HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 5 February 2009.

PRESENT: Councillor Dryden (Chair); Councillors Carter, Dunne, Purvis and P Rogers.

OFFICERS: J Bennington and E Williamson.

**** PRESENT BY INVITATION:**

Councillor Brunton, Chair of Overview and Scrutiny Board

Elaine Wyllie, Assistant Director, Commercial & Market Management, Tees Primary Care Trusts

Des Robertshaw, Principal Audiologist, South Tees Hospitals NHS Trust

Middlesbrough Primary Care Trust:
June Johnson, Senior Practice Based Commissioning Manager

Chris McEwan, Assistant Director of Health System Developments

Chris Grace, Practice Based Commissioning Manager.

**** APOLOGIES FOR ABSENCE** were submitted on behalf of Councillors Cole and Lancaster.

**** DECLARATIONS OF INTEREST**

No declarations of interest were made at this point of the meeting.

**** MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 15 January 2009 were taken as read and approved as a correct record.

AUDIOLOGY SERVICES UPDATE

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from the local NHS to provide an update on local audiology services.

Members were reminded of the Panel's Final Report into Audiology Services, which had been completed in July 2008. A copy of the Executive summary had been circulated for Members' information. One of the main areas identified in the Final report related to the service in respect of waiting times which had been found to be substantially longer than the 18 week Department of Health target, with the Royal National Institute for the Deaf listing the South Tees waiting times as 54 weeks.

A copy of a briefing paper from the local NHS representatives outlining actions taken in response to the Final Report had been circulated which indicated the following: -

i) The average patient journey (referral to fit) for hearing aids in the Specsaver Hearcare pilot was reported to be six weeks.

It was confirmed that the South Tees Hospitals NHS Trust (STHT) Audiology service had achieved the Government's 18-week target from referral to having a hearing aid (s) fitted.

It was noted that waiting times at STHT had further reduced since the completion of the Final Report from 27 weeks to 12 weeks in general with four patients out of 1,010 being outside of the 18-week target at the end of December 2008.

ii) In terms of promotion it was reported that the Tees PCTs had advertised in December 2008 to tender an Adult Hearing Service from high street locations in Middlesbrough, Redcar, Stockton and Hartlepool PCT areas. The Panel was advised that bidder responses from the Independent Sector had been positive and the PCT was conducting bidder evaluation sessions and expected to award a contract in early February.

It was pointed out that STHT Audiology Service provided services in the Lifestore twice a week.

iii) Confirmation was given that a coaster style patient paging system for use by hearing impaired patients had been installed in the Audiology department at James Cook University Hospital.

iv) In addition to the information already provided to patients in STHT's information leaflets, the signage in the Audiology reception area had been reviewed and would be further strengthened.

v) It was reaffirmed that the STHT PALS team already had links with the Deaf Centre in Middlesbrough but it was intended to increase their involvement and frequency of their meetings. It was confirmed that any new concerns raised by the Deaf Centre regarding Audiology services would be forwarded to the Audiology Manager.

The Chair welcomed Elaine Wyllie, Assistant Director, Commercial & Market Management, Tees Primary Care Trusts and Des Robertshaw, Principal Audiologist, South Tees Hospitals NHS Trust who focussed on the key areas of improvements achieved since the publication of the Panel's final report on local audiology services.

Members were advised that although the Government's 18-week target from referral to having a hearing aid (s) fitted had not been in place at the time of the scrutiny investigation there had been acknowledgement by the local NHS of the need for the service to be vastly improved. It was confirmed that STHT and the PCTs had undertaken much work in achieving such improvements. It was noted that information regarding the Healthcare Commission targets was still awaited.

The Panel was advised that the18- week target had been achieved in respect of 95% of patients (4,500 patients between 1 April and 31 December 2008) and that a tolerance of 5% would be built in to allow for those patients who could not be clinically treated at the time of referral.

In terms of commissioning a service from the independent sector it was confirmed that it had been the subject of a competitive process and tenders had subsequently been submitted. The Panel would be advised in due course of the successful tenderer. In commenting on the success of the previous pilot scheme it was acknowledged that it had stimulated the market in the area and demonstrated that patients had been willing to access services not traditionally based in hospitals. The commissioning of a service in the independent sector was seen as providing additional capital and relieving pressure in assisting the audiology service in meeting the overall targets and required needs.

Further details were provided of the coaster style patient paging system for use by hearing impaired patients, which had been installed in the Audiology department at James Cook University Hospital for several months. Although take up of the facility had so far been low those who had used them had been pleased with the equipment which had worked well. As the pager worked within a radius of 100 yards it had proved to be particularly useful for patients with multi-appointments.

The Panel discussed in general terms some of the factors that had resulted in the pressures on the service a few years ago and the likelihood of the current service level being sustained. It was explained that the resources allocated prior to 2006/2007 had proved to be insufficient to cope with an increasing demand for the service. In 2006/2007 a financial commitment of

£170,000 had been made to re-invest in the service ahead of the national target requirements. An assurance was given of the ongoing commitment of both the PCT and STHT to maintain high standards and continue to make improvements. It was acknowledged that given the demographic changes in particular the ageing population and increased demands on the audiology services it was considered important to continue to access additional resources to maintain standards.

In terms of the future the NHS representatives were reasonably confident of sustaining current levels of service subject to market forces in terms of the retention and recruitment of staff across the UK. Members were advised that the situation was slowly improving in this regard and that STHT had made significant efforts into recruiting well-qualified staff and in relation to working arrangements to assist with retention of staff. Reference was made to ongoing efforts to raise the overall profile of the service and of the close links with the University of Teesside to assist in attracting newly qualified professionals.

The Panel acknowledged the significant improvements which had been achieved and of the ongoing joint efforts to sustain standards and seek further advancements.

AGREED that the local NHS representatives be thanked for the information provided

PRACTICE BASED COMMISSIONING BRIEFING

Further to the meeting of the Panel held on 15 January 2009 the Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from Middlesbrough Primary Care Trust to provide an initial briefing on Practice Based Commissioning (PBC).

The Chair welcomed the local NHS representatives who gave a presentation focussing on the policies driving PBC and how PBC was working across south of the Tees.

The aim of PBC was described as improving the access to and quality of such services. Following the first announcement of PBC in the NHS Plan 2000 it had been further developed in the NHS Improvement Plan which stated that from April 2005, GP practices that wished to do so would be given indicative commissioning budgets.

Reference was made to extensive guidance which had subsequently been produced including In October 2004 the Department of Health set out proposals for PBC which incorporated the following: -

- that GP practices would play an important role in commissioning services for their patients and local populations;

- that patient choice would be a key driver for quality and empowerment and PBC would secure a wider range of services, responsive to local needs and giving patients wider choice;

- that practices would be able to direct funding of packages of care for long term conditions;

- that a greater variety of services from more providers outside of hospitals where applicable and cost effective in convenient settings for patients would be provided;

- that more efficient use of services would be provided;

- there would be a greater involvement of frontline doctors and nurses in commissioning decisions.

It was noted that patients would not be unfairly disadvantaged should a practice decide not to take up PBC. In order to prevent any disparities there was a national tariff for services. The development of local services where appropriate skills were available for more minor procedures out of hospital locations allowed more available time to focus on the more complex services in acute settings.

Unlike GP Fund Holding PBC did not have additional resources going to GP practices that took PBC on board and there was a level playing field for all practices whether they wanted to take advantage of PBC or not. Government policies encouraged a plurality of providers aimed at putting the patient's interest first. It was considered important for the PCT to work with GPs to ensure that appropriate checks and balances were in place to increase patient's choice and access services locally where appropriate. It was acknowledged that appropriate governance arrangements needed to be established which should assist in avoiding any conflicts of interests.

The current position of PBC across GP practices in Middlesbrough PCT and, Redcar & Cleveland PCT was indicated as follows: -

- Middlesbrough PbC Group (21 GP practices) 153,000
- Langbaurgh PbC Group (15 GP practices) 97,392
- Eston PbC (5 GP practices) 36,000
- Ravenscar practice had chosen to be stand alone commissioning practice.

- All PbC Groups were working towards a Commissioning Plan and GP practices within the three groups had a formal agreement;

- All Practices had received a fair share of indicative budget for agreed scope of services;

- Commissioning Groups had agreed and signed up to 2008/2009 Incentive Scheme;

- PCT provided minimum activity data via MIDAS to practices and additional support to practices for example, PbC Account Managers, Finance Manager and Information support;

It was acknowledged that one of the key areas was the need to improve relationships between the PCT and some GPs and of the need to gain a better understanding of the objectives of PBC.

Members asked for clarification on the likely consequences should GPs overspend the budget. In response the Panel was advised of the intention for the PCT to have performance management systems in place and for budget monitoring in a constructive challenging way. Should all GPs overspend the PCT would ultimately have statutory responsibility to resolve the situation. Department of Health guidance provided a 5% variance.

Reference was made to a new quality framework to be developed to ensure that a patient received the same level of service wherever they go.

The Panel was advised that in order to take PbC forward the following was needed: -

- effective systems for Clinical leadership and processes that supported all clinicians leading and shaping design;

- a clear shared vision for how PbC could help deliver the PCT's strategic agenda and a good alignment between strategic (PCTs) and operational PbC commissioning plans;

- to have clear rules of engagement as to how the PCT/PbC groups would work together to deliver what was wanted and needed to be delivered;

- processes and governance that enabled and were supportive, transparent and defendable;

- integrated working between PbC and Service reform teams that ensured a streamlined systematic approach to developing new pathways of care and services;

- Patient and Public Involvement throughout.

The current challenges were seen as follows: -

- weak clinical leadership in some cases in that PbC Chairs lacked ability and time to take PbC forward within working practice hours;

- engaging primary care colleagues other than PbC Leads and Practice managers;
- basics such as information/ budgets and support needed to be dealt with and processes and governance in place which enabled and supported;
- PCT and PbC Groups needed to develop a 'critical friends' and open/transparent relationship;
- PbC Groups feeling threatened by PCT's strategic agenda and continuing to just focus on operational (PbC) commissioning plans;
- PbC and PCT agreement on rules on engagement needed to be more robust;
- Potential unwillingness/lack of clinical skills for PbC team to integrate with Service Reform team to ensure a streamlined systematic approach to developing new pathways of care and services.

In commenting on the extent to which the 21 GPs were involved with PBC it was noted that there currently only approximately six GPs who were fully committed and involved with PBC. One of the challenges was to improve clinical engagement and to achieve a better understanding of the aims and benefits of PBC.

It was acknowledged that the development of PBC should be gradual in that one or two aspects should be initially focussed upon and once implemented progressed to other areas. There was a need for GPs and PbC Groups to gain a better understanding in terms of budgetary arrangements and that the PCT had overall commissioning responsibility.

PBC was regarded as adhering to the principles of the central policy drive of world class practice commissioning delivering Darzi's Vision and Strategy which incorporated the following: -

- clinical engagement should be real and robust to help shape and inform local strategy;
- commissioning would be based on real local needs assessment and PbC Groups would be key local partners;
- PbC Groups would help to design local quality contracts and quality outcomes would be monitored and audited;
- Genuine local targets would be developed;
- Meaningful partnerships with the local population would be developed in order to bring evidence to policy and prioritisation of interventions;
- budgets would be managed locally in order to get high quality cost effective health care;
- reliable local data streams would be created to inform and supply world class primary care provision;
- PbC Groups would bring vitality and responsiveness to PCT.

Reference was made as to how PBC fitted into other health facets such as the public health agenda. It was recognised that this was one area where PBC could link into. PBC was not just about additional resources but to support the delivery and development of services in more local settings to achieve better outcomes for the patient. It was considered important for the PBC Groups to adopt a more lateral approach as to how PBC fits into the overall health agenda.

In conclusion the Panel identified a number of areas for further information and clarification including the need to achieve further clinical engagement and how PBC fitted into the public health strategy approach going beyond the traditional GP methods.

The Panel supported the intention to invite Dr Nigel Rowell, a lead on one of the PBC Commissioning Groups and suggested that the possibility of inviting Dr John Canning, Secretary, Local Medical Committee be examined.

AGREED as follows: -

1. That the local NHS representatives be thanked for the information provided which would be incorporated into the overall review.

2. That further information be submitted on the areas as outlined.

OVERVIEW AND SCRUTINY UPDATE

In a report of the Chair of the Health Scrutiny Panel, Members were advised of the key matters considered and action taken arising from meetings of the Overview and Scrutiny Board held on 13 January 2009.

NOTED