### Personal Health Budgets Project Board Meeting

**Minutes & Action Notes**

Conference Room B, Jubilee House, John Smith Drive, Oxford

Business Park South, OX4 2LH

**Tuesday 3rd August 2010**

09:00 – 12:00

1. **In attendance:**
   
   Marie Seaton (chair), Trudy Reynolds, Suzanne Jones, Jacqui Connelly, Julia Boyce, Dan Harbour, Judy McCulloch, Nick Horn, Ian Bottomley, Mark Dillon, Shereen Bayat (minutes)

2. **Progress Report:**

   TR reviewed the latest PHB progress review with the group and highlighted the key points:

   - Self Directed Support had similar issues when setting up financial processes such as change over and amounts of money paid
   - Provider conference gave a mixed response to personalisation. Some providers are obviously ready to change the way they work but other smaller providers are having a difficulty (a) accepting the change and (b) adapting their services to the change.
   - The publicity given to the project by the announcement from the Minister in the House of Commons has encouraged a move forward in the project from the PCT’s point of view.
   - We have had several calls from patients with LTC’s enquiring if they can have a Personal Health Budget. Before the pilot can be extended to other area’s SJ will need to write to DoH to explain the proposed plan.

   **Presented by:** Trudy Reynolds

3. **Risks and Issues:**

   Currently the Risk and Issues log is on SCAN to be viewed. TR asked the group if this is the most efficient and correct manner in which to view and progress with this document.

   The group felt that TR should bring the top 10 risks to the Project Board so they can be discussed and resolved.

   **Presented by:** Trudy Reynolds

4. 

5&6. **Budget Setting Process and Direct Payment Status:**

   JB reviewed the following document with the group and highlighted some key points:

   **Presented by:** Julia Boyce
• When a client is already under CHC, the PCT will continue with the budget already allocated to said patient. A new client will go through the tariff setting process.

• The PCT needs to refine the budget setting process to include all tariffs’ e.g. personal assistants.

• SB is having regular meetings with CHC to keep everything up to date.

• Direct Payments will be paid by OCC finance.

• Monitoring is required every 3 months and every 6 months a budgetary review will take place.

• A4E are able to report on payments made by monies spent.

The 100k additional funding from DoH has not yet been received however has been confirmed by DoH.

Current budget stands at £178K

The group agreed to moving forward with the OCC process.

7&8. Health White Paper – prominent role of personalisation and future of health reforms and feedback from PHB ‘Big Get Together’ 17\textsuperscript{th} July 2010 & Single Integrated Personal Health Budget:

PHB has been strengthened by the Coalition Government and as soon as the pilot has finished the Coalition Government want to roll this project out on a national basis. The question was raised about how this may change due to GP involvement, the Minister made clear that this process is not about systems and structures but about culture.

There currently are 68 pilot sites / 19 with full pilot status / 9 allowed to make direct payments. The PCT are in all three categories.

If at anytime we would like to make changes to or extend the PHB pilot across other service area’s all the PCT are required to do is write a letter to the Department of Health outlining the proposed changes. The Minister has delegated full responsibility to the pilot sites.

The end point the Coalition Government would like to get to is total personalisation and an ‘Individual Life Budget’

| 7&8. |  
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| **Health White Paper – prominent role of personalisation and future of health reforms and feedback from PHB ‘Big Get Together’ 17\textsuperscript{th} July 2010 & Single Integrated Personal Health Budget:** | **Suzanne Jones** |
| PHB has been strengthened by the Coalition Government and as soon as the pilot has finished the Coalition Government want to roll this project out on a national basis. The question was raised about how this may change due to GP involvement, the Minister made clear that this process is not about systems and structures but about culture. | TR & SJ to meet to provide ops plan with evidence on how savings will be realised with PHB and the reasoning behind it for the Health Economy. |
| There currently are 68 pilot sites / 19 with full pilot status / 9 allowed to make direct payments. The PCT are in all three categories. | **SJ & TR** |
| If at anytime we would like to make changes to or extend the PHB pilot across other service area’s all the PCT are required to do is write a letter to the Department of Health outlining the proposed changes. The Minister has delegated full responsibility to the pilot sites. | **SJ & TR** |
| The end point the Coalition Government would like to get to is total personalisation and an ‘Individual Life Budget’ | **SJ & TR** |

9. Potential Development of PHB in to different area’s:

A discussion around the possibilities of development of PHB in to different areas. The group highlighted that this potentially would be a lot of work involved and the group wondered has there been enough steps completed in the current area (CHC) to justify moving the project in to any additional service areas.

Learning difficulties has already been assessed for SDS.

Within Mental Health there are issues between choice.

| 9. | **All** |
| Potential Development of PHB in to different area’s: | SJ and TR to have discussions with leads in area’s identified as area’s of interest. |
| A discussion around the possibilities of development of PHB in to different areas. The group highlighted that this potentially would be a lot of work involved and the group wondered has there been enough steps completed in the current area (CHC) to justify moving the project in to any additional service areas. | The project board had requested a paper assessing the implications of the PHB pilot in |
| Learning difficulties has already been assessed for SDS. | **SJ & TR** |
and control. Mental health however, is an obvious choice for PHB and is appropriate. But the group will need to look at processes such as tariff.  

A mental health PHB would enable patients to get to a point in their treatment where there would be no need to fund healthcare as the patient would have recovered.  

The DoH have a mental health learning set that will run for 2 years that will be supported by a ‘PHB Guru’.  

The budget setting for LTC’s is extremely difficult and pilot sites using LTC’s are being held up with progressing the project.  

The project team need to get permission for areas we would like to look at but don’t need to jump in to those areas straight away.  

Learning and Physical disabilities is a good area to look at as it runs from childhood in to adulthood.

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<td>10.</td>
<td><strong>Project update from Continuing Care Lead lead:</strong></td>
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| 11. | **Project Update from Governance Lead:**  
   The Risk Panel have agreed processes & guidelines to manage risk and to manage risk on an individual basis.  
   HW to meet a HCM to discuss safeguarding issues for providers  
   Innovative treatments will come to the panel for sign off.  
   There will be criteria for random payments such as ‘hair washing’.  
   The risk panel will meet fairly regularly.  
   Risk assessments are about management and minimising risk. The culture needs to shift from need rather than want. We need to be very specific about outcomes in comparison with needs. |
|   | **Project Update from Market Development lead:**  
   MD thanked TR for all her assistance. The provider conference was very helpful. Still very much in ‘chicken and egg’ stage.  
   Brokers are challenging providers to provide a different service. Some small providers are struggling with this process.  
   In mental health market development is about services rather than providers. Patients find it difficult to get to grips with purchasing services from different sources. Brokers are key here and all need to be skilled up to deal with patients who have mental health issues. |
|   | **Project Update from Comms and PPI Lead:**  
   Reference group set up to test issues and mechanisms against people who are currently in this situation.  
   Reference group commented on how systems currently don’t work for them and on their frustrations from the past. |
|   | Trudy Reynolds |
|   | Mark Dillon |
Mobility to manage is a major issue for this group.

We will be testing mechanisms such as patient information leaflets with this group.

JM tabled the current patient information leaflet in its draft format for comment from the project group.

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The same designers that created the TASC publications have been asked to create this document. The PCT would like a design that we can carry through in to other documentation. This leaflet will go to the Patient Reference Group on 5th August for comment on design.

There is an open consultation page on Talking Health. The purpose of this page is to act as a place where the group could open a discussion forum to bounce ideas off the public & ask for their views.

An FAQ will be developed for users from questions suggested by the public.

Currently there are 600 users registered on Talking Health.

NH commented that a service user reference group is invaluable & they now act as advocated in community and would assist with a link in terms of taking control.

The patient reference group notes will be brought to this group for information and discussion.

Currently the agenda for the Patient Reference Group id worked up by TR and JMc but hopefully in the future we will be able to pass this responsibility to the group itself.

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**15. AOB**

PHB Project Board meetings to be held bi-monthly.

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### Future Meeting Schedule:

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<tr>
<th>Date</th>
<th>Venue</th>
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<tbody>
<tr>
<td>5th October</td>
<td>Conference Room A, Jubilee House</td>
<td>09:00 – 12:00</td>
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<tr>
<td>7th December</td>
<td>Conference Room A, Jubilee House</td>
<td>10:30 – 13:00</td>
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