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AGENDA ITEM: 4

HEALTH SCRUTINY PANEL

10 AUGUST 2009

PRACTICE BASED COMMISSIONING
DRAFT FINAL REPORT

PURPOSE OF THE REPORT

1. To present to the Health Scrutiny Panel a DRAFT Final Report, following the evidence gathered during the review into Practice Based Commissioning (PBC).

RECOMMENDATIONS

2. That the Panel considers the DRAFT Final Report and considers the Conclusions and Recommendations it would like to make.

EVIDENCE GATHERED

3. In considering a review into PBC and its impact on the health and social care economy in Middlesbrough, the Panel felt that a briefing on the origins and content of PBC policy would be highly beneficial. This briefing took place at the Panel's meeting on 5 February 2009.

4. The Panel heard that the overall aim of PBC was to improve access to and quality of services. The advent of PBC was first announced in the NHS Plan in 2000. It was further developed in the NHS Improvement Plan, which stated that from April 2005, General Practices that wished to be active in PBC would be given indicative commissioning budgets.

5. The Panel heard that extensive guidance had been produced including in October 2004, the Department of Health set out proposals for PBC which incorporated the following:

5.1 That GP practices would play an important role in commissioning services for their patients and local populations

5.2 That patient choice would be a key driver for quality and empowerment and PBC would secure a wider range of services, respond to local needs and give patients wider choice

5.3 That practices would be able to direct funding of packages of care for long term conditions

5.4 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

5.5 That more efficient use of services would be provided

5.6 There would be greater involvement of frontline doctors and nurses in commissioning decisions

6. The Panel was advised that patients would not be unfairly disadvantaged should a practice decide not to take up PBC. In order to prevent any disparities, it was said that there is a national tariff for services. The Panel heard that 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 hospital settings.

7. There was an enquiry as to whether PBC was actually just GP Fund Holding under another name. The Panel heard that, in the view of those presenting to the Panel, this was not the case. Unlike GP Fund Holding, PBC did not have additional resources going to General Practices which took PBC onboard and there is a ‘level playing field’ for all practices whether they wanted to take advantage of PBC or not.

8. It was said that current government policy encouraged a plurality of providers aimed at putting the interests of the patient first. The Panel heard that it was important for the PCT to work with local General Practice to ensure that appropriate checks and balances are in place to increase patients’ choice and access services locally where appropriate. The Panel felt that if this was to be genuinely delivered, appropriate governance systems would be required to be put in place to avoid any conflicts of interest.

9. The Panel heard that the current position of PBC across General Practice in Middlesbrough PCT and Redcar & Cleveland PCT is as follows:

9.1 Middlesbrough PBC Group (21 GP Practices) serving a population of 153,000

9.2 Langbaurgh PBC Group (15 GP Practices) serving a population of 97, 392

9.3 Eston PBC Group (5 GP Practices) serving a population of 36,000

9.4 Ravenscar Practice in Redcar has chosen to be a stand alone commissioning practice

10. It was confirmed that all PBC Groups are working towards a Commissioning Plan and General Practice with the three groups have a formal agreement that

10.1 All Practices have received a fair share of indicative budget for the agreed scope of services

10.2 PBC Groups have endorsed and signed up to the 2008/9 incentive scheme

10.3 The PCT provides minimum activity data via MIDAS to practices and additional support to practices

11. The Panel heard that one of the key objectives was to improve relationships between the PCT and some GPs. Secondly, it was felt that a better understanding of the objectives of PBC was required.

12. The Panel was interested to hear about some possible challenges facing PBC and made enquiries about ramifications should General Practice overspend its allotted budget. The Panel was advised that it was hoped that such a scenario would never arise, as there was an intention for the PCT to have performance management systems in place and for budget monitoring in a constructive challenging way. It was confirmed that should all GPs overspend, the PCT would ultimately have a statutory responsibility to resolve the matter. The Department of Health guidance indicates that there is a 5% variance provided.

13. The Panel also heard about a new quality framework to be developed to ensure that patients receives the same level of service wherever they go in the PCT area.

14. The Panel was interested to hear the views of those present about what was needed to advance PBC in Middlesbrough. The Panel heard that the following were important points to bear in mind.

14.1 There should be effective systems for clinical leadership and processes that supported all clinicians leading and shaping design.

14.2 There should be a clear and shared vision for how PBC could help deliver the PCTs strategic agenda and good alignment between strategic plans (PCTs) and operational PBC commissioning plans.

14.3 There should be clear rules of engagement as to how the PCT/PBC groups could work together to deliver what was wanted and needed to be delivered.

14.4 There should be processes and governance that enabled PBC to advance, but were supportive, transparent and defendable.

14.5 There should be integrated working between PBC and Service Reform Teams that ensure a streamlined and systematic approach to developing new pathways of care and services.

14.6 The Panel was also told that there should be detailed patient and public involvement throughout.

15. The Panel was interested to hear about the challenges that were currently faced when attempting to implement PBC across Middlesbrough.

16. The Panel heard that, in the view of those present, there is in some cases weak clinical leadership and that in some instances, PBC Chairs lack the ability and time to progress PBC in working practice hours.

17. It was felt that a fuller range of primary care colleagues should be engaged with and that there should not be the level of concentration of engagement that there is with such people as PBC leads and practice managers. The Panel heard that such people are important to engage with, but are not the only people that should be engaged with.

18. The Panel was told that fairly basic topics such as information on budgets and governance processes could be improved and more widely communicated, in addition to improving the transparency of relationships of those involved, particularly between the PCT and PBC groups with a willingness to develop 'critical friend' relationships.

19. The Panel heard that there is a potential danger that PBC Groups will feel threatened by the PCTs strategic agenda, and continue to focus upon operational plans for commissioning. This is a theme that the Panel expressed an interest in exploring as the review went on.

20. The Panel was interested in the level of clinical involvement/enthusiasm about PBC. It was said that of 21 GPs involved with PBC, it was probably only around 6 GPs who were fully committed and involved with PBC. It was felt that this highlighted a point perfectly, in that there was a significant challenge to improve clinical engagement and to achieve a better understanding of the aims and benefits of PBC.

21. The Panel heard that it was widely 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 Clusters to gain a better understanding in terms of budgetary arrangements and that the PCT had overall commissioning responsibility.

22. The Panel heard that PBC is 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: -

22.1 clinical engagement should be real and robust to help shape and inform local strategy;

22.2 commissioning would be based on real local needs assessment and PBC Groups would be key local partners;

22.3 PBC Groups would help to design local quality contracts and quality outcomes would be monitored and audited;

22.4 Genuine local targets would be developed;

22.5 Meaningful partnerships with the local population would be developed in order to bring evidence to policy and prioritisation of interventions;

22.6 budgets would be managed locally in order to get high quality cost effective health care;

22.7 reliable local data streams would be created to inform and supply world class primary care provision;

22.8 PBC Groups would bring vitality and responsiveness to PCT.

23. 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. The Panel heard that 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.

Meeting of the Health Scrutiny Panel on 26 February 2009

24. Following the initial briefing received by the Panel on 5 February 2009, the Panel was keen to advance the discussions and at its meeting on 26 February 2009, considered the views of the chair of the Middlesbrough PBC cluster, who is also a serving GP in central Middlesbrough. In preparation for the meeting, the Panel posed some initial questions it wanted to focus upon. Those questions were

24.1 What are your views on the origins of the PBC policy? Specifically, has your experience indicated that the policy aims of PBC are being met?

24.2 What are your views on how PBC is organised in Middlesbrough?

24.3 What sort of impact has PBC had on service design/service provision in Middlesbrough

24.4 How would you like to see PBC develop in the next 3 years?

25. The Panel received a paper from the Middlesbrough PBC Cluster Chair outlining some views on the above question and the meeting took the form of a debate about the issues raised.

26. The Panel heard that PBC is fundamentally concerned with engaging General Practice and other primary care professionals in the commissioning of services. The Panel heard that whilst PCTs are the budget holders and have overall

accountability for healthcare commissioning, PBC is crucial at all stages of the commissioning process.

27. It was said that the policy aim was that front line clinical staff would become integral in the commissioning of high quality services for patients in local and convenient settings. Further, that primary care clinicians, such as GPs and nurses, are in a prime position to translate patient need to redesign services that best deliver what local people want.

28. The Panel heard that one of the inherent challenges in PBC is that it can take time to do it well. The Panel was given an example of when the Middlesbrough PBC cluster undertook a great deal of work in identifying patient needs/wishes in relation to sexual health services. It designed a service around those needs and calculating the likely infrastructure cost, before being told by the PCT that the services designed would be required to be put out to competitive tender.

29. The Panel heard that the experience of PBC to date highlights that to do it well, takes time. It can require detailed analysis of patient need and then the designing of services and development of staff to fit those needs. It was highlighted however, that government policy can change very quickly, thereby necessitating that certain things do or do not happen. It was said that clinical professionals do tend to think more long term and do not put the same degree of emphasis on meeting short-term political needs.

30. The Panel heard, therefore, that it is perhaps not a surprise that only 62% of practices support PBC and only two thirds of practices have agreed a commissioning plan, with 58% confidence that their commissioning plan will improve the quality of patient care.

31. The Panel heard that with a national perception amongst those in primary care that the goalposts are often moved, it is easy for practices to feel disenfranchised.

32. In so far as the development of PBC in Middlesbrough is concerned, the Panel heard that its progress had suffered as a result of the PCT reorganisation in 2006. the Panel heard that there were PBC teams developed in practices in 2005, but between 2006 and 2008 they lacked the requisite managerial support from the PCT. When the PCT appointed a new commissioning team, the Panel was told, it was unsure of its role in relation to PBC and demonstrated a fairly risk averse approach.

33. The Panel heard that it is ultimately the PCT which has responsibility for financial balance and therefore ‘holds the purse strings’. It was said that because of this, the PCT is very unwilling to let go of the money and allow General Practice to take any risks, in the sense of trying new approaches, which may or may not work. Whilst understandable in a national political climate which is very critical of any sort of perceived inappropriate NHS spending, the Panel was told that it can and does inhibit new developments and innovative thinking.

34. In addition, the Panel heard that the PBC Cluster was unable to spend any money until it had made some savings, which takes time.

35. The Panel was told that the development of community services in Middlesbrough is actually quite advanced and seemed to be well placed when compared to elsewhere. It was confirmed that there are now community services available in muscular skeletal medicine, dermatology, genitourinary medicine, minor operations and skin surgery. The Panel heard that the Middlesbrough PBC Cluster has started to look at ear nose and throat (ENT) and gynaecology services to identify some elements that could be provided appropriately in the community.

36. The Panel was told, however, that in services being moved out into the community, there are financial ramifications particularly for the big hospitals. An example was given around a screening service to identify patients with heart failure, due to start in May 2009, which would be using up to date echocardiography machines and BNP blood testing. BNP Blood testing is only available to a minority of patients in the UL and is a model favoured by the British Society of Heart Failure. It was said that this service has the potential to prevent 400 people having to go to James Cook University Hospital. It was acknowledged that whilst it was good for these people, it also meant that the money associated with those patients also does not go into James Cook, which means that less money goes into an excellent local hospital.

37. The Panel was interested to hear that in the view of the PBC Cluster, the internal market which is now prevalent within the NHS is a major barrier to working together to provide services across the primary and secondary care sectors. The Panel was told that it is difficult for hospitals to work with other service providers, aiming to re-provide their services in the community when it will financially disadvantage the hospital. The Panel heard that whilst this is indicative of national policy, it requires hospitals to consider actively diverting some of their income. The Panel felt that this was an important point to consider. In addition, the Panel heard that GPs have no wish to deprive such hospitals as James Cook University Hospital of income. It would be of no benefit to the community to have a hospital with less income, so the policy can place considerable tensions on the local healthcare system. In addition to the theme of 'joint working', the Panel heard that a lot of NHS money sits in 'silos' and is forcefully guarded, which can make joint working extremely difficult.

38. Nonetheless, the Panel was told that there has been some significant success stories for local PBC, with the genitourinary clinic certainly being one. In addition, the Panel heard that educational sessions for GPs and practice nurses have been successful. The sessions were proposed by the PBC Cluster Chair to promote good practice, and the effective use of local resources. The sessions are apparently well attended and growing in popularity and they are fundamentally aimed at ensuring GPs and practice nurses are as well informed as possible, which will in turn improve the quality of referrals and the appropriateness of those referrals. It was felt that the role of some sort of 'policeman' was a role that PBC could assume in the future, dealing with practices who perhaps over or under refer, or over prescribe.

39. In conclusion, the Panel heard that in the view of the PBC Cluster, progress of PBC had been slower than one would have liked, due to the reorganisations of PCTs and the Cluster has also felt that at times it is not a priority. The Panel heard that it is only in the last year or so that a workable team has developed.

40. In terms of developing PBC within Middlesbrough, the Panel heard that the Cluster would like to see greater public involvement within PBC and a greater involvement of senior managers within the PCT with PBC. The Panel heard that the PBC Cluster would also like to see a climate whereby PBC can experiment with new ways of working, without a lot of blame if the new way of working is not particularly successful.

Panel meeting on 19th March

41. The Panel was keen to hold one further meeting, whereby it could discuss the points raised and evidence gathered at the previous meetings. The Panel hosted a roundtable debate with representatives from the Commissioning Directorate of Middlesbrough PCT and the Middlesbrough PBC Cluster.

42. One of the key themes that the Panel wanted to explore about PBC was the topic of NHS performance measures, which at times can be fairly quantitative, over quality of service, where the patient experience is investigated. Members were also keen to debate the point around the equality of service quality, which is particularly pertinent when one considers the notion of General Practice commissioning services.

43. It was said to the Panel that as a policy, PBC is not necessarily focused on the quality of services, but to ensure that General Practice is much more involved with the Commissioning processes.

44. Whilst accepting the reality of the policy's intention, the Panel was concerned that PBC did not have more of a focus on the quality of services that were being commissioned or provided by General Practice. It was said that to ensure the quality of GP services, the system had to ultimately rely upon the formal complaint route, or the General Medical Council route, which can strike people off.

45. A comparison was made with the National Service Frameworks (NSFs) which exist for a number of conditions. For instance, the Cancer NSF stipulates the standards of care and the associated timeframes that someone can expect to be applied to them when having their treatment. Whether a person lives is Cornwall or Northumberland, or anywhere in between, there are a core set of standards which exist to stipulate that any given person should receive certain treatment, within a certain timeframe.

46. It was noted that there is no such accompanying document or standard in General Practice. It was acknowledged that GPs were judged on their performance against the Quality Outcomes Framework (QOF), although that is much more of an NHS process, which doesn't necessarily help 'the man in the

street' in understanding whether he is receiving appropriate services from General Practice. Further, it was said that a given GP's prescription activity could also be monitored and checked to investigate their conduct.

47. The Panel felt, however, that what the system seemed to lack was a process which guaranteed (as much as is possible), that person A would receive the same treatment as person B, when they are accessing different GPs with the same sort of symptoms.

48. The role of the Patient Advice & Liaison Service (PALS) was discussed. The purpose of PALS is a system whereby people make enquiries, ask questions and submit comments before entering the formal complaint process. It was felt that PALS was useful in addressing people's concerns or queries over services received in General Practice, but at present it could be argued to suffer from a lack of clinical input.

49. It was felt that if an individual had concerns over the care they had received by a GP, it would be useful for a clinical input when the person's query was considered by PALS,. This would enable an assessment to be made as to whether the individual, given their circumstances, was treated appropriately by the GP and their case handled appropriately. The Panel felt that this seemed like an idea that could be built on.

50. The Panel was also keen to explore whether PBC will deliver equity of services, as well as hopefully improved services. It was confirmed that services commissioned by the PBC Cluster would be available to all GP referrers, even if they were not involved in the services' commissioning. It was therefore confirmed to the Panel that no patients would be excluded from services. The Panel was pleased to hear this and to have it confirmed that people would not have better or worse access to PBC commissioned services, due to the General Practice they were registered at.

51. The Panel was interested in the views of those present as to how PBC could be improved in the next two to three years. The Panel heard that it was felt important that more GPs become involved in the process, so a strong clinical leadership, which was more diverse than it is currently, could drive PBC.

52. The PCT told the Panel that it was confident that GP engagement would improve in the near future, partly due to an incentive scheme (launched in April 2009) agreed with General Practice in Middlesbrough. The purpose of the incentive scheme is to encourage practitioners to attend forums and contribute to the debate on given topics. The incentive scheme pays for such things as locums to cover surgery, to ensure that GPs have the time and opportunity to engage with the PBC process. The Panel felt that the PBC would therefore inevitably benefit from having such expertise and experience in regular attendance. In addition, the Panel was advised by all present that there was reason for optimism in relation to GP engagement, specifically due to much improved relationships between the PCT and the PBC Cluster and it was felt that the incentive scheme would bear fruit over time.

53. In relation to GP input, it was felt that even those GPs who are not necessarily involved with PBC presently are grateful for their colleagues who are, although it was felt that getting more GPs involved with the process, would be beneficial. It was also suggested to the Panel that some GPs may become more interested in PBC if it was felt to be a swifter process from the conception of a service development, to it being enacted. It was felt that the current period of two years to develop and enact a new service was slow and would discourage some people from getting involved.

54. It was also felt that PBC provided opportunities for General Practice to become involved in the provision of services as well as the commissioning of them. Should GPs have a special professional interest in a given service area, they could become involved in the provision of that service.

55. The Panel was told that the PBC Cluster in Middlesbrough was keen to look into possible new services and it was felt that there may be potential for service developments around elderly care practitioners.

56. Nonetheless, it was confirmed that when new services are investigated, researched and enacted, it was important that they fit into the regional and local strategies for health and health service development. It was said that themes such as alcohol and obesity were a good example, where PBC could play a part in tackling them, although it was a fundamental problem for wider society, in which GPs are only one cog.

57. The Panel heard that GPs and the Middlesbrough Cluster were also not averse to resources being spent on services, which are not traditionally ‘healthcare’. It was said that a good example of this was the programme of spending PCT monies on free swimming for example as an excellent proactive initiative. The point was made to the Panel that Public Health Directorates of PCTs would have their own funds to support such developments, although it was felt that PBC Clusters could offer additional funds to assist such initiatives.

58. Nonetheless, the point was made to the Panel that PBC would be required to work across all strategic priorities of the local NHS, which would also include some areas of service that were concerned with assisting people who are already unwell or have existing problems. Whilst investing PBC funds in preventative measures was important, it was acknowledged that PBC had wider responsibilities across a spectrum of patients, which could assist Public Health directorates but not necessarily repeat their functions.

59. Having made that point, it was said that public health has never had a higher profile than it currently enjoys in the NHS, with a realisation that paying for services that are not traditionally ‘healthcare’ can be beneficial. It was felt that this was likely to be borne out when PBC Clusters are considering services to commission. The Panel was certainly clear that in the coming ‘leaner years’ for the NHS, it would not want to see the great work around public health be a casualty.

60. In terms of what needs to happen now, the Panel heard that the PCT needs to continue its support for PBC, at the highest level, and its needs to support the incentive scheme for General Practice to become involved in discussions. The PBC Cluster also needs to demonstrate that it is having an impact and is playing a substantial role in delivering better services.

61. The Panel also heard that there needs to be a greater 'can-do' approach to service development, in the sense that if a proposal is workable, fits with strategy and looks like a positive development, it should be enacted quicker. Swifter delivery of service developments will also encourage more people to become involved as they will see the impact PBC is having.

62. In conclusion, the Panel heard that PBC needs to maintain and develop its momentum, with the whole local health economy needs to see PBC as important. The Panel heard that there is a perception within the PBC Cluster that its ideas can be 'parked' and the Cluster would like to see that change. The Panel also heard that the PBC Cluster would like to see wider clinical engagement. It was said that people like nurse practitioners have a great deal of experience in, and exposure to, particular topics and that should be tapped into.

Meeting of the Health Scrutiny Panel on 1 June 2009

63. Following on from the evidence gathered up to this point, the Panel was interested in hearing the views of the Director of Social Care at Middlesbrough Council and the Chief Executive of Middlesbrough PCT. The Panel considered a paper prepared by the Director of Social Care outlining the departmental experience of PBC in Middlesbrough thus far.

64. The Panel heard that when Practice Based Commissioning (PBC) was introduced in 2005, it was 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 to be played by PBC on enabling patient choice, but it also emphasised the pivotal role of PBC in delivering "care closer to home."

65. The Panel was advised that Our Health, Our Care, Our say made it clear that "care closer to home" meant care delivered in a place other than a large hospital. This shift was justified by the Department of Health on the grounds of more convenience for patients, who, it is justifiably argued, do not want to plan their lives around multiple visits to large hospital sites.

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

67. In short, the focus of PBC was driven by a medical model in which clinical interventions predominate.

68. The Panel heard that in the view of the Department of Social Care It is not surprising, therefore, that the implementation of PBC in Middlesbrough has largely taken place without the active engagement of the Local Authority Social Care Department.

69. The Panel heard the view expressed that for PBC to realise its full potential it needs to shift from being regarded as an NHS issue, to something that is part of a wider inter-connected system. There are many common agendas between primary care and social care. PBC has the potential to enable GPs to provide truly integrated care from a primary care base. It was said that it is understandable as to why PBC has consistently been clinically focussed, although it remains the case that by confining thought to clinical matters represents an opportunity missed.

70. The Panel learned that the relationship between PBC and social care has, in fact become even more pertinent following the recent DoH document on commissioning for health and well being. This identifies PBC as a way in which person-centred care can 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."

71. It was said that for this to happen there needs to be an effective mechanism to ensure that people are supported seamlessly through the boundaries of primary, secondary and social care.

72. The Panel heard that a 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 reduce independence. Some examples were given to the Panel as to the sorts of things that PBC could address:

- 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

73. It was felt that none of the above might be regarded as a traditional NHS function, but all of which make a significant contribution to health and well being.

74. The Panel heard that in the view of the Department of Social Care, there is little tangible evidence that Practice Based Commissioners have yet reached a full

understanding of this. The Panel was told that Social Care does not seem to feature significantly in PBC's thinking.

75. The Panel was interested to hear about the views of the Department of Social Care about a way forward. It was suggested that the following two actions will make a significant contribution to ensuring that PBC genuinely does become part of the wider inter-connected system:

- Much greater engagement with the Local Authority (via Social Care) by the PBC Clusters. This could take the form Social Care reps attending PBC meetings, and/or Social Care being a formal consultee on all PBC business cases prior to their submission to the PEC.

- 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 etc) and agreed outcomes. It is not clear, for example, how PBC contributes to delivery of the Community Strategy, or the Local Area Agreement.

76. In conclusion, the Panel heard that the Department of Social Care has many years experience of commissioning services to meet need and deliver good outcomes, with many years experience of engaging users and carers in shaping services to meet needs. Social Care has a statutory responsibility to promote community well being and has well developed networks with so called "hard to reach groups."

77. The Panel was told that it seems wasteful for PBC not to make use of Social Care's resources, knowledge, networks and experience, and the lessons it has learned from mistakes along the way.

78. At the same meeting, the Panel also heard from the Chief Executive of Middlesbrough PCT. The Panel heard that so far, the PCT has found the amount of progress made by PBC frustrating. The Panel heard that practices across the South of Tees area have received around £2.5 million and is highly debatable as to whether there has been a return consistent with that level of investment. A detailed picture of investment in PBC is outlined below.

79. The PCT has invested significant resources to support PBC as follows:

- PBC Incentive Scheme Almost £1million over the last three years

- Chairs £10,000 in 08/09, to be repeated in 09/10

- Delivery Agreement £50,000 for delivering agreed objectives in 2008/09

- Five clinical leads £50,000 in 2008/09 looking at agreed priority areas [Out of Hours / Long Term Conditions / Mental Health / orthopaedics / community services]

- Education Sessions Delivering monthly education, support and development opportunities for PBC at a cost of almost £38,000

- There are also dedicated staff for PBC including a senior PBC Manager, Senior Finance Manager for PBC and PBC Account Manager

80. In addition, to the above areas of investment in PBC, the Panel has noted that PCT also provides a degree of challenge to proposals which is essential as the responsible financial authority, although perhaps this is not always entirely appreciated by PBC. The Panel heard that the PCT Chief Executive would agree that the PBC model does not, at presently, sufficiently involve Social Care and has an overly clinical focus.

81. It was said that there are around 5 or 6 GPs in Middlesbrough who are actively engaged with PBC and the PCT supports those GPs in their PBC related endeavours. Nonetheless, it was said that for PBC to become an integral part of the healthcare planning environment, there needs to be greater involvement from the majority of GPs who are currently not particularly involved. If nothing else, it was noted that the 5 or 6 GPs currently and actively involved run the risk of ‘taking too much of the weight’.

82. It was felt that there is probably scope for a debate about what PBC means for Middlesbrough and to specifically consider the following questions.

83. At what stage of PBC do GPs want to be involved?
84. Do GPs want to be commissioners or service providers?

85. The Panel was interested to hear about how PBC and particularly the engagement of GPs in PBC, could be improved. The Panel was told that the PCT ha recently published a new Strategy which has eight core themes. Each of those core themes has a multidisciplinary Strategy Delivery Group responsible for delivery of the PCT Strategy. It was felt that PBC representatives could be active participants in those groups and such involvement may encourage more interest and recognition of role that PBC can play.

86. The Panel heard that the PCT was keen to identify other ways in which it could provide incentives for General Practice to get more involved with PBC. It was said that the PCT is considering allocating around £500,000 for PBC to control and utilise for pump priming projects to deliver improvements in community services. Specifically, it was said that dealing with people with respiratory illness was a good example of where services could be improved with such money.

87. The Panel heard that presently too many people with respiratory illness ‘end up’ in JCUH with crises in their condition, when such a condition could be better managed by experts in the community, which would also reduce the number of crises. This would have a two-fold benefit, which would reduce the number (and expense) of people having to enter JCUH and it would be much better for the

patient to avoid the trauma of such crises. As an example it was said that an appointment with an appropriate specialist costs around £75, whereas as soon as someone requires a bed the costs can start at around £1000.

88. The Panel heard that there is a clear need for such innovative thought about service design, as despite Middlesbrough having a high level of need in some areas of medicine, there is a disproportionately high reliance on hospital services.

89. It was felt, therefore, that if such pump priming funds are well used, such investment would pay for itself over time. A clear benefit for General Practice was the suggestion that any savings made could be re-invested in General Practice services. The Panel was told that a natural consequence of this would be that JCUH could receive less money, although there are other areas where it could develop income.

90. As a point of clarification, the Panel enquired as to whether the PCT could ascertain the nature of practice surpluses and ensure that those surpluses were appropriate. The PCT assured the Panel that through such tools as clinical audit, practice activity can be monitored to sure that the area and amounts of savings are appropriate.

91. It was said that PBC will probably always be clinically led, although most interventions it could design should have a substantial element of Social Care type involvement. It was confirmed that to look at PBC as a purely medical tool operating in purely medical circles would mean that it was missing a massive area of opportunity.

92. The Panel heard that one issue to consider is that when debates are established (such as those which would take place in Strategy Delivery Groups) about development of services, it can be perceived that there are 'winners' and 'losers'. Nonetheless, the local NHS, led by the PCT, is obliged to look at the optimum service configuration for patients and their experiences, not necessarily what providers of services would most like to see.

93. It was confirmed that a commitment exists on behalf of the PCT to make PBC, and the view remains that PBC can play a hugely important role in developing services for the best interests of patients. Vital to its success, the Panel heard, was that PBC had more than the current (rather low) numbers of clinical leaders and that clinical engagement increase significantly.

94. The Panel heard that there were two outstanding benefits to greater clinical engagement with PBC. Firstly, a PBC programme with greater General Practice input stands a much better chance of accurately understanding the local health need and delivering the services to match that need. Secondly, a major component of a GPs work is concerned with making accurate and appropriate referrals to address a patient's complaint. General Practice has a much better opportunity to be aware of all that is available to refer to, if it is actively involved with PBC.

95. Related to this point, the Panel has subsequently heard that only a small proportion of a PBC innovation fund was used in the last year, which is of great interest to the Panel and probably strikes at the heart of the PBC paradigm. Most GPs will (probably) become involved in PBC when it has some impact to its name, although that success will probably only come about when there is greater clinical involvement. The Panel would be interested to see ways in which that funding could be used more, as the only restrictions on the funding seems to be that it would reduce the patient flow (where appropriate) into JCUH and helps to deliver a theme of the PCT's Strategy.

96. In addition to the above point, the Panel heard that it is important to recognise that PBC is ultimately **Practice** Based Commissioning, as opposed to exclusively GP based commissioning. There are a number of highly knowledgeable and skilled medical staff in based in General Practice that could contribute a great deal to the debate if they could be engaged.

97. The Panel also explored the suggestion that getting services implemented that have been conceived through PBC can take a long time. It has been accepted that it does seem to take a long time, although service design can take a long time to get right. The Panel heard that the perception that nothing was happening as a result of PBC was incorrect and there were services developing past the business case stage including:

- Vasectomy service
- Waiting list initiative to reduce physiotherapy waiting time
- Practice Pharmacist
- Long Term Condition Nurse Practitioner
- Heart Failure

98. In conclusion to the discussion, it was felt that a key element to establishing PBC as an important part of the local health and social care economy, one key question had to be tackled. That was the question was how could General Practice become involved in PBC and consider PBC beyond the boundaries of their practice. By definition, PBC requires a degree of altruism from General Practice and a degree of thought about the workings of a system beyond their practice.

Conclusions

The Panel is asked to consider what Conclusions it would like to make in relation to the PBC Review.

Recommendations

The Panel is asked to consider what Recommendations it would like to make in relation to the PBC Review.

BACKGROUND PAPERS

Please see the minutes of and the supporting papers to the Health Scrutiny Panel on 5 February 2009, 26 February 2009 and 19 March 2009 and 1 June 2009.

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