HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 19 March 2009.

PRESENT: Councillor Dryden (Chair); Councillors Carter, Cole, Dunne and McIntyre (as substitute for Councillor Purvis).

OFFICERS: J Bennington, R Hicks, J Ord and P Stephens.

**** PRESENT BY INVITATION:** Councillor Brunton, Chair of Overview and Scrutiny Board

Middlesbrough Primary Care Trust:
Chris McEwan, Assistant Director of Health System Developments
Grace Rosbotham, Practice Based Commissioning Manager.

Dr Nigel Rowell, Chairman, Middlesbrough Practice Based Commissioning Group, Endeavour Practice, Middlesbrough

Liam Brownell (work placement) Middlesbrough Council.

****APOLOGIES FOR ABSENCE** were submitted on behalf of Councillors Lancaster, Mrs H Pearson and Purvis.

**** DECLARATIONS OF INTEREST**

Name of Member	Type of Interest	Item / Nature of Interest
Councillor Brunton	Personal Non-Prejudicial	Agenda Item 4 – Practice Based Commissioning – registered at GP practice

**** MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 26 February 2009 were taken as read and approved as a correct record.

PRACTICE BASED COMMISSIONING

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from the Middlesbrough Practice Based Commissioning Cluster and Middlesbrough Primary Care Trust.

The report summarised the evidence received so far by the Panel which had covered the following areas: -

i) extensive national guidance indicated that PBC incorporated the following:-

a) GP practices played an important role in commissioning services for their patients and local populations;

b) patient choice was a key driver for quality and empowerment and PBC would secure a wider range of services, responsive to local needs and give patients wider choice;

c) GP practices were able to direct funding of packages of care for long term conditions;

d) a greater variety of services from more providers outside of hospitals, where applicable and cost effective, in convenient settings for patients could be provided;

e) more efficient use of services could be provided;

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

ii) the current position of PBC across GP practices in Middlesbrough PCT and, Redcar & Cleveland PCT had been indicated as follows:-

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

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

c) Eston PbC (5 GP practices) 36,000

d) Ravenscar practice had chosen to be a stand-alone commissioning practice;

iii) the Panel had been advised of a number of challenges in relation to PBC including:-

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

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

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

d) PCT and PBC Groups needed to develop a 'critical friends' and open/transparent relationship;

e) PBC Groups felt threatened by PCT's strategic agenda and their continuing focus on operational (PBC) commissioning plans;

f) PBC and PCT agreement on rules of engagement needed to be more robust;

g) 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.

iv) other issues identified following a meeting with the Chair of the Middlesbrough PBC Cluster had included the following:-

a) around 50% of GPs, on a national basis, had commissioned services through PBC;

b) lack of significant incentives, certainly of a financial nature, for GPs to be involved in PBC;

c) as the PCT was ultimately responsible for meeting financial balance, it was felt by some GPs that it was unwilling to release funding to allow practices to take risks on services for patients which inhibited new developments and innovative thinking;

d) for GP practices to be asked to spend savings, which had to be culminated in the first place, was considered to be extremely difficult;

e) no formal mechanisms existed to ensure quality although the Panel had been advised that the 'quality agenda' was on the PCT's priorities for the coming year or so;

f) it had been agreed that there was a place for PBC in the public health strategy approach and preventative agenda;

g) GPs had recognised such a need and were developing a more cohesive approach to tackle the whole issue;

h) a view had been expressed that there were a number of barriers to overcome, including a strong blame culture attached to financial risk and an internal NHS market it was felt that nonetheless with appropriate measures PBC would assist in the commissioning of appropriate services in community settings for the benefit of patient outcomes.

The Chair welcomed the local NHS representatives and sought their views by means of a roundtable debate about the future of Practice Based Commissioning in Middlesbrough (PBC) to assist the Panel in formulating the Final Report on the subject matter.

The subsequent deliberations focussed on the following areas.

Patient Empowerment – Performance and Quality Measures

Members sought assurance as to the mechanisms in place to ensure quality and consistency of service. The local NHS representatives agreed that PBC was not designed to address such matters and that other measures in place including the collation of information, reporting mechanisms, patient outcomes and performance systems assisted in identifying any inadequacies and/or inconsistencies. It was felt by some, however, that there were no clear mechanisms or policy in this regard and that often it relied on complaints or representations to the General Medical Council.

The Panel was keen to establish the steps a patient could take if they had any concerns. In response reference was made to the Patient Advice and Liaison Service (PALS) information on which was available in various ways including at GP practices. In addition to providing a range of information on health-related issues they supplied details of the NHS complaints procedure and how to get independent assistance on making a complaint. It was pointed out that GP practices also had their own systems of registering complaints.

Reference was also made to the process of the Quality and Outcomes Framework a process whereby GP practices were reimbursed for implementing improvements in quality of care. It was felt that such a framework would assist in identifying any variations across the GP practices.

It was acknowledged that the development of such areas as the internet over the last 5 to 10 years had helped to empower patients in terms of easier access to a wide range of information. It was felt that the internet played an important role in providing information on health conditions and potential treatments. The importance of promoting PALS which provided the opportunity for patients to give feedback which helped to structure future services was highlighted. It was suggested that the current process of PALS could be strengthened by further input in a structured way from a clinical panel advising on good practice in an educational and non threatening manner. Working in collaboration with GPs and sharing information and good practice was seen as positive way forward to improve services.

For those patients who were sometimes bewildered especially by the terminology used when attending GP practices it was suggested that an increase in the national standard minimum time for a GP consultation should be increased from 7/10 minutes towards 15 minutes which would allow more time for explanation and also improve job satisfaction for GPs.

The Panel agreed that it was important for patients to have easy access to detailed information, advice and the complaints procedure.

Clinical Engagement

Previous evidence had suggested that not all GPs were fully supportive of PBC and therefore Members sought assurance that there wouldn't be variations in standards and access to services. In response the Panel was advised that services would be accessible to all patients. An indication was given of a current service being developed in relation to care for the elderly by improving access to primary care and reducing often unnecessary admission to secondary care. The availability of a website for GPs to disseminate information on the development of PBC was supported.

In terms of the development of community services Middlesbrough was seen to be far more advanced than many other areas in the UK. It was considered, however, by a number of GPs that there were a number of barriers to overcome in order for GPs to be fully supportive of PBC as a means of commissioning appropriate services in community settings. The PCT representatives expressed a more positive view of the current PBC model in that an increasing number of GPs had shown commitment to the aims of PBC and how it fitted in with NHS world class commissioning programme to ensure effective services that met the needs of the population. It was hoped that further recruitment could be achieved to identify GPs with specific skills to become clinical leads.

The local NHS representatives indicated that there were no major disagreements between GPs and the PCT and that improvements and a better understanding of the process had been gained over the last two years.

Members sought clarification regarding current incentives to encourage GPs to be more fully committed to PBC. Reference was made to difficulties previously mentioned regarding the lack of resources to become available to develop innovative services. It was confirmed that in order to assist GPs to become involved in developing PBC there was a standard payment system whereby GP practices received between 60 pence to £2 per registered patient to reimburse them for clinical time spent on planning and developing local commissioning, attending meetings with the PCT and providing cover at the GP practices.

How PBC activity fitted within the strategic vision for services in Middlesbrough, particularly public health/ preventative services.

Given the increasing difficulties associated with alcohol abuse and obesity there was much evidence of health related problems seen at GP practices on a day to day basis. The importance of joint working arrangements to promote improved lifestyles was regarded as a very important aspect of current developments. Specific reference was made to ongoing joint working between the Council and the PCT in pursuing a Tees strategy for a health improvement programme.

Members asked the extent to which organisations were competing for the same resources in pursuing the public health agenda and enquired as to the likely impact of the current overall financial constraints on the PBC agenda. It was confirmed that the aim was for an integrated approach but there was acknowledgement of difficulties should there be any reduction in resources given the increasing demands on health services although it was emphasised that PBC continued to be part of the Tees Strategy for health improvement.

How local Practice Based Commissioning fitted in with national policy direction.

Confirmation was given that locally PBC was ahead of national direction and that with appropriate incentive schemes and refinement of current arrangements it was hoped to achieve greater engagement to PBC.

It was considered important to demonstrate that PBC made a difference and enabled the freeing up of resources to be allocated appropriately to ensure better health outcomes for patients.

It was acknowledged that there was a need to promote PBC to both health professionals and the public and to share information to a wider group of stakeholders. Specific reference was made to the south of the tees pbc website.

The mains areas identified by the local NHS representatives to secure improvements in Middlesbrough were indicated as follows:-

- maintain momentum and continue to progress current objectives;
- in order to extend the current commitment to PBC appropriate measures be taken to ease the development of new primary care based services;

- encourage greater clinical engagement from primary care professionals including nurse practitioners.

AGREED as follows:-

1. That the local NHS representatives be thanked for their contribution which would be incorporated into the final report.

2. That local NHS representatives be invited to a subsequent meeting to report on progress.

SCRUTINY REVIEW – RECOMMENDATIONS IMPLEMENTATION

In a report of the Scrutiny Support Officer details were provided of progress achieved with the implementation of agreed Executive actions resulting from the consideration of Scrutiny reports since the last update to the Panel.

It was confirmed that of the 97 recommendations, the 78 Executive actions, which should have been implemented by February 2009, had been completed.

It was suggested that future reports should include further information in respect of the Health Scrutiny Action Plans for those cases where the target date for the implementation of recommendations had not been achieved.

NOTED AND APPROVED

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 2 and 10 March 2009.

It was confirmed that consideration of a report outlining significant progress and improvements which had been achieved since the submission of the final report of the Health Scrutiny Panel on Audiology Services had been deferred to the meeting of the Board to be held on 7 April 2009.

Reference was made to the Board's consideration of the appropriateness of undertaking a scrutiny review into a suggested topic from a member of the public regarding dog fouling.

Specific reference had been made to a previous scrutiny review of Streetscene services, which had included the area for suggested investigation.

Whilst the Board considered that the topic was not appropriate for a scrutiny review at the present time it was felt that further measures could be undertaken to raise the public's awareness to the problems. It was also suggested that the possibility of increasing enforcement action should be examined. It had been agreed that the Director of Environment be advised of the Board's comments.

NOTED

STRATEGIC PLAN 2008 TO 2011 – REVISION 2009 TO 2010 – PROMOTING ADULT HEALTH AND WELLBEING – TACKLING EXCLUSION AND PROMOTING EQUALITY THEME

The views of the Panel were sought on the proposed health related content included under the themes of Promoting Adult Health and Wellbeing, Tackling Exclusion and Promoting Equality sub-sections of the 2009/2010 revision of the Council's Strategic Plan as outlined at Appendix A.

The Panel was advised that it had been proposed to fully revise the Strategic Plan for 2009/2010 in order to address changes to the national performance framework, including the introduction of Comprehensive Area Assessment (CAA) from April 2009.

The outline content was divided into two parts: -

- progress against 2008/2009 planned actions to address strategic priorities;
- 2009/2010 planned actions to address strategic priorities.

Members were advised that the proposed content was an early draft and would be subject to further change as the emerging Strategic Plan was reviewed and developed in collaboration with partner agencies. Target and outcome figures would also change as performance data was finalised for the end of the financial year.

It was intended that a report on the draft Strategic Plan incorporating the comments arising from the Scrutiny Panels would be considered by the Overview and Scrutiny Board at its meeting to be held on 7 April 2009.

The Panel acknowledged the work achieved in respect of progress against 2008/2009 planned actions to address strategic priorities.

At the Panel's request further information was provided in respect of each of the planned actions to address strategic priorities for 2009/2010.

As previously indicated Members emphasised the importance of including the Council's strategic aims in respect of the specific health and social care aspirations and Healthy Town initiatives for children and young persons. Members also indicated the need for reference to be made to the significant work being undertaken in relation to the Dementia Strategy.

AGREED as follows:-

1. That the progress achieved against 2008/2009 planned actions to address strategic priorities be noted.

2. That the information provided in relation to the draft health related content under the different themes of the Promoting Adult Health and Wellbeing, Tackling Exclusion and Promoting Equality sub-sections of 2009/2010 revision of the Council's Strategic Plan be noted and supported.

3. That the Panel's comments as outlined be incorporated into the report on the draft Strategic Plan to be considered by the Overview and Scrutiny Board at its meeting held on 7 April 2009.