Stop Smoking
The present target may well be ratcheted up. There is a similar quit rate for all 3 options, at ~ 30 to 40%. Most commissioners across the country try to go for a balance of providers of Stop Smoking services.
Option 2 was agreed, in principle by all localities. Locality groups are to come back with confirmation to **Richard Walker** – who is to be the contact point for West Herts for Stop Smoking.

Parkinson's Disease Nurse
A Luton PD nurse has been running for 3 years. In Year 1 she saved 130% of her salary in admission costs. From surveys of the service, there is great background satisfaction and patient satisfaction. Barnet PCT has a SLA for PD nurse from Edgware Hospital. This could be adapted.

Diabetes Pathway
There was extensive discussion about this. Two of the lead GPs, Mike Walton (St Albans) and Marie Anne Essam (Watford) addressed the meeting.

3 weeks ago external support was suggested; the process for this was initiated. Internal support was sought in parallel, and commitment from people to be part of an internal team was established. The internal resources identified have considerable expertise and will be less expensive.

Clinicians emphasised that the support must be there. There is an urgent need to progress the project, with no further delay. The clinical issues with the pathway have been largely resolved. The next step for is for clinical leads and the internal support group to meet. There is a need for strong leadership and direction rather than just management support. The project group needs to become a separate business unit with its own governance. With the change of employment status of consultants and nurses, a robust business model is required.

This is the first of several such projects and all parties have got to work together. The diabetes project will be the first test of this co-operation, and is a unique opportunity – PBC must get it right. There are also issues for the acute Trust.

Significant dedicated management and clinical input may be harder with the federated input suggested. Ownership and leadership are needed to carry PBC groups, diabetologists, and nurses, to produce a new team. East & North Herts groups are costing the whole entity from end to end.

A stocktake was advised – the scope of the work and the tasks to be done. Powerful synergy will produce a strong team. Clinical leadership is important. Provider Services have been given notice of in-year changes. There will be transfer of the workforce from in Trust to out Trust; this will not be just clinical transfer.

Concerns were expressed that the project group would be trying to commission and provide also. PCT directors advised that this is a legitimate function of commissioning. Marketing and an in-service specification would be developed. The new provider would include the current clinicians. The terms of the specification and business arrangements would be agreed. TUPE implications need to be met. PCT directors do not advise a big organisational change.

The diabetes group clinicians require a mandate in writing, not just verbally. It was agreed that TOR for the diabetes group would be clarified and formalised. PCT managers will work with PBC.
The Diabetes Group meeting will be at: **7.30am on 17 April at Manor Street Surgery, Berkhamsted**

Provider Services

Adult Services

Carol Hill is working with West and East & North PBC IC Leads on longer term planning. Janet Lewis is working on what needs to be done now, i.e. the transfer of beds from Hemel to Watford and what will remain at Hemel. The clinical model for IC beds was discussed at a meeting yesterday.

Each locality receives the following core community services:

- Community Nursing
- Community Matrons (DH must do) – a certain number must be recruited per PBC group
- IC home-based

Integrated early intervention teams are being developed, as for the model already in place with St Albans and Hertsmere. Adult Services are working with localities. WatCom is providing community nursing services investment in collaboration with PCT Provider services and Commissioning services. The date for the Hemel IC beds has been agreed.

Janet's role is to facilitate provision and the services which PBC wants. Katrina Hall is responsible for providing basic adult services, palliative care services, and continuing care commissioned in the new continuing care framework. Palliative care links are being fast-tracked – Tracey Cooper is undertaking an End of Life review, and linking with the hospices.

Must Dos

National

Split CM requirement into Community Matrons and case management (i.e. Specialist Matrons)

SHA / PCT

DQHH (Delivering Quality Healthcare for Herts) – sign up to adding IC bed based
20 additional community beds and additional home based
Positive publicity campaign – with pump-priming
Population based model

LAA (Local Area Agreement)

Targets still in negotiation
Target in IC but definition narrow – will bring back to PBC when projects are more worked up
Maintaining people's independence
Avoiding admissions

Children's Services

See separate handout

Specialist Adult Services

Janet was a PCT Provider. She is now working with Moira McGrath on core pathway redesign.

Services include:

- Diabetes – 2 areas have specialist diabetic nurses (St Albans and Hertsmere); 2 areas do not
  - Community diabetic retinal screening
- Respiratory – the respiratory team covers all localities, but pulmonary rehabilitation only in St Albans
- MSK – 2 aspects
  - OPD Physio – Provider Services is provider for Dacorum – WatCom out to tender – St Albans private and Trust
  - Herts-wide Chronic Fatigue Service [50:50 W:E&N] West hosts it
  - CATS service – Provider Services is provider for WatCom and DacCom – not provider for Hertsmere – subcontracted (Mark Beavis) for St Albans & Harpenden

- Cardiac rehabilitation for localities – across the area. Local Heart Failure nurse have suffered from recruitment issues re: grading (to get the right grade); this is a national problem. The aim is to work with PBC on whole system redesign
- Neurology rehabilitation – West Herts – 6 beds across whole county – working with East & North to support similar beds
- Podiatry – dropped domiciliary chiropody – used resource to reinvigorate
  - MSK gait analysis to decrease orthotics
- Dietetics – move to integrate into IC – anomalies in GP access – Watford Trust sub-contracted – Dacorum is PCT
- SALT – maternity blight – 5 out of 8 are on maternity leave
- Wheelchairs – specialist seating – negotiations with provider – going out to tender at end of March – Stanmore is current provider
- Prison – HMP The Mount – should not be in budget – outside scope of PBC✸
- Physio – acute services in Trust – should not be there✸
- Community Dental therapies – part of 18 weeks

✸ Roger Hammond to take these out

Budget Setting for 2008/09
Also see separate handout.

In 2007/08 Provider Services were divided by capitation. During Sept/Oct 2007 the information department tried to map services to locality; this was rather rough and ready. Since then, the Commissioning Information Team has been transferred to Provider Services. The team has tried to move to an activity process.

PBC groups could have budgets set by:

- Capitation
- Cost centre mapping
- Referral information where available (not all services are on computer)
- FCEs (community hospital)
- Contact information
- Bed day information

The 2008/09 budget includes 2.3% uplift on the baseline and £5 million given back.

Some services may be better shared, due to the risk element. Where there is no activity information, the team used the mapping developed in Sept/Oct 2007. A measure of activity may be a better reflection of the services used. Once budgets have been mapped, PBC groups must set aside funds for services. Baseline activity will be rolled over.

At yesterday's meeting IC Leads said they would like to see a mix of budget setting. Where there is clearly locality activity, this must be maintained but patient flows must not be restricted. E.g. some beds would be spread out amongst the 5 groups on a capitation basis. Universal services (i.e. walk-in – as in many Children's Services) don't have referrals.

PBC groups have to come back to Provider Services to say what they are willing to spend in 2008/09. Loss leaders for PBC can be met by grossing up. In this way, PBC would operate like secondary care services – some things are easier to provide than others. Either the commissioner needs to hold the risk reserve or provider need to hold the risk reserve.

Catherine and Janet will offer support to PBC to signpost to Provider Services what PBC wants to commission. There is a timescale issue. The PCT has to have something signed off by 31/3/08. Catherine says Must Dos **must** come out of growth monies – Must Dos are at back of PCT Provider Services' business plan. Some are target driven.

Janet has spoken to Tad Woroniecki. The suggestion is that funds are maintained in PBC until the commissioning budget recruited to, and transferred over bit by bit. A simple flow chart has been developed.

Budgets include total establishment and costing to cover maternity leave. Herts has "elderly staff"; this is a national problem but Herts is especially hard hit because it has not been able to offer training for a couple of years. Lots of areas are 'turning the recruitment tap on' therefore prospective staff now have a lot of choice nationally. It is harder to turn the tap back on than to turn it off.

Agreeing Future Working Arrangements, Identify and Clarify Actions from this Meeting
All information should be shared at different levels. The next Leads' meeting is on 17 April. Headline budgets and detail should be discussed by PBC groups. Look at the total and see if it is allocated correctly. Use the Activity data.

Heather Moulder asked that the sooner the PCT receives decisions about reinvestment the better. It can then get on with recruitment. They will factor in 15% for leave etc. (The Acute Trust factors in 20%). Traditionally the NHS has relied on under-recruitment.

Janet said that Community Care is moving from Provider-led to Commissioner-led. However, at present, the Provider is producing a written specification as to what they are delivering. There are no penalties in SLA. Commissioners need to agree standards re: maternity, sickness and availability, together with monitoring.

The proposed DH Community Contracts have not materialised. PCT Commissioners are therefore having to use modified Acute Trust contracts and build in KPIs (Key Performance Indicators) and performance measures.

Regular contract review meetings are needed – quarterly was suggested. 'Variation from contract notices' are required. The contract will be circulated to PBC Leads. Janet wants Head of Terms signed off. A more formal contract can then be developed later. PBC groups need to nominate individuals to go to contract meetings. More IC beds will need more infection control and clinical audit.

Catherine wants to go ahead with agreed Must Do work and start on operating plans. She wants agreement now. The cost will be ~ £750,000 across West Herts, divided amongst the 5 PBC groups. Janet emphasised that PBC does need to give Provider Services a broad Heads of Terms Agreement.

It was agreed that 4 PBC groups are not challenging the overall total. They are agreeing to the total sum of money. However, they are not agreeing to the split. For the Red House, Ken Spooner did not agree to the total sum, and he would not give his agreement now. There was much discussion. The other groups agreed that they need to be asked, not told, although they had given no indication of disinvestment in their Commissioning Summaries.

Decisions are to be communicated to Janet.