Middlesbrough Council

Middlesbrough moving forward

AGENDA ITEM: 4

HEALTH SCRUTINY PANEL

19 MARCH 2009

PRACTICE BASED COMMISSIONING – A ROUNDTABLE DISCUSSION ON FUTURE DEVELOPMENT

PURPOSE OF THE REPORT

1. To introduce representation from the Middlesbrough Practice Based Commissioning Cluster and Middlesbrough PCT, in attendance at today's meeting to take part in a roundtable debate about the future of Practice Based Commissioning in Middlesbrough.

RECOMMENDATIONS

2. That Members consider the views expressed today, note the evidence gathered by the Panel so far during the review and give thought as to whether the Panel is now in a position to compile a final report.

CONSIDERATION OF REPORT

3. As the Members will recall, the Health Scrutiny Panel has considered the topic of Practice Based Commissioning (PBC) in two previous meetings. On the 5 February 2009, the Panel received a detailed briefing on the national policy background to PBC, from Middlesbrough PCT.

4. At a meeting on 26 February 2009, the Panel received a paper from the Middlesbrough PBC Cluster Chair and held a lengthy debate on the topic.

5. At the meeting with the PCT on 5 February 2009, there were a number of key points identified about PBC as a policy.

6. The Panel heard that extensive national guidance indicated that PBC incorporated the following.

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

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

6.3 that practices are able to direct funding of packages of care for long term conditions.

6.4 that a greater variety of services from more providers outside of hospitals, where applicable and cost effective, in convenient settings for patients can be provided.

6.5 that more efficient use of services can be provided.

6.6 there will be a greater involvement of frontline doctors and nurses in commissioning decisions.

7. It was confirmed to the Panel that the current position of PBC across GP practices in Middlesbrough PCT and, Redcar & Cleveland PCT was indicated as follows

7.1 Middlesbrough PbC Group (21 GP practices) 153,000

7.2 Langbaurgh PbC Group (15 GP practices) 97,392

7.3 Eston PbC (5 GP practices) 36,000

Ravenscar practice had chosen to be a stand-alone commissioning practice.

8. The Panel heard that there are a number of challenges in relation to PBC, such as

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

8.2 engaging primary care colleagues other than PBC Leads and Practice managers;

8.3 basics such as information/ budgets and support needed to be dealt with and processes and governance in place which enabled and supported;

8.4 PCT and PBC Groups needed to develop a ‘critical friends’ and open/transparent relationship;

8.5 PBC Groups feeling threatened by PCT’s strategic agenda and continuing to just focus on operational (PBC) commissioning plans;

8.6 PBC and PCT agreement on rules on engagement needed to be more robust;

8.7 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.

9. Following the initial briefing from the PCT on 5 February 2009, at its meeting on 26 February 2009 the Panel received a briefing paper from the Chair of the Middlesbrough PBC Cluster. The Panel noted that there were a few key issues that came out of that discussion.

10. The Panel heard that around 50% of GPs, on a national basis, had commissioned services through PBC. There was debate around how GPs are incentivised to be involved in PBC and it was accepted that there are not any significant incentives, certainly of a financial nature.

11. In addition, as the PCT was ultimately responsible for meeting financial balance, it was felt by some that it was unwilling to release funding to allow practices to take risks on services for patients, and therefore inhibited new developments and innovative thinking. The Panel heard that inevitably, some things may be tried and not work as well as hoped, although that was part of establishing what is best for any given area. It was felt that such a strongly risk averse culture was not helpful. For practices to be asked to spend savings, which had to be culminated in the first place, was considered to be extremely difficult.

12. It was also discussed about services being provided on a local basis as opposed to a hospital environment. Members were interested in hearing about how it could be ensured that services moved into a local community setting were of the same quality. In short, the Panel heard that PBC does not include any mechanism to ensure quality, which was something of a concern to the Panel. Nonetheless, the Panel heard that the 'quality agenda' is very much on the PCT's priorities for the coming year or so.

13. Members were interested in how PBC can fit into a strategic vision, particularly around public health measures. It was agreed that there was a place for PBC in the public health strategy approach and preventative agenda. GPs had recognised such a need and were developing a more cohesive approach to tackle the whole issue. One of the main areas of work involved tackling obesity.

14. The Panel heard that there are a number of barriers to overcome, including a strong blame culture attached to financial risk and an internal NHS market. It was felt, nonetheless, by the PBC Group that with appropriate measures, PBC will assist in the commissioning of appropriate services in community settings for the benefit of patient outcomes.

Issues to be considered at today's meeting

15. Following the meetings to date and considering the issues discussed by the Panel, the Panel felt that one more meeting would be advantageous. It was

felt that it would be very useful if the final meeting took the form of a roundtable debate, covering a number of points, which the Panel has noted, are central to the issue.

16. To that end, representatives of Middlesbrough PCT will be in attendance at today's meeting, in addition to the Chair of the Middlesbrough PBC Cluster. It is intended that today's meeting will take the form of a roundtable debate on a number of key questions.

17. Key questions, which the Panel has identified as central to the debate, and could be used to guide today's discussion, are listed below.

17.1 How can clinical engagement be improved?

17.2 How do we ensure, in practice, that PBC activity fits with the strategic vision for services in Middlesbrough, particularly public health/preventative services?

17.3 How do we ensure that patients of practices not engaged in PBC are not disadvantaged in terms of the availability of services or equity of access to certain services?

17.4 Should PBC be looking to spend money on services not strictly health care related, such as subsidised leisure opportunities?

17.5 What needs to happen for PBC in Middlesbrough to be the sort of programme envisaged by national PBC policy?

18. As mentioned above, the questions outlined above are themes, which have emerged during the Panel's consideration of the topic. It is suggested that the above themes are used to guide today's debate.

19. Following today's meeting, it is anticipated that a Final Report will be prepared, outlining the evidence considered by the Panel and making any conclusions and recommendations the Panel is minded to make.

BACKGROUND PAPERS

20. Please see the supporting documents to, and minutes of, the Health Scrutiny Panel meetings on 5 February 2009 and 26 February 2009.

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