**West Hertfordshire Primary Care Trust and**
**East and North Hertfordshire Primary Care Trust**

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5 December 2007

Jan Filchowski
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Dear Jan

**Re: Possible Contract amendments 2006/07 & achievement of the 18 weeks Milestone.**

I am writing in response to your letter of 3rd December. At the end of our meeting on Wednesday my understanding was that Ross & Alan would talk or meet later in the day to discuss and understand the detail of the financial figures that you had put forward. I do not believe that this discussion resulted in a firm PCT offer; although I understand agreement was reached on a number of principles to begin to move issues forward.

In answer to the four specific points you detail in your letter, where you believe the PCT has agreed to fund additional costs, I would wish to make the following comments:

**1. Funding the SLA to full value & Delivery of 18 weeks.**

1.1 I do not believe that Alan or myself agreed to meet the full value of the SLA without applying any penalties or withholding payment for work done. The PCT cannot pay the Trust for activity that has not occurred. We are very clear that the full SLA value has been budgeted for within the organisation and that this money is available to the Trust, should activity take place to require it. This includes meeting the costs of subcontracted activity at tariff price.

1.2 In terms of the out patient activity, the East of England was very clear with commissioners about the clauses to be inserted in the contract with regard to first to follow up ratios. The PCT is currently reviewing the ratio figures for quarters 1&2 and the detail of the contract. Having discussed your concerns with the PBC groups we would propose a further meeting involving primary care representation to review the existing levels by speciality and reach agreement on any areas where we would consider paying for activity above the ratios stated in the contract. We would also seek to agree a tight work plan to review any specific specialities which required further pathway work to reduce follow up ratios.

Stuart Bloom, Chair, West Hertfordshire PCT
Anne Walker, Chief Executive
Pam Handley, Chair, East and North Hertfordshire PCT

*West Hertfordshire PCT and East and North Hertfordshire PCT are working together to improve health in Hertfordshire*

Beverley Flowers will lead on this area with Clare Jones and will contact Russell Harrison to arrange a convenient time to meet next week.

1.3 The delivery of the 18 week milestone at the end of March is not optional for any organisation within the NHS and it is important that the Trust secures enough capacity to deliver the activity needed to enable both the Trust and all its commissioners to achieve the 18 week wait milestones at the end of March. It is not acceptable for the Trust to 'return' patients to commissioning organisations and as already stated we remain very happy to work in partnership with you to help establish the exact number of patients at 'risk' of not being treated within the national waiting time standard. The PCT has already taken the following actions:

- Provided the Trust with some of David Adler's time to review the actual demand and capacity to establish the total number of patients who the Trust will not be able to allocate a slot for treatment. We would be happy to allocate more of David's time during December to help the Trust consider how to maximise the available internal capacity.

- Identified capacity at Herts Eye who have agreed to triage all non-cataract ophthalmology work with a view to carrying it out on the Potters Bar site under existing contract arrangements. We are also in negotiations with them about the possibility of them providing a team to operate within the Trust if a theatre could be made available to clear any cataract waiters which you are unable to treat within your own capacity. Kirsty Green is the lead for this piece of work.

- Capacity has been identified at UCLH to treat some orthopaedic patients (initially back patients). The PCT is also negotiating With UCLH about the possibility of them taking a small number of gynaecology patients. It will be vital that if this capacity is made available that the Trust quickly identifies patients who are willing to have their treatment transferred, to ensure this capacity is not lost to other commissioners. Kirsty Green is the lead for this piece of work.

- Oxford Radcliffe & Capio have also indicated that they may have some additional orthopaedic capacity which could be offered to the Trust. Clare Jones is the lead for this piece of work and you should make contact with her to establish what procedures or capacity is available.

- Contact information for MACRAM for orthopaedic capacity was also shared with the Trust in September, but as I understand it the Trust has not taken forward this option. The organisation still has some remaining ability to deliver orthopaedic activity and therefore it is recommended that the Trust discuss this option further. Trudi Southam has the contact details should they be required again.

- Made initial contact with NetCare who are interested in the possibility of providing surgical teams to work within un-utilised theatre space. The contract details have been passed to Russell Harrison for follow up.

1.4 It is important that the Trust ensures that it maintains high standards of 'house-keeping' of all waiting lists including regular validation and review of suspended patients. This includes implementing the DH and NHS Institute recommendations around DNAs. The Trust also needs to fully utilise its internal capacity for the rest of the financial year especially on the St Albans site. We would like to see the full planned operating

schedules for the rest of the financial year by the end of December, including any un-allocated theatre sessions. We will also be requiring a weekly update on the amount of additional capacity (either internal or external) secured by the Trust at a speciality level.

**2. High Cost Drugs.**

2.1 Currently high cost drugs form part of the block element of the contract. We are however as discussed, willing to work closely with you to establish the actual costs of providing these high cost drugs and if appropriate enter into a risk share arrangement to meet this year's additional costs, where they are above last years actual costs plus inflation adjustments. Rasila Shah our prescribing lead in this area has already made contact with Joan Craig in your prescribing team with a number of specific requests to move this issue forward. The plan is to confirm the list of PbR excluded drugs and audit that the agreed pathways/ approvals /clinical indications have been followed and from that to assess the actual size of the financial value of high cost drugs above the current level of funding.

**3. Development of an Intermediate Care Facility on the Hemel Site**

3.1 We wish to continue working together on the extension of intermediate care facilities for the population of West Hertfordshire, including the opening and funding of additional beds on the Hemel site as an interim measure. At this stage the opening of these beds would be temporary and linked to winter planning escalation, whilst the longer term structure and location of intermediate care facilities is agreed with PBC groups. We would want to see a phased opening of additional beds, to enable us all to be happy that a suitable model of care was being developed and delivered. The initial agreement would be for 10-12 beds (equivalent to half a ward), with a formal review after the beds had been operational for 4 weeks.

3.2 The PCT has a number of requirements which must be met in order progress this service development:

- The intermediate care facility would need to be excluded from the excess bed day calculations, so the patients would need to be discharged from their acute episode of care.
- A clear written admission pathway would need to be in place, ensuring that the facility provides on going treatment and therapy and is not just a holding ward.
- As the facility is intended to relive surgical pressures on the Watford site it would be expected that the focus of the beds would be on the rehabilitation of surgical particularly orthopaedic patients.
- Gate keeping arrangements will need to be agreed involving nominated staff of the PCT and our provider arm.
- All patients will need to be 'fit' for discharge from an acute setting and have had their full assessments completed prior to admission to the facility.
- The beds cannot be used to treat patients who have been assessed as requiring on going social care.
- The acute trust will set up and staff the facility with nursing, HCA and therapy staff.

- The acute trust will need to provide medical cover to the beds, unless subsequent agreement is made with local PBC groups to provide this cover.

3.3 The detailed operational issues and pathways will need to be agreed between yourselves, Heather Moulder on behalf of the provider arm and Carol Hill on behalf of the PCT. The formal agreement of the bed day/ bed week cost for the operation of these beds will need to be agreed between our organisations. We will wish to engage the PBC leads in this process.

3.4 Additionally as the facility is being set up to specifically ease the pressure on the Watford site and thus decrease the pressure on elective beds and elective cancellations, the PCT will expect to see a reduction in the number of cancelled operations on this site. In order to monitor this we will require a daily update on the number of operations cancelled and to see the internal daily bed state figures.

3.5 The PCT provider arm is also working with Adult Care Services and the Trust to review the discharge planning process to try and make it more proactive across all sites of the Trust. It must however be remembered that all organisations must follow the national guidelines set down around the defining of DTC patients, including the fact that the recently published continuing care guidance reminds organisations that a patient must have completed their rehabilitation/recovery before continuing healthcare is considered and this along with the need for full assessment of need is taken into account when setting the tariff rates and trim points within PbR. Therefore we would only expect fully assessed patients to be transferred unless there was specific agreement that the length of the assessment had gone beyond the normal timescales.

## 4. Additional Year End Financial Support.

4.1 The PCT has already agreed to give the Trust in the region of £2-3 million this year to cover the one-off cross-over work in progress accrual and the outstanding sum for additional activity from last year. We are also willing to consider using any financial flexibility we may have at the end of the year to help the Trust achieve a breakeven position but would expect any such payment to be treated as a loan with an agreed timescale for repayment and this would need to be formally agreed with the West Hertfordshire PBC groups. Any specific payments for work above tariff would need to be agreed with both the PCT and PBC groups and would only be considered once the indicative activity levels set out in the contract had been delivered in full.

In terms of the funding of the specific back patients whom you are currently unable to treat within existing capacity we are as already stated willing to work with you to identify additional capacity. Russell Harrison also agreed earlier this year with Peter Jones that we would instigate a wider review of the pathway for back surgery patients, particularly as both Luton & Dunstable and RNOH are experiencing similar pressures, with small teams of surgeons and increasing volumes of work. The Operational Standard for March 2008 is 85% of admitted patients to have received first definitive treatment within 18 weeks of initial referral and therefore if we are unable to successful find additional reasonably priced capacity for these patients they may need to form part of the 15% tolerance.

I hope that this clarifies the PCTs' current position and shows that we clearly remain committed to working jointly to resolve the on going financial and operational issues as soon as possible.

Yours sincerely.

Anne Walker.

Anne Walker
Chief Executive.

CC: Tom Hanahoe
Phil Bradley
Stuart Bloom
Beverley Flowers
Dr R Sage
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Nick Evans
Russ Dunworth
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