate care, has been developed and needs taking forward.

- The need to carefully monitor the transition of the arrangement for the new oxygen service.

- The impact of the Dispensary Services Quality Scheme for 2006/2007 needs to be assessed.

- The pharmacy out of hours service is still under discussion.
Key issues:-

The PCT Boards have agreed that primary care services during the Out of Hours period should be put out to tender on the basis of value for money and the fact that it is not known whether the call triage would be then core business of Staffordshire Ambulance Service. A full report is available.

The four PCTs have been working together and the following is in progress.

- The tender document will be available to PCTs/PECs for comments by 29 September 2008.
- Current stakeholders, including Health Scrutiny and Staff Side Representatives will be included in the consultation process.
- An advert to establish expressions of interest place in the HSJ in the 2nd week of September.
- Open meeting with potential providers 10th October 12 – 2 p.m.
- Late October, new South Staffordshire PCT Board agrees to tender the service.
- Invitation to tender issued early November.
- Contract awarded early December.
- HR implications to be addressed.
- Evaluation criteria to be developed.
PEC WORKSTREAM UPDATE

TITLE: Modernising Dentistry PEC Sub-Group

Lead Director: Jan Warren
Lead Officer: Lynne Deavin & Oliver Bennett

Key issues:

The aim of the Modernising Dentistry PEC Sub-Group was to oversee the implementation of new commissioning arrangements for primary care dental services in line with Department of Health and Strategic Health Authority Guidance. A robust and comprehensive plan was put in place to deliver this. The PCT was successful in the implementation of the new arrangements. The Subgroup was also responsible for overseeing the implementation of the Dental Action Plan, which was intended to improve access to NHS dentistry in SWS PCT.

The current issues are:

- Proposals for re-commissioning lost activity as a result of the new contract - A framework was developed, which would enable the PCT to replace dental capacity lost as a result of the new contract. Progress has been made, but some commissioning is still required.
- Proposals to commission new activity to enable the delivery of the SiHA dental activity planning assumption, which is supported by an oral health needs assessment - The PCT is still required to commission an additional 8,500 units of dental activity during 2006-07, in order to achieve the SiHA planning assumption.
- To resolve outstanding contractual disputes - On 1st April 2006, 14 contracts were either signed in dispute or were not signed in dispute but where there were pre-agreed amendments that needed to be reflected in certain contracts post April. As of 1st September, only one contract remains under dispute.
- Review of Orthodontic Provision - to undertake a review of orthodontic services both in the acute and primary care sectors. This is to get a better understanding of the provision of orthodontics and the capacity to meet required demand. Waiting targets for outpatient care also needs to be addressed, i.e. the 18-week target.
- Prison Health Dental Services Review - A review of dental health care within the four prisons is currently underway. Some changes to working practices have already been made. There is also a requirement to review the service to ensure a fair and equal deal is sustained with the four prison dentists.
- Change of ownership at two dental practices - A dental practice in Perton and one in Central Stafford have been sold and the PCT needs to agree a new contract with the new dentists.
- Dental Action Plan - National Funding - The PCT developed a Dental Action Plan in 2004-05 to improve the capacity for NHS dental services in SWS PCT. To date significant progress has been made, particularly with the opening of two new dental practices. However, the PCT appears not to have been allocated £400K funding in its baseline budget for 2006-07, which supports this plan. Action is being taken to determine the reasons for this.
A New Ambition For Old Age: Next Steps In Implementing The National Service Framework For Older People

There are three themes:
- Dignity in care
- Joined up care
- Healthy Ageing

Within each of these themes there are ten programmes:
- Dignity in Care
- Falls and Bone Health
- Urgent Care and Care Records
- Independence Well-being
- Dignity at the End of Life
- Mental Health in Old Age
- Healthy Ageing
- Stroke Services
- Complex Needs
- Choice

Stroke

There needs to be greater public awareness about stroke, the risks and symptoms. See separate report on stroke.

Falls and Bone Health

The cost of generic biphosphates has reduced, GP's should be encouraged to use them. Work is ongoing with GP's to keep a register of patients at greatest risks with diagnosed osteoporosis and the monitoring of medication. It should be noted that the only dexascanner is in Cannock.

Intermediate Care

The increasing emphasis on keeping people out of secondary care is placing considerable pressure on Community Therapy Services. There has been a reduction in the number of community intermediate care beds this needs to be monitored to ensure that there are sufficient to meet demand.

Joined up Care

The Single Assessment Process, set up in partnership with Social Care and Health, is due to be audited in SWS-PCT and CC PCT. The audit will be led by SC&H and is expected to take place in October.
Carers

The Quality Outcomes Framework states "the practice has a protocol for the identification of carers and a mechanism for the referral of cares for a social service assessment."

It is vital that all stakeholders work together to provide support that will help carers carry on caring. The PCT has a contribution to make by promoting initiatives that improve health, well-being and life opportunities and by encouraging practices to identify carers and offering them health checks. The NSF for Older People Sub Group are to contact all practices to request that they action this.

Primary health care teams are regularly updated on what is available for carers and how to refer to key partner organisations including the Carer Associations.

Orbit Care and Repair Home Improvement Agency

The scheme provides assistance and contributes to older, disabled and vulnerable people being able to remain at home with such work as adaptations for the disabled, improving home security, minor repairs and improved heating systems.

The scheme is funded via a number a time limited grants of 1-3 years. These funding arrangements make the scheme insecure and continually at risk of being unable to continue. SWVS-PCT were asked to make a financial contribution but were unable to do so. Loss of this agency will result in the PCT being unable to access such services as minor adaptations for hospital discharge and improved heating systems for patients with respiratory conditions.
PEC WORKSTREAM UPDATE

TITLE: CHD

Lead Director: Zafar Iqbal

Lead Officer:

Key Issues:

Revascularisation:
- Current levels of commissioned angiographies are leading to a growing waiting list.
- The PCI CABG ratio is lower than expected and is being looked at.
- There has been an increase in work for Wolverhampton Trust and this could be due to a shift in referrals from North Staffs Trust to Wolverhampton. Discussions are ongoing to influence referral pathways.

High Technology Procedures:
- Ablation surgery for atrial fibrillation bi-ventricular pacing and ICD are being considered on a case by case basis. There is pressure to introduce this as a policy but this needs to be undertaken in a planned and prioritised way.

Heart Failure:
- A separate Heart Failure Annual Report is being presented to the September 06 PEC.
- Future funding is a prior commitment (as part of the original proposal). An evaluation of the heart failure project is being undertaken by York University.

It has not been possible to persuade Mid Staffordshire and Wolverhampton Trusts to carry out BNP testing. A report from the Healthcare Commission Review is awaited and this is likely to make recommendations on diagnostic care pathways for heart failure.

Non-Cardiac Chest Pain:
- There are excessive lengths of stay for non-cardiac chest pain. The hospital needs to introduce a rapid diagnosis and discharge policy for non-cardiac chest pain.

Continuity Arrangements:
The DPH chairs the CHD LIT across South Western Staffordshire and Cannock Chase PCTs. There should be PCT representation at the CHD LIT.
PEC WORKSTREAM UPDATE

TITLE: Stroke

Lead Director: Zafar Iqbal
Lead Officer: Zafar Iqbal

Key Issues:

Acute Stroke Care:
- A national evaluation in 2005 showed that acute stroke care was poor at Mid Staffs District General Hospital (MSDGH). The PCT has worked with MSDGH to improve stroke care and a 4 bedded stroke unit has been established.

In addition there is a stroke co-ordinator at the hospital, who co-ordinates care for patients not admitted to the 4 bedded unit. However, the status of the 4 bedded unit in terms of stroke only patients is under review by the Trust.

There also needs to be sufficient diagnostic capacity (CT scan) to enable urgent diagnosis of stroke 24/7.

- Wolverhampton acute stroke care appears to be meeting standards.

TIA:
A successful rapid access TIA Clinic is established. However, waiting times need to be monitored to ensure that patients are seen within 7 days.

Community:
A care pathway across primary and secondary care needs to be developed. The Stroke LI T Group is developing a process to progress this.

Continuity Arrangements:
The PCT needs to ensure continued representation at the Stroke Implementation Group.
South Western Staffordshire NHS
Primary Care Trust

PEC WORKSTREAM UPDATE

TITLE: PALS/Patient and Public Involvement

Lead Director: Zafar Iqbal  Lead Officer: Vanessa Day

Key Issues:

National Diabetes Survey (NDS)

The NDS is a DH initiative co-ordinated by the Healthcare Commission. The Healthcare Commission randomly selects 10 GP Practices in each PCT area. Patient data is extracted from GP Practices’ diabetic registers electronically and transmitted to a commissioned provider, in this case Quality Health, who send out questionnaires to 85 diabetic patients in each of the 10 Practices to glean their experiences on primary care diabetes services. The option of undertaking the survey in a merged form was available and taken up in South Staffordshire.

Problems have been experienced with the data protection aspect of the survey, in that the BMA and GMC have not fully sanctioned the survey if information is passed to a third party. As their governing body, GPs are not prepared to undertake the survey without their endorsement. These concerns have now filtered through to all Practices, making it very difficult to proceed. The Healthcare Commission are trying to resolve these problems, but this is taking time.

The results of the survey will be fed into the Healthcare Commission’s performance assessment framework, as a performance indicator for 2006-07 and as a data source for the 2007 diabetes improvement review. The NDS is a ‘must do’ and penalties will be imposed on any PCT not co-operating fully. The penalties have yet to be decided. The timetable for collection and submission of the data is October 2006.

Expert Patient Programme (EPP)

PCTs are required to deliver an agreed number of EPP annually. The number of courses is set by the local SHA and in this locality the number of courses to be delivered per year is three, which is also reflected in the Local Delivery Plan. The PCT is on track to deliver its set number of courses.

Continuity Arrangements:

The PPI/PALS officer will continue to be part of the South Staffordshire PCT’s network to take forward the National Diabetes Survey.

The PPI sub-committee of the Board has met infrequently. Post October a new committee will need to be established by South Staffordshire PCT.
South Western Staffordshire
Primary Care Trust

PEC WORKSTREAM UPDATE

TITLE: Smoking Cessation Service

Lead Director: Zafar Iqbal
Lead Officer: Anne Macleod

Key Issues:

- Health Care Commission has given a provisional grading of fair. The main issues are our tobacco related HR policies and involvement of users in the service.
- Maintain the current level of service delivery to meet the targets set for the next two years and future challenges and targets set by the DoH and local councils.
- Data collection, monitoring and reporting needs to continue to meet the DoH and County Council guidelines.
  - 4-week quit data required quarterly to the DoH
  - 52-week quit data required quarterly to the County Council
- Payments and reporting to all service providers meeting the criteria’s agreed for the PCT.
- Choosing Health – The development of Surgical Care pathways to include Smoking Cessation pre operatively, still needs to be developed and implemented providing additional funding can be arranged.
- The close partnership and funding developed with the tobacco control posts within the local authorities of Stafford and South Staffordshire needs to be continued and support to support the introduction and implementation of the new Health Bill – Smoke free legislation in the summer of next year.
- Smoking data in pregnancy has been an issue and systems are being developed by HIS to address this.
- Prison Smoking Cessation Schemes.
  - HMP Featherstone and Drakehall – Their schemes are well established. But there will be capacity issues, this was being addressed by looking to include the Prison officers that are based within the Gym department.
  - HMP Stafford will continue to be monitored and supported to develop and deliver their Scheme.
  - HMPYOI Brinsford – There is a very new scheme within this prison which will continue to need support to develop and deliver the service.

Continuity Arrangements:

- Smoking Cessation Pharmacy Scheme – Additional funding needs to be identified to make up the deficit in the Nicotine Replacement Therapy budget as there may be a short fall even though there has been recent changes made to the administration of NRT via a PGD through the pharmacy.
- HMP Stafford – To continue to support the implementation and deliver of a Smoking Cessation scheme that is equivalent to the Smoking Cessation Services that are available to the general population.

PEC Agreement

Agree model tabled in September PEC
South Western Staffordshire NHS

Primary Care Trust

PEC WORKSTREAM UPDATE

TITLE: Choosing Health

Lead Director: Zafar Iqbal  Lead Officer: Sue Wardle

Key Issues:

The Public Health White Paper ‘Choosing Health’ outlined service developments to deliver the commitments in the white paper in the priority areas of:

- Diet activity and obesity – need to continue to implement Active Living Plan
- Alcohol interventions – see handover report on Drugs and Alcohol
- Smoking Cessation/Tobacco control – see handover report
- Sexual health modernization – see handover report for sexual health
- Chlamydia screening – see handover report for sexual health
- Health trainers
- School nurse modernisation
- Well being support (mental health)

Cross cutting themes to be delivered by these programmes are: to improve the health of children and older people and to reduce health inequalities.

Local priorities, agreed at the Choosing Health Sub Group and discussed a SWS Strategic Commissioning Group are: Chlamydia screening, sexual health; diet and obesity, health inequalities and smoking cessation. The highest priorities are Sexual Health and Inequalities.

To address the wider determinants of ill health, Local Strategic Partnerships and Local Area Agreements are important developments to agree a joined up approach and key outcomes and targets across agencies.

Continuity Arrangements:

A paper on proposed choosing health allocations will be submitted to the September Board. Further details will be produced by the Choosing Health PEC Sub Group.

Until suitable arrangements are agreed it is proposed that the Choosing Health Sub Group continue to meet with partner agencies to oversee the local public health agenda.

The PCT has representation on Local Strategic Partnerships (Dr Zafar Iqbal and Tilly Flanagan)

Public health reps attend South Staffordshire PBC Locality meetings to discuss choosing health issues.

Risk Implications:

- Locality engagement (PBC groups) with LSPs and LAAs.

PEC Agreements:

Support the Choosing Health agenda and in particular the above priorities
PEC WORKSTREAM UPDATE

TITLE: Prison Healthcare

Lead Director: Zafar Iqbal
Lead Officer: Jacky Punch

Key Issues

The agenda for Prison Healthcare is a large and complex area. At a strategic level this is being driven by the Prison Health Partnership Board working in partnership with the SHA – the SHA Lead being Jane Bakewell. SWS-PCT has 4 prisons within its catchment area:-

- HMP Stafford – a Cat C Male adult training prison. 543 beds for "normal Cat C prisoners" and 84 beds for sex offender/vulnerable prisoners. Healthcare provision is Type 2, ie no inpatient beds, no 24 hour healthcare provision, but 7 days a week cover
- HMP Featherstone – a Cat C Male adult training prison with 615 beds. No inpatient beds, no 24 hour healthcare provision, but 7 days a week cover
- HMP Drake Hall – a semi-open female prison and a foreign nationals centre with 315 beds. No inpatient beds, no 24 hour healthcare provision, but 7 days a week cover
- HMYOI Brinsford – a split site juvenile/young offender establishment with 493 beds. It caters for young men aged from 15-21 years. It has an 11 bedded inpatient unit, catering almost exclusively for young men with severe mental health issues, and provides 24 hour healthcare cover

Key Issues are:-

- Implementing the National Offender Management Strategy.
- Developing and managing SLA's for commissioned services eg. Mental Health Inreach, GP's, Optometry, Chiropody, Dentistry and Physiotherapy.
- Tendering for new pharmacy provision
- Developing primary care health promotion services. Drake Hall and Stafford prisons have been chosen as pilot sites for the Offender Health Trainer project
- Developing substance misuse services – Featherstone and Stafford prisons have been chosen as pilot sites for the Integrated Drug Treatment Service.
- Recent policy on Continual Watches proposes that healthcare staff should provide continual watches based on clinical need. Previously continual watches had been completed by prison discipline staff.
• IT project has stalled due to lack of finance. This is a national project with each SIHA being given a sum of money to provide clinical IT systems in all prisons. The Funding was to provide all cabling, hardware and escorts, but has proved insufficient to meet the need.
• Infection Control SLA awaiting agreement by HPA. This will provide a specialist communicable disease service to the four prisons in the present cluster.

Continuity Arrangements

• In the interim, until suitable local arrangements are established, the Prison Health Partnership Board will continue to meet. The Partnership Board has delegated authority to act and this will need to continue within the new organisation.
• The Prison Working Group and Healthcare Managers Group will continue to meet in order to inform the Prison Health Partnership Board. Healthcare Managers from Swinfen Hall and Dovegate will be invited to join HCM's group.
• All other sub-groups will continue to meet to enable continuity of services and monitoring of SLA's to ensure value for money for the new PCT.
• Tendering process for new pharmacy provision to continue – PCT’s involved in the re-configuration of Staffordshire PCT are already involved in this process.
• Present performance monitoring arrangements will continue.

Risk Issues

• DOH has not released funding to PCT for prison healthcare for 2006/07
• All parties involved may not agree on pharmacy tender. This carries both a financial and clinical risk due to issues with present provider.
• Outcome of 3 on-going investigations – unlikely to be resolved prior to re-configuration.
• The four prisons within SWS-PCT have no clinical IT systems. Money has been made available but this does not meet the need. Nationally insufficient money available.
• Ongoing Death in Custody investigation.
• Three out of the four prison Governors have not signed the SLA for delivery of Prison Health Service. This will be discussed at the Partnership Board meeting in September.
South Western Staffordshire NHS

Primary Care Trust

PEC WORKSTREAM UPDATE

TITLE: Sexual Health

Lead Director: Zafar Iqbal

Lead Officer: Tilly Flanagan

Key Issues:

Chlamydia Screening

The PCT has worked closely with South Staffs PCTs to plan Chlamydia Screening. Funding released from the DoH last year has supported set up costs e.g. appointment of Screening Coordinator, purchase of equipment etc. The PCT will benefit from these set up costs, however, the PCT has not identified funding to pay for test and treatment for 06/07.

Chlamydia screening will be rolled out across the South Staffordshire PCT area from Jan 07. This will be phased in. SWS-PCT will benefit from the DOH support money to equip screening sites however screening will not take place until after April 07 when funding is available for Chlamydia screening through the Choosing Health budget.

GUM Access target

MSGH access target for Stafford Clinic has shown a downward trend. The PCT has produced an initial capacity plan for the Strategic Health Authority. Furthermore, the Sexual Health National Support Team will be visiting both Stafford and Cannock GUM clinics in the middle of September. The purpose of this team will be to identify problems in reaching the targets.

Other

- Awaiting report on the sexual health needs of prisoners. This report will also identify recommendations for service delivery.
- LDP identifies development of Clinic in a Box Services in High Schools. The PCT is on target to deliver.
- Two Clinic in a Box Services have been funded by a Teenage Pregnancy Partnership Grant. As part of the LDP discussions the PCT agreed to mainstream these two services (£10k) from next year.
- There are issues about access in relation to hormonal implants. Only 7 practices provide this service through a LES. Child & Adolescent Sexual Health (CASH) is currently not funded to provide this service across the patch. This has implications in delivering NICE guidelines on Long Acting Hormonal contraception.

Continuity Arrangements:

1. Ensure PCT representation at the South Staffordshire Chlamydia Screening Group – Tilly Flanagan
2. Ensure PCT representation at the Staffordshire Teenage Pregnancy Group – Tilly Flanagan
PEC WORKSTREAM UPDATE

TITLE: Medicines Management

Lead Director: Jan Warren  Lead Officer: Cathy Riley

Key Issues:

Prescribing Budget
- Budgetary position part of recovery plan. There is a need for continued mixed strategies to achieve financial balance, (i.e. address on practice-specific basis, rather than one set of targets covering all).
- NB: continued difficulty with dispensing doctors re. SHA prescribing measures (cost saving). This is a high level risk around Prescribing Budget and a priority for focus.

Prescribing Budget Methodology
- See PEC Paper (Feb 06). MYR for high cost drug and ASTRO-PU changes required Dec 06 (using data end Oct 06)

Patient Group Directions
- Currently being put into same format across footprint of new organisation. There is an issue around signing them off for new organisation for Oct 1st, since existing PGDs will no longer be legal once existing organisations cease to exist (DH and legal advice is being sought).

Rheumatology Recovery Board project
- Requires continued development & implementation after re-configuration in order to contribute to financial recovery

DN Initiative
- “Top tips & handy hints” - requires regular feedback to Care Managers, and it links to continued funding of “First Dressing Initiative”

Palliative Care boxes
- Service needs to be rolled out as an enhanced service (pilot) for community pharmacists. Lead – Palliative Care Nurse Consultant Nurse. Boxes have been purchased. Pilot service budget (as topslice to 06/07 Prescribing Budget)

Implementing “Securing Proper Access to Medicines OOH”
- Implementation remains incomplete. Risks with current medicines system (maybe resolved before October)

Controlled Drugs
- Accountable Officer appointment required in new structure, and review of current monitoring systems/networking