Report to the Middlesbrough Council Health Scrutiny Committee.

Middlesbrough Practice Based Commissioning Group

Practice based commissioning is about engaging practices and other primary care professionals in the commissioning of services.
Primary care trusts are the budget holders and have overall accountability for healthcare commissioning, however practice based commissioning is crucial at all stages of the commissioning process.
In particular practice based commissioners, working closely with PCTs and secondary care clinicians will lead to work on deciding clinical outcomes.
They also play a key role supporting PCTs by providing valuable feedback on provider performance.
PBC is about engaging practices and through it front-line clinicians are being provided with resources and support to become more active in commissioning decisions.
The theory is that this will lead to high quality services for patients in local and convenient settings and that GPs and nurses and other primary care professionals are in a prime position to translate patient need to redesign services the best deliver what local people want.

A very good example of this is the recent transfer of genitourinary medicine ("STD") clinics from hospital setting to the community.
The practice based commissioning group undertook a detailed survey in 2006/7 of young people in pubs, clubs & nightspots to find out where they would wish to receive care in the event of them contracting a sexually transmitted disease.
We then designed a service around their needs.
The service involved identifying clinicians – GPs - with an interesting genitourinary medicine; identifying nurses with an interest; sending doctors on training courses; identifying premises, equipment, and infrastructure that would support their clinical role.
The estimated cost of the same care in hospital was going to escalate dramatically to £1.9 million and it was thought that we could do this for a fraction of the price and even improve the patient experience.
After 22 months the service was ready to go live on Valentine's Day 2008!
We were then informed by the Executive of the primary care trust that the service we had designed would have to be put out to tender to the private sector!

There are many lessons to be learnt from this: the first is that government policy changes very rapidly and secondly, that identifying needs in the population and training personnel to meet that need takes considerable time.
Doctors and nurses in this area tend to be in the business for the long term and not to meet short-term political needs.

It is therefore no surprise that only 62% of practices support practice based commissioning of 20% neutral and only two thirds of practices have agreed a

commissioning plan with only 58% confidence that their plan will improve the quality of patient care. (DoH 16.6.08)
With constant moving of the goalposts it is very difficult for practices to feel involved and very easy for them to feel disenfranchised.

Locally the development of practice based commissioning has suffered from the merger of the two primary care trusts Middlesbrough and Redcar and Cleveland. Practice based commissioning teams within practices were developed in 2005 but between 2006 and 2008 lacked appropriate managerial support from the PCT and when the new commissioning team in the PCT was appointed they were unsure of their roles and responsibilities and demonstrated a risk averse culture.

Ultimately the PCT holds the purse strings and are responsible for meeting financial balance and expenditure but because of this are very unwilling to let go of the money and allow practices to take any risk at all in his expending on services for patients. This tends to inhibit new developments and innovative thinking.
Because the PCT holds the money we are unable to spend any money as a practice based commissioning group until we have some savings.
It takes time to do this.
To be asked to spend savings which you don't have is extremely difficult.
T spend them takes many journeys through committees.

So far development of community services and Middlesbrough have come a long way and indeed seem to be more advanced than any other than many other parts of the country.
There are now community services available in muscular skeletal medicine, dermatology, genitourinary medicine, minor operations and skin surgery, and recently the practice based commissioning group has started to look at Ear, Nose and Throat and Gynaecology services to identify some elements that could be provided appropriately in the community.
In January the PBC group commissioned a consultation event about care of the elderly which was led by one of our local GPs, Dr Tony Boggis. This was extremely successful with a wide variety of stakeholders taking part with the ultimate aim of improving medical care in the community for the elderly and those in residential and nursing homes. One of the aims of this consultation event was to look at the feasibility of a consultant led elderly care service in the community.
A screening service to identify patients with heart failure is due to start in May of this year using state-of-the-art echocardiography machines and BNP blood testing. The latter is only available to a minority of patients in the UK and it is a model favoured by the British Society of Heart Failure
However it should be noted that it is nearly 5 years since this service was conceived and three years since the relevant piece of hardware was bought in preparation!
PCT mergers, changes in personnel and identifying sources of funding were the main problems in delivering the service. Heart failure was not deemed to be a high enough priority despite 20% of the very elderly having this condition.

For the average GP and practice that are not enthusiasts there is little or no incentive to get involved with practice based commissioning. The money is perceived as being held tightly and centrally and everything has to fit into a centrally motivated plan -as Henry Ford would have said "you can commission any colour so long as it's black"
what little freed up resources have been made available to practices to spend require a seven page document to be completed before it goes back to a subcommittee for approval for spending One practice has been unable to secure pay for training personnel and pieces of equipment, both of which were allowable under DoH rules.

The internal market between GP practices and hospitals is a major barrier to working together to provide services across the primary-secondary divide.
It is difficult to work with hospitals to move the service out into the community when they will be disadvantaged financially. Why would a turkey want to vote for Christmas?

One of the major problems within the NHS both locally and nationally is the amount of money that sits in silos jealously guarded, which makes joint working very difficult. Despite this there have been some marked successes with the practice based commissioning effort in Middlesbrough of which the genitourinary clinic is certainly one.

The other major achievement is the development of educational sessions for GPs and practice nurses across Middlesbrough and Redcar and Cleveland. I propose the sessions over a year ago as a way of promoting good practice and use of local resources and so far they have been well attended and are growing in popularity
I felt that a better informed and educated Doctor will make a more appropriate referring decision.
These educational sessions involve aspects of health promotion, clinical sciences, and service use.
Practice based commissioning is also about reflecting on your own use of services and expenditure and about being responsible for them. So far no formal mechanisms are in place to police a practice that is over referring or overspending as the argument also runs that similar pressure should be put on practices that under refer and under spend!

In answer to your specific questions:

Q1 what are my views on the origins of PBC policy?
A: I think the government wanted to see all the advantages of fund holding with none of the embarrassments. Unfortunately there are very few incentives around the practices to want to undertake practice based commissioning

Q1b has my experience indicated that the policy aims of PBC are being met?
A: my experience is that we are having a marginal effect on achieving policy aims because of the issues outlined above.

Q2 what are my views on how PBC is organised in Middlesbrough?
A: PBC organisation has been thwarted so far by lengthy reorganisation of the two PCTs and we have not felt as if we are a priority. It is only within the last year that a workable

team has developed. We still have very little resource available in terms of secretarial backup. Incentives to practices are mainly around delivering financial balance rather than involvement in the whole process.

Q3 what sort of impact has PBC had on service design or service provision in Middlesbrough?
A: I think that local GPs would have had an impact on service design and provision in Middlesbrough anyway without practice based commissioning.
There was always a commitment from certain GPs to help develop service re-design ever since 1994, when cluster groups were in existence and then through fund-holding and then the primary care group development.
There was a very useful committee called the service development committee which ran for some years under the original Middlesbrough PCT but this was disbanded although this committee did a lot to develop community based services.

Q4 how would I like to see PBC develop in Middlesbrough in the next three years?
A:I would like to see the public as well as directors and chief executives within the PCT taking more of an active interest in practice pace commissioning and I would like to see money being set aside for practices to try new ways of working without blame if the new way of working is not successful.
There is a strong blame culture and aversion to any sort of financial risk.
However the main barrier remains that of an internal market and I do not see us working closely with hospital colleagues for the benefit of patients until this artificial barrier is broken down.

It is after all public money.

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