HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 1 June 2009.

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

OFFICERS: J Bennington, J Douglas and J Ord.

** **ALSO IN ATTENDANCE:** C McCleod, Chief Executive, Middlesbrough Primary Care Trust.

**** APPOINTMENT – VICE CHAIR – HEALTH SCRUTINY PANEL**

The Chair sought nominations for the appointment of Vice-Chair of the Health Scrutiny Panel for the Municipal Year 2009/2010.

ORDERED that Councillor Dunne be appointed Vice-Chair of the Health Scrutiny Panel for the Municipal Year 2009/2010.

****APOLOGIES FOR ABSENCE** were submitted on behalf of Councillors McIntyre and P Rogers and, Dr N Rowell, Chairman, Middlesbrough Practice Based Commissioning Group, Endeavour Practice, Middlesbrough.

**** DECLARATIONS OF INTEREST**

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

**** MINUTES**

The minutes of the meetings of the Health Scrutiny Panel held on 30 April and 8 May 2009 were taken as read and approved as a correct record.

PRACTICE BASED COMMISSIONING – PANEL'S CONCLUSIONS AND RECOMMENDATIONS

Further to the meeting of the Panel held on 30 April 2009 the Scrutiny Support Officer submitted a report the purpose of which was to introduce the Council's Executive Director of Social Care and the Chief Executive of Middlesbrough Primary Care Trust.

The Panel's attention was drawn to Appendix 1 of the report submitted which outlined the evidence received so far in respect of its review on Practice Based Commissioning (PBC).

The Chair welcomed Jan Douglas, the Council's Executive Director of Social Care, who outlined the main thrust of the briefing paper provided at Appendix 2 a copy of which had previously been circulated.

Reference was made to the main drivers for the introduction of PBC, which had been introduced in 2005 and described as a key enabler for the policy of patient choice. The publication of Our Health, Our Care, Our Say in 2006 expanded on the part played by PBC on enabling patient choice, but also emphasised the pivotal role of PBC in delivering 'care closer to home'. Such a publication made it clear that 'care closer to home' meant care delivered in a place other than a large hospital.

PBC had therefore been promoted as a means of creating innovative pathways for patients in which a range of diagnostic tests, minor procedures, consultations and follow up appointments were delivered outside of hospitals. PBC had also been promoted as a means to control and ultimately reduce where appropriate the overall rate of GP referrals into the hospital sector.

As the focus on PBC was driven by a medical model in which clinical interventions predominated it was considered that the implementation of it had largely taken place without active engagement of the Authority's Social Care Department. It was felt that there were greater opportunities for Social Care to work collaboratively on PBC.

In order for PBC to realise its full potential it was felt that there needed to be a shift from PBC being regarded as a solely NHS issue but part of a wider inter-connected system. PBC had the potential to enable GP's to provide truly integrated care from a primary care base. It was acknowledged that clinical needs were impacted upon by social situations and therefore it was considered important to look at a persons' overall circumstances and improve the quality of life of patients and carers. There was an opportunity to examine current health budgets and how best they could be used for people with long term and chronic conditions and look at overall needs.

Following the recent Department of Health document on commissioning for health and well-being it was considered that the relationship between PBC and social care had become more pertinent. Such a document identified PBC as a way in which person-centred care could be enhanced 'by supporting discussions between GPs, social care practitioners and individuals, together with their families and carers, about how health and social care resources can best be deployed to better fit an individual's needs.'

In order for this to be achieved it was considered that there needed to be an effective mechanism to ensure that people were supported seamlessly through the boundaries of primary, secondary and social care.

It was felt that more flexible use of NHS funding through PBC, in collaboration with Social Care, would provide a much more appropriate alternative to hospital admission, or avoid more expensive interventions, which also reduced independence. An example was given as to how PBC could address the following all of which would make a significant contribution to health and well being: -

- purchase of respite care;
- supporting carers of terminally ill people;
- crisis avoidance and intervention;
- supporting healthy lifestyles;
- supporting independence of people with long term conditions;
- provision of citizen's advice, money debt management, advocacy, and return to work advice sessions;
- practice-based multi-disciplinary mental health resources;
- social and practical support for isolated older people.

In order to secure progress it was suggested that:

a) there should be much greater engagement with the Local Authority (via Social Care) by the PBC Clusters by means of social care representatives attending PBC meetings and /or Social Care being a formal consultee on all PBC business cases prior to their submission to the Professional Executive Committee;

b) the Local Authority contributing to the production of annual/biennial/triennial PBC strategic commissioning priorities based on analysis of need (such as the JSNA) patient/public engagement (via LINks for example) and agreed outcomes.

The report concluded that Social Care had many years experience of commissioning services to meet need and deliver good outcomes and of experience of engaging with users and carers in shaping services to meet needs. Social Care had a statutory responsibility to promote community well being and had well developed networks with persons who were regarded as 'hard to reach groups.'

In commenting on some of the hindrances of achieving greater engagement with Social Care it was acknowledged that PBC was relatively new and understandably initial focus had been on clinical and medical interventions.

The Executive Director of Social Care confirmed that although there was a standing invitation to attend PBC Cluster Group meetings the extent of involvement in such meetings was difficult given the focus on clinical intervention. It was felt that there was scope for a more positive engagement from Social Care. It was acknowledged however that PBC was relatively new

together with many other recent changes and initiatives which were currently being developed by the NHS. An assurance was given however that there was a willingness to engage further.

Colin McCleod, Chief Executive, Middlesbrough PCT concurred that PBC was considered to be relatively new and that at the same time the NHS had been subject to many other changes.

The Panel was advised that in response to a concern regarding a lack of drive for PBC a meeting had been arranged for all GPs and representatives of the Local Medical Committee. It was confirmed that significant resources had been allocated to support PBC which included a sum of £600,000 per year, which had been allocated to pay GPs for active participation and delivery of PBC.

Mr McCleod acknowledged that clinical interventions would always be the main driver for PBC and there was much work to be achieved however it was recognised that although difficult there would be scope for more involvement of social care in future deliberations.

Of the 21 GPs involved with PBC it was reiterated there was probably only around 6 GPs who were fully committed to PBC. For many GPs, PBC represented a major change of culture and moving from a position of diagnosis, prescribing and referring. The need to improve clinical engagement and to achieve a better understanding of the benefits of PBC remained a significant challenge. It was noted that not all GPs would be working on major service issues. Given the long-standing relationship between Middlesbrough and Eston (Redcar and Cleveland) PCTs and as Eston had been seen as a catalyst of change it was felt that there was potential for joint working.

As an incentive to GPs 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. Apart from financial assistance reference was made to other support such as the dedicated PBC staff and the provision of training/education sessions on a monthly basis.

To ensure further progress there was a recognised need to go beyond the involvement of around 6 fully committed GPs to PBC and to involve other agencies. It was intended to establish a Strategic Development Group involving multi organisations to deliver PBC strategies. In order to achieve greater involvement of GPs it was thought necessary for current systems to be made easier to encourage such engagement. The current process was considered to be very time consuming and there was a risk that people could easily loose the momentum and a concern that they don't necessarily see the eventual outcomes and results. It was considered that the Strategic Development Groups could examine these issues together with the opportunities of improving the current incentive schemes. It was also felt that utilising the current service network with greater involvement of service users would be beneficial to the overall process.

Reference was made to specific strands of work in particular the re-designing of elderly care, which involved a number of agencies such as the Authority's Social Care. Other key areas of work included areas such as achieving a reduction in the admissions to hospitals.

The Panel specifically referred to the work commissioned in terms of elderly care. The development of such a project which was seen as providing an opportunity of moving away from a purely medical model to that of a clinical and social care model.

Members sought clarification as to the opportunities for GP practices to re-invest. Reference was made to the current system of fair share allocation for practices where the amount of resource was allocated to a practice based on the relative needs of their populations.

An indication was given of the mechanisms in place to ensure quality and consistency of service. It was reiterated that PBC was not designed to address such issues and that other measures were in place including clinical audits and performance systems in place.

The establishment of 8 specific workstreams was considered helpful in providing strategic direction in driving PBC forward.

In response to clarification sought from Members an assurance was given of the governance arrangements which provided clear requirements to deliver PBC. Whilst the Middlesbrough PbC Group had been assigned to deliver health improvements through a commissioning process the responsibility of delivering PBC remained with the PCT.

Whilst there was a clear commitment to deliver PBC it was acknowledged that there were opportunities to make improvements with particular regard to pursuing further engagement with Social Care.

Reference was made to the main objectives of world class commissioning which would enable the NHS to meet the changing needs of the population and deliver a service which was patient centred and responsive to local needs. It was also noted that the aims of world class commissioning encouraged greater patient engagement. Although world class commissioning supported the shift from treatment and diagnosis to prevention and the promotion of well being it was recognised that in areas such as across Teesside there were industrial scale problems to tackle. It was felt that with current directives/measures together with appropriate training GPs had greater opportunities to take a more holistic approach to treating patients.

Members expressed concerns as to what measures were in place to ensure the empowerment and assist vulnerable patients. A comparison was made with the introduction of Direct Payments which at first involved 40 people and now after two years nearly 500 persons had opted for this procedure. It was agreed that a joint approach was required involving families, carers, social workers together with NHS representatives.

Members asked about the availability of comparative information of other PCTs in progressing PBC. In response it was noted that in overall terms most PCTs were facing similar challenges and with current guidance an assessment was presently being carried out to determine the current position.

Although it was acknowledged that there were constraints in the system it was suggested that the establishment of the Strategic Development Groups with different workstreams would assist in progressing PBC.

AGREED as follows: -

1. That the Council's Executive Director of Social Care and the Chief Executive of Middlesbrough PCT be thanked for the detailed information and participation in the subsequent deliberations the outcome of which would be incorporated into the overall review.

2. That the Chair and Vice Chair consider the evidence so far in relation to Practice Based Commissioning and that a further report be submitted to the Panel.

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 the meetings of the Overview and Scrutiny Board held on 16 April and 5 May 2009.

NOTED