Discussion following first 3 PBC Leads Presentations

Radiologist – not always level playing field
Where are governance issues that the Trust has to satisfy

LM – issue for commissioners

SBJ – young organisation – very naïve management

LM – Andrew Parker should be working for PBC not PCT

David Law – skills issue problem in Trust and PCT

Diabetologist – good middle management
Worried about private companies

LM – there are some, but there are other organisations that work co-operatively

Gastroenterologist – lack of holistic care
Creating chaos
Patients being treated for different conditions

LM – need to be cute, smart
Get supply chain integration
Language is wrong
"Acute" = care that could be provided in community settings

Other partners – social care
Domiciliary care providers
Even independent providers

DL – can't have 4 versions – got to standardise care

Richard Walker
There are 4 different areas
Our hospital is going to get a lot smaller
Present 33,000 sq m → $1/8^{th}$ of this for a community hospital
UCC is up for grabs earlier – get it sorted
Flex in the future → Integrated Care
Get organisational arrangements sorted

COPD – ideas and structures developed – bringing it into play difficult because of security of tenure for consultants
If employment is moved across, need to be confident it will last
Problem with taking care out of the acute unit
Can tariff flex fast enough for what is left in acute unit, e.g. MDT meetings
If take out easy bits, tariff will not pay its way for the difficult work
"What are you for" – benefit to patients

GPs have to think about this also
PBC is equivalent to taking people off allotments to formulate agricultural policy – enthusiastic and naïve and not restrained by targets, clinical governance, etc.
Only game in town so running with it
Need to be cautious of scope
Don't take on too many projects at the beginning
Still bidding to take on income

How engaging with secondary care, PCT, patients, own GP colleagues – not that well
Because too many GPs just want to see patients and not too interested in commissioning
Lever for dialogue
Not had data
Now have relatively elderly data, PACT, QOF achievements, and can talk about it
Some performance management
Pilot projects to influence referrals and engage with practitioners
Need choices in referrals
Need support in saying 'no', 'not appropriate way to deal with issue'

Discussion
Steve Laitner – nationally and locally all ducks are in line
National and local consensus
Manage demand going to secondary care and interface by CATS/CAS and UCC
Also need to be truly patient centred – look at pathway of care
Without thinking too early on unintended consequences – not do it too early on
We are in charge of the population's health needs

LM – 'Truro trick'
Decentralise – may find turnover higher but operating costs lower

DL – don't get hung up on employment changes – frighten consultants
Look at skills – will achieve that in spite of organisational changes

SBJ – second services

LM – internal relationships within PBC groups
Support for primary care groups to do job well

HRGs – range of services in prices
Have conversation about boundary
Will get more sophisticated
Will do horse trading
Unbundling tariff upsets finance people
All sorts of contract which lay across system – primary care / PCT / independent providers
Much more sophisticated