SHIP PCT CLUSTER
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Councillor P. Eddis
Chair, Health Overview and Scrutiny Panel
Portsmouth City Council
Guildhall Square
PORTSMOUTH
PO1 2AZ

Dear Councillor Eddis

Quarterly Update September 2011

As the Interim Director of Communications and Engagement for the SHIP PCT Cluster, it is now my responsibility to compile our quarterly update for you. I am therefore writing to you to provide three updates on items of previous interest to the Panel and two new issues that I wish to bring to your attention this quarter. These are set out below.

1 Updates

a) St Mary's NHS Treatment Centre

At its meeting in June, the Panel requested further information in respect of St Mary's NHS Treatment Centre as follows:

1. Patient numbers compared with target/contracted numbers. Is the centre meeting these?

For the financial year 2010/11 the total activity for the Minor Injuries Unit and Walk in Centre was as follows:

Budget – Minor Injuries Unit	24,000 contacts
Budget - Walk In Centre	12,000 contacts
Actual - Minor Injuries Unit	23,458 contacts
Actual - Walk In Centre	12,163 contacts

In total this area of the contract underperformed by 379 contacts.

The monthly activity is set out below. The pattern of the activity looks reasonable to account for bank holidays, summer holidays, school terms etc.

	MIU	**Walk In**
April	2114	1105
May	2279	1187
June	2294	901
July	2400	947
August	1960	954
September	2110	832
October	1887	947
November	1694	854
December	1329	1445
January	1664	1082
February	1646	936
March	2081	973
	23458	**12163**

Since November 2010, rather than contracted (block activity), payment has been made by results.

2. What work is being carried out with schools to raise awareness on access to treatment and "Choose Well"?

Choose Well featured in the 2011 Spring issue of Term Times, a city council produced magazine provided free to every city school. Choose Well leaflets, flyers and mouse mats displaying the Choose Well information have been distributed widely to people of all ages, families and young people at events across the city in the past three years. Most recently this has been at a Communities Day event held in Arundel Street in early July 2011. In the past it has included market stall at Cascades, notably in December 2010 at an event to mark the turning on of the Christmas lights.

We are also looking at the feasibility of approaching schools to incorporate some Choose Well information in a letter to parents in the lead up to winter – something successfully undertaken within the NHS Hampshire area last year.

3. What literature is provided to GPs regarding the Treatment Centre?

From July 2011 Care UK which runs the Treatment Centre, is producing a bimonthly newsletter for GPs. This is posted on the Primary Care Information Portal (an extranet service for GPs) which is hosted and kept up-to-date by NHS Portsmouth communications staff.

For those members of the population that use the world wide web, Choose Well information may also be found on NHS Portsmouth's web site via the Home Page where it is prominently displayed on the page banner: http://www.portsmouth.nhs.uk/ It also features on the Treatment Centre's own website at: http://www.stmarystreatmentcentre.nhs.uk/index.php

b) PCT Finance and Performance: Delayed discharge of Care and Emergency Re-admission and Cancer Standards

The Chair requested further information in relation to figures produced following presentation of the above at the SHIP PCT Cluster's Public Board meeting in July 2011. This is provided at appendix 1 to this letter.

c) Pain Pathway

In December 2010 the PCT updated the Panel on a review of the pain service to provide relief for patients whose conditions give them chronic pain. This had been a Public Health review of clinical effectiveness of procedures offered to these patients which have traditionally been hospital based and included treatments that have provided short term pain relief.

The Panel will recall that the review concluded that there was limited clinical evidence for many chronic pain treatments. However, the commissioners asked Public Health to undertake further work in this area to clarify any evidence for a procedure that may have some clinical efficacy, the most appropriate time for that intervention to be introduced and for how long.

Following that further review of the clinical evidence, commissioners now plan to cease routinely funding a number of pain procedures. This is on the grounds that the clinical evidence does not support their routine use. Procedures for the treatment of cancer pain will not be affected by this change.

The PCT already commissions a community pain service. This provides self management interventions, the clinical effectiveness of which are strongly evidence based. Prior to decommissioning the procedures that will not be funded in the future, the PCT will ensure the community service is sufficiently resourced to manage any extra demand in terms of volume and complexity of patients resulting from service change.

2 New items

a) Treatment of Age Related Macular Degeneration

The drugs Avastin and Lucentis can both be used in the treatment and management of wet age-related macular degeneration (AMD), a common condition causing poor sight or blindness particularly for people in their late 50s onwards. It has the potential to get worse quickly if left untreated.

Evidence suggests that the two drugs have similar effectiveness in the management of the condition though one, Avastin, costs much less than the other, Lucentis, and there are therefore significant annual savings to be made in switching to Avastin.

A proposal is under discussion by the SHIP PCT Cluster Board to consider implementing a formal policy recommendation that would allow Avastin to be used as an alternative to Lucentis

Whilst Lucentis currently has a specific licence for use in treating AMD and is therefore supported by the National Institute for Health and Clinical Excellence (NICE) guidance, Avastin is licensed as a cancer drug, but not specifically for use with AMD. However, Avastin can be, and is, used widely by clinicians for that purpose if they feel it is appropriate.

Local clinical commissioning groups (CCGs) have signalled their support for the proposal. Quality, outcomes and safety should not be compromised by any switch, provided it is implemented appropriately. As part of this consideration plans are being discussed with clinicians, patients and the public with a view to implementing the change during the autumn.

b) Any qualified provider

In the White Paper, ‘Equity and Excellence: Liberating the NHS’, the Government made a commitment to extend the choices people have over their healthcare, as part of its vision of patients and the public being at the heart of the NHS.

The goal is to enable patients who are referred for a particular service to choose, where appropriate, from a range of qualified providers and select the one that best meets their needs. Extending the choice of provider is expected to enhance quality, where patients have identified this as variable in the past and provides an opportunity to improve access and address gaps in inequalities.

By extending choice of provider, we mean that when patients are referred for a particular service, they can choose, where appropriate, from a range of qualified providers and select the one that best meets their needs. For example, most forms of hearing loss do not involve illness or disease and therefore people do not need to be treated in hospital. Given a wider choice, many people with hearing problems may prefer instead to visit a provider located in the high street or a mobile clinic because it is more convenient and doesn't make them feel like they are 'ill'.

Increasingly we expect that patients will seek information about the quality of care when choosing which provider to select. Extending choice of provider will enable patients to access better quality services provided by a wider range of provider.

The roll out will start with selected community and mental health services from April 2012, with these in place by September 2012. We are now supporting a piece of work happening across the country which asks people their views on which of these service areas they think might benefit from having an extended choice of provider in terms of meeting the needs of patients and delivering quality improvements. This needs to be undertaken by the end of September this year and we have a communications and engagement plan in place to help us seek people's views on this issue.

Based on what patients have said might benefit from extended choice of provider, these services are:

- Musculoskeletal services for back and neck pain
- Adult hearing services in the community
- Continence services (adults and children)
- Direct access diagnostic tests
- Podiatry services
- Wheelchair services (children)
- Leg ulcer and wound healing
- Primary care psychological therapies - adults ('talking therapies')

Feedback from this engagement will help inform commissioners on which local community and / or mental health services would benefit from becoming an extended choice of provider. Under Government requirements, at least three local services need to be identified. Other services may be chosen which are higher local priorities, if there is a clear case to do so based on the views of service users and potential gains in quality and access. Locally, members of the public will be able to comment on the proposals through their local PCT websites which will link to a survey on the NHS Hampshire site (or directly via https://engage.hampshire.nhs.uk/consult.ti/system/calendar .)

Yours sincerely

Sara Tiller
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SHIP PCT Cluster