ATTACHMENT 2.3

Draft

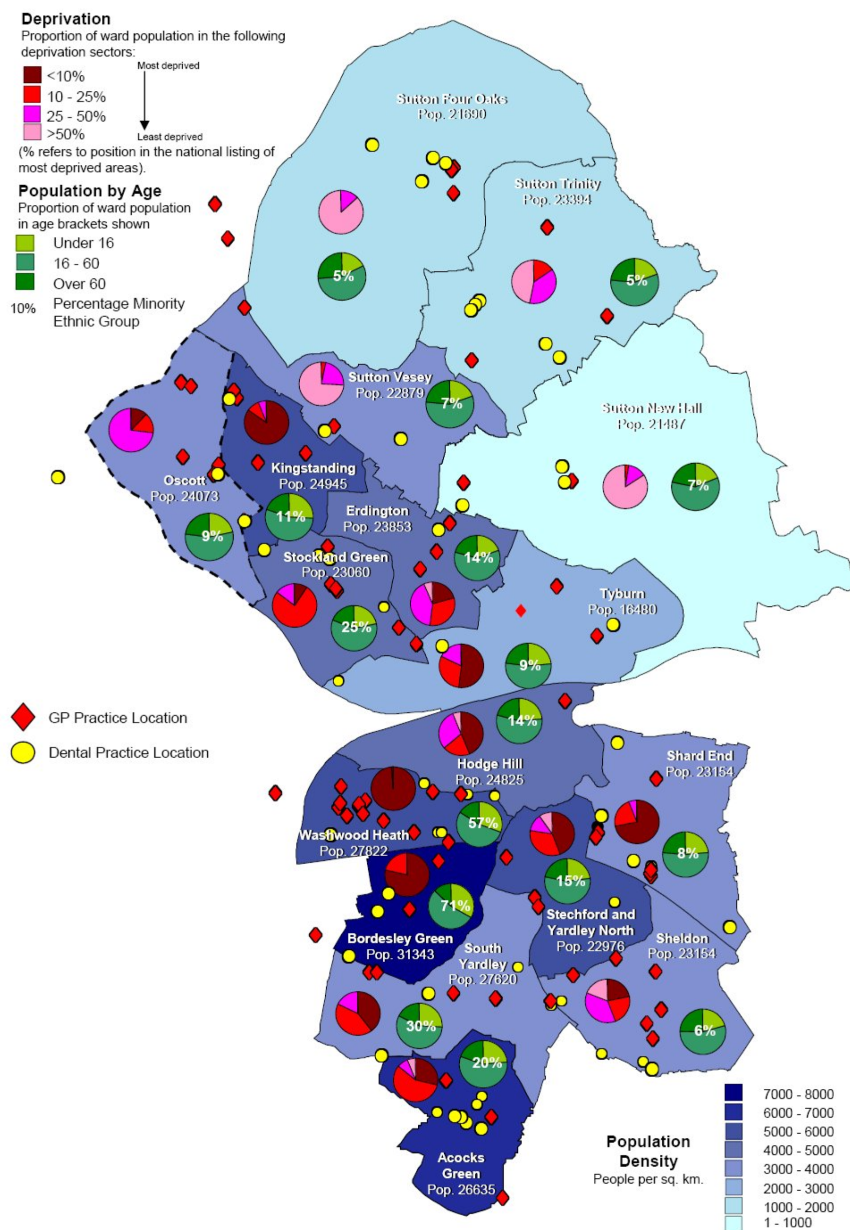
Birmingham East and North Primary Care Trust

Primary Care Overarching Strategy

1. Context & Scope

1.1 BENPCT is one of 153 Primary Care Trusts within the English NHS. As a PCT it is responsible for the wise investment of public money to secure health improvement, access to health services and where appropriate the provision of health services to a local population of some 438,000 people. Geographically, the PCT covers seventeen wards along the eastern half of Birmingham City Council, Britain's second city and the single largest metropolitan authority in Europe.

The registered population is diverse, with significant differences in profile at ward level; Washwood Heath is 70% black and ethnic minority (mainly of Pakistani or Bangladeshi Muslim origin) with less than 15% over 60s and some 30% under 16 year olds; in contrast, Sutton Four Oaks has only 5% ethnic minority (mainly Indian) and 25% over 60s, with only some 15% under 16s. The diversity of demography is reproduced in significant disparities in socio-economic status with no super output area in Sutton in the most deprived percentage for England but 100% of the population in Washwood Heath living in an area falling within the highest 10% deprivation for the country as a whole. Not surprisingly, this disparity is again reflected in significant inequalities in health status and mortality with an over 6 year difference in average life expectancy between the two wards. Whilst these two illustrate the most extreme differences, each local area has distinct characteristics, within a majority deprived area.



1.2 The PCT is responsible for improving the health status of this diverse population and for ensuring access to high quality and safe services to meet their various needs at all stages of life. This core role of commissioning includes investing some £630m of public money each year. The PCT is unusual in that it is responsible for the whole pathway of commissioning from primary care and community services, through local acute, to hosting the specialised services commissioning function for all seventeen West Midlands PCTs (an additional £680m expenditure for which the PCT is budget holder and accountable body), and enjoying membership of the National Specialised Services Commissioning Group. In addition, the PCT is the lead commissioner across the city for Mental Health, Learning Disabilities, Sexual Health and Addiction Services, working closely with partners in adult social care, Housing and the criminal justice system.

1.3 The PCT is the local commissioner of primary care services, most of which are provided by small independent contractors. The PCT works with some 82 general medical practices of which 39 are single partners. These practices have been encouraged to collaborate at a local level in 6 locality groups to deliver practice-based commissioning each covering between 55,000 to 100,000 people. We are building on our learning with family practice, in developing our relationships with other key contractors, including the 56 dental practices, 98 community pharmacies and 64 optical contractors, who we commission to provide services in the area. A number of local independent medical and other practitioners are employed on a sessional basis by the PCT as Clinical Directors or Clinical Leads.

1.4 This paper sets out our overall vision and approach to the commissioning of primary care services, it will be supported by a series of specific commissioning documents, of which the specification for General Practice Services and the Strategic Service Development Plan driving capital investment through the Birmingham and Solihull Local Improvement Finance Trust will be the first.

2. Vision

2.1 The PCT has a clear core purpose and set of aspirational goals which provide the framework for our approach and drive investment decisions:

Our core purpose

‘Working in Partnership to tackle inequalities and improve health and well-being ’

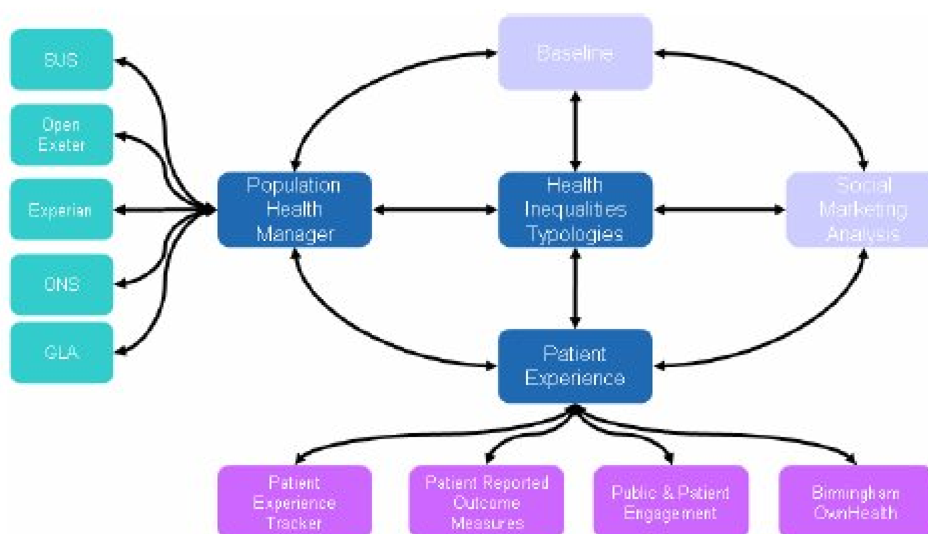
Our goals

- To be so responsive to the population we serve that no-one waits for the quality care they need
- That the health and well-being of the population will have improved so much that people will enjoy 10 more years of healthy life
- That people regard us as the first choice organisation to work with and for
- Our communities will be the most involved, informed and empowered in the country

2.2 A robust infrastructure in Primary Care is essential to the delivery of this ambition. Primary care is by definition the key access point to services and has been the bedrock of the English system within the NHS for the last 60 years. It is critical to the identification of disease, provision of immediate access to advice, diagnosis and treatment in urgent situations, long term management of chronic illness and onward referral to specialist advice. For many contractor services it is characterised by long-term and personal relationships with families and individuals and is generally where personalised care is currently most firmly established in the health care system.

3. Relationship Management

3.1 The PCT is committed to taking forward our goal of the most informed and empowered community in the country. We shall make full use of all the tools available to deliver this, as in the context of our changing demography and patterns of disease it will be key to the delivery of our goal of 10 more years of healthy life. The PCT is the responsible public body for health improvement and investment of public resource to meet health need, we shall be seeking to maximise the intelligence available to us from a variety of sources to drive investment and improvement. The PCT has entered into a partnership with Doctor Foster Intelligence that will help us develop new relationships with the public, patients and partners by using a wide range of information sources and innovative tools.The diagram below highlights the information sources that can provide the set of tools to profile the population of BEN PCT to enable the systematic targeting of information and services to that population that engages the public



Increasingly we shall seek to develop a direct relationship with local people which engages them on issues of interest, both in relation to managing their own and family health, understanding issues and solutions at a community level, and as

local citizens. Core to this will be direct access to and management of an increasingly sophisticated range of population information by the PCT.

3.2 The relationship between the PCT and local General Practitioners has developed over some 18 years of health policy making, and is probably the most well-established set of relationships between PCT and the various primary care contractor professions. It is not always the most healthy however, an unfortunate side-effect of successive contracts having been to define that relationship increasingly by a set of transactional payments. We want to move beyond this transactional relationship to strategic partnering based on an aligned vision and commitment to take forward key national priorities and local goals. This is developing with some practices, but needs to become more systematic and formal in approach, with practices identified as strategic partners enjoying access to a range of opportunities and benefits in return for delivery and excellent performance.

3.3 The relationship with other contractor professions is under-developed by comparison with general practice, and where it exists at all has largely been governed by contractual discussions. More recently this has been extended to include the development of quality and safety assurance activity. A development programme will build on what has been achieved so far. The PCT is committed to building on our learning with general practice to develop a set of positive and effective relationships across primary care, which will underpin excellent, responsive services for local people.

3.4 The PCT also enjoys a significant relationship with the City Council, which is essential to address the determinants of health and thus to tackle inequalities. The City Council processes and services are organised geographically, largely reflecting ward boundaries and to support joint commissioning and integrated services, the PCT needs to move towards much closer alignment with this geography. In addition, historic practice of growing lists by drawing patients from across the city has raised issues of patient safety as local professionals struggle to communicate effectively with teams outside their geography, and significant challenges to efficiency as non-medical health professionals spend hours in cars attempting visits outside the patch. This is an expensive carbon footprint which also puts continuity of care at risk. The PCT will establish new recommendations for travel and GPs registering beyond this will become personally responsible for delivery of all care.

3.5 In the context of choice, it is essential that we enable patients to make informed decisions about registration and streamline processes which support them in changing their primary care contractor where they choose to do so. This requires a more open sharing of information on services available and the performance of those services and ready access to the registration team. Those practices seeking to serve larger populations will need to identify local points of service delivery and resource these with an appropriate level of staff and skill mix.

3.6 Historically, the focus of a profession has been in the technical skill of the practitioner, however there is a lively tradition of art as well as science amongst health care practitioners. The public have made it clear in successive surveys that

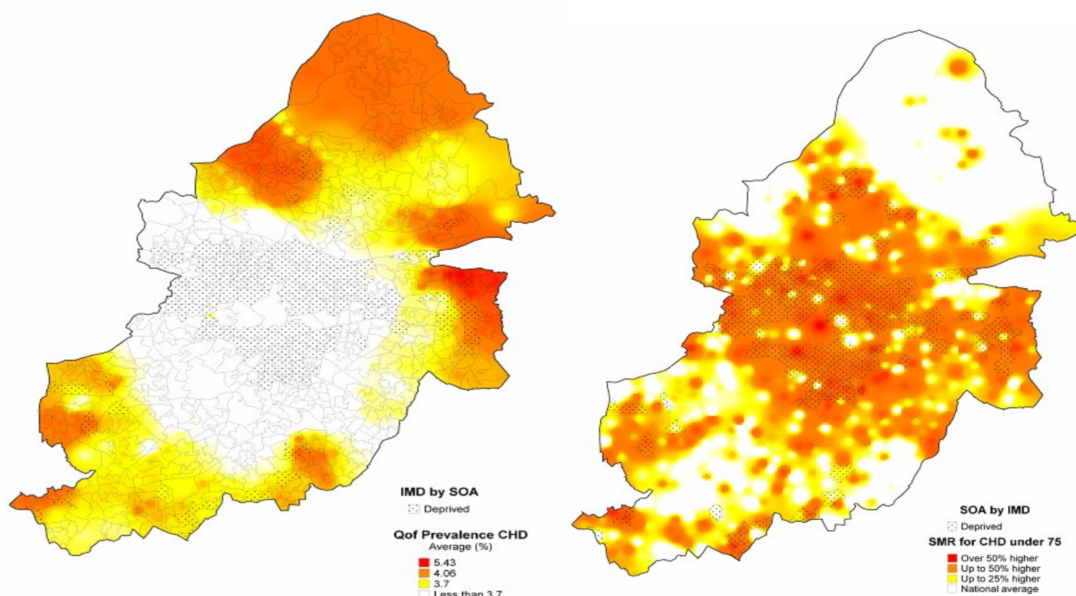
they regard issues of dignity and respect and effective communications as being key to a successful health care intervention. Increasingly, we expect that all our health care practitioners will evidence effective communication skills as rated by their patients, and increasingly will develop a consultation approach which engages the patient in self care and a good understanding of how best to look after oneself, and in what circumstances to seek appropriate help.

4. Local Profile

4.1 General Practice

4.1.1 The PCT currently holds contracts with some 82 practices across the PCT, spending £54.4 million directly and a further £71.0 million on prescriptions written in primary care. The scale of practice runs from 1 doctor with 1,400 patients on their list to a practice with over 8 doctors serving over 15,000 patients. There is no direct correlation between the size of practice and performance: some of our single-handed practices deliver the highest performance on systematic care against the Quality and Outcomes Framework, although no team Practice currently falls within the group of poor performers, which the PCT has identified as requiring immediate improvement.

4.1.2 The role of General Practice is so central to the health system, that variability in the capacity and capability of primary care has the potential to have a significant impact on both the health experience of individuals and the health outcomes of whole populations. The population of the PCT currently has below average life expectancy, high infant mortality and a significant burden of chronic disease. General Practitioners play a key role either in tackling these inequalities or in sustaining them. We have seen significant improvements in the identification and management of chronic disease over the last five years in active health improvement interventions (particularly smoking cessation) and this is reflected in significant reductions in mortality. However, there is still unacceptable variation in practice and delivery which must be addressed if people across the PCT area are to enjoy the same opportunities for a long and healthy life.



4.1.3 There is huge variation across the PCT in the standard of premises from which General Practice operates, with too many still struggling to deliver 21st century health care from converted early 20th century houses. The Strategic Service Development Plan will set out the key priorities for investment and buildings. In making this investment (an average of some £5m per building), it is essential that the physical infrastructure supports best practice emerging models of care.

4.1.4 General Practice has been characterised by the large-scale adoption of information technology to support patient information, professional communications and access to decision-support. However, a significant minority of practices continue to rely on out-dated systems and need to learn to realise the benefits of technology. Digital communications offer further significant opportunities for communications, patient tracking, patient and professional information, which we shall seek to realise over the next 5 years.

4.1.5 Although General Practice has a proud tradition of scoring consistently highly both for public respect and in relation to satisfaction with services, there is variability across the PCT as demonstrated through the NHS Patient Satisfaction Survey and the MORI surveys commissioned by West Midlands SHA. Particular concerns have been expressed about:

- Opening hours
- Ability to book appointments in advance
- Access by telephone
- Lack of systematic health promotion advice and support.

Of particular concern is that low satisfaction is significantly higher amongst Black and Ethnic Minority patients. The PCT will seek to understand in greater detail and for specific communities the nature of these concerns and will monitor and take action on the service response from local practices.

A Clinical Governance Support Programme is well established within General Practices. This is currently being strengthened through the development of Practice Quality Profiles and though a more streamlined and coherent approach across the PCT to practice support, assurance and development activities

4.2 Dental

4.2.1 The PCT currently holds contracts with 65 dental contractors who provide NHS Dentistry within 56 practices across the PCT. The planned expenditure on Dentistry is £15.03 million for the financial year 2007/08. The contracted level of activity varies at each practice depending on the number of dentists and the number of sessions they undertake.

4.2.2 One of the key aims of the PCT is to promote good oral health for all patients who reside within BENPCT and to address the health inequalities that exist across the PCT

4.2.3 As with general practice there is a huge variation in the standard of premises from which dentistry is provided ranging from converted residential properties to modern purpose built accommodation. In 2006/07 and 2007/08 BENPCT received a Capital funding allocation totalling £872,000 to invest in Capital Projects to improve practice premises and to improve the patient experience. A proportion of the allocation has been invested in ensuring contractors meet DDA Compliance within practices.

4.2.4 The new Dental Contract was introduced in April 2006 this saw the introduction of new patient charges and was not universally welcomed by the dental community. As result of this some practitioners decided to no longer provide NHS care and this has led to access issues in some areas of the country. The PCT is committed to ensuring that all patients have access to NHS dental care and will continue to invest in services to deliver this aim.

A Clinical Governance Support Programme for Dental Practices was introduced in November 2007 and is being developed and strengthened within the context of a review of PCT capacity and capability to deliver the required support and assurance activity.

4.3 Pharmacy

The role of pharmacy is growing significantly particularly in the areas of urgent care, health advice and lifestyle management, screening, substance misuse in addition to the traditional strength in medicines management. We need to harness this expertise and resource more formally alongside general practice in developing the infrastructure of local primary care, maximising the opportunities offered within the new contract.

4.3.1 There are currently 98 community pharmacies providing pharmaceutical services under the community Pharmacy Contractual Framework across the PCT. Opening hours run from the required minimum 40 core hours per week in the smallest pharmacy to 100 hours in four pharmacies that have opening in the last two years under the exemptions of the revised 2005 Contractual Framework. Access to services is therefore good, particularly as the pharmacist workforce also reflects the diversity of the local population in the localities they serve.

4.3.2 The number of locally commissioned services is increasing with quality and safety standards being established through the introduction of more robust service level agreements. Enhanced services that are currently commissioned from our pharmacies include:

Locally Commissioner Enhanced Services	Number of pharmacies
Smoking cessation	41
Supply of Emergency Hormonal Contraception	40
Drug Misuse	27
Support for Care Homes with nursing	16
Early Pregnancy Testing	11
Heart MOT	6
Stock held for Palliative Care	12

More robust contractual agreements have also been developed for the delivery of selected Locally Enhanced Services in respect of General Medical Practices. A programme for the strengthening of all contractual agreements for enhanced services is being established.
There are 68 pharmacies currently offering Medicines Use Reviews to individual patients under national Advanced Services. There have been concerns generally around the quality of the Medicines Use Reviews and the lack of control for PCTs who reimburse £27 per review under the contractual framework. The pharmacy White Paper for pharmacy indicates that this situation will be addressed and the PCT will continue to strive to improve quality and maximise the potential of such reviews through engagement with pharmacists.

4.3.3 The introduction of the Electronic Prescription Service is a major development for primary care as a further step towards an integrated care record system and as an early implementer site, the PCT is supporting the preparation in pharmacies. The service requires updated information technology and as a result of recent upgrades patients will benefit from pharmacists now having greatly improved electronic access to healthcare information.

Whilst offering many opportunities for improving healthcare and access the changing role of community pharmacy will bring its own challenges to pharmacy contractors and standards of premises and practice may need improvement to allow full participation. In a competitive environment, this has a positive effect in raising standards generally and the PCT will continue to support developmental needs identified through the contract monitoring process. The opening of a number of 100 hour pharmacies across the PCT is creating tensions amongst contractors as dispensing of prescriptions, the main source of income, is diluted and some pharmacies currently offering good services may be put at risk. The PCT will need to be mindful of these effects when considering provision for new pharmacies in health centre developments.

4.4 Opticians – Optometrists

4.4.1 The PCT currently contracts with 55 optometric practices, of these 20 practices provide Digital Diabetic Retinopathy Screening and 20 provide additional mobile

services to bring primary eyecare to patients unable to leave their homes unaccompanied due to illness or disability. This is further supported by 20 independent and corporate out of area mobile providers.

4.4.2 BENPCT has firmly established a retinopathy screening service which started in January 2007. This allows all eligible patients with diabetes to be offered this service at a location convenient for them with dedicated IT connectivity to the Heart of England NHS Trust Screening Centre of Excellence and data storage. The PCT will be looking at other ways of working with optometrists to deliver enhanced services as part of the new contractual arrangements which will come into force in August 2008

4.4.3 Overall satisfaction with optometry services is high however the PCT's Healthcare Goverance team, will continue to work with optometrists, to provide training around safeguarding children, risk management, record keeping and infection control. An on going audit programme will ensure compliance with standards in relation to the Quality in Optometry Toolkit. This enables optometric practices to measure their performance against Standards for Better Health. Ongoing audit programmes for General Pracitce, Pharmacies and Dental Practices are in place as part of the PCT Clinical Governance Support Programme. These include a range of quality and safety assurance workstreams, including infection prevention and control. These activities are more extensive and more well established than those with optometry which requires further development and the promotion of greater engagement.

5. Strategic Approach

The PCT has five core strategies informing our commissioning approach.

- Promoting Health and empowering people
- Quality safe services
- Extending working together for health
- BRISK[1] Processes
- Consistently fit for purpose

5.1 Promoting Health and empowering people

5.1.1 Given the existence of significant local health inequalities and a high burden of disease, the PCT seeks to commission services which will assertively identify and reach out to those individuals and communities most at risk of disease and disability, or of dis-engagement from traditional services. Services will need to be accessible and responsive to very different local and personal circumstances and expectations. We shall support practices in identifying high risk groups and share intelligence as to how best to reach them and what style of services may be most appropriate for optimum impact. We expect all contractors to work with us in developing these new models of care and to actively signpost and support patients into the appropriate programme.

[1] BRISK – Bold Re-design, Investment, Sustainability, Knowledge

5.1.2 The PCT expects all local contractors to engage in active health promotion and to signpost patients and public through to sources of support for lifestyle change or access to health service information. A strategic and consistent approach to smoking cessation, advice on diet, alcohol and physical activity and sexual behaviour will be key to making an impact on local health status through supporting individuals to make different lifestyle choices.

5.1.3 Patients live with their conditions 24 hours a day and we need to engage them as active participants in their own care. Empowering them to feel in control of their condition and enabling them with education and the tools to look after themselves as far as possible, and know how and when to seek help if a condition deteriorates.

5.1.4 All contractors have a key role to play in the early and active identification of disease and in referral on to the relevant professional where there are concerns about a patient's presentation. The PCT expects all contractors to support their patients in making full use of the range of services available within the PCT to maximise their chance of staying as well as possible for as long as possible.

5.1.5 Given the burden of worklessness and low skills base characterising much of the PCT, and its relationship with poor health, the PCT expects contractors to use their role as local employers to maximise opportunities for people from priority wards to access employment and training within work to increase accredited skills and attainment. The PCT can support contractors to access government support to small business to maximise our impact locally.

5.2 Quality safe services

The PCT applies Maxwell's multi-modal approach to health care quality (ref) and is equally concerned with all 6 elements:

- Effectiveness
- Efficiency
- Relevance
- Equity
- Acceptability
- Access.

The PCT will continue to develop its quality and safety assurance activities within the three key themes identified in 'High Quality Care' (2008) Patient Safety

- Patient experience
- Effectiveness of care

The PCT quality and safety assurance support and development programmes will build on existing clinical governance arrangements to further develop

- Bringing clarity to quality
- Measuring quality

- Publishing quality performance data
- Recognising and rewarding quality
- Raising standards
- Safeguarding quality

5.2.1Across the PCT, there have been huge improvements in contractor performance, with parallel improvements in reducing mortality. Having demonstrated it is possible to deliver the highest quality of services nationally, to one of the most deprived populations, the PCT now seeks to ensure consistent and universal excellent practice, with a particular focus on delivering world class chronic disease management, benchmarked against best in class organisations globally. Whilst different contractor professions have different roles to play in this delivery, we expect that world class chronic disease management will be characterised by :

- Early and active identification of disease, and assertive benchmarking against epidemiological benchmarks
- Developing and maintaining disease registers
- Consistent application of the evidence in treatment and management
- Active recall and supervision of patients
- Patient education to support self care and engagement in taking best care of oneself.

5.2.2 Patient safety is paramount and the PCT is signed up to the Patient Safety First Campaign as part of its commitment to making the safety of patients the highest priority . It has been acknowledged that the current focus of the national campaign is largely on the acute sector. The PCT has been nominated to work with the Campaign Director in order to further develop understanding of PCT interventions that will ensure an environment where continuous improvement in the reduction of harm and the promotion of patient safety becomes routine.

The PCT have signalled a commitment to participating in the ‘Leading Improvement in Patient Safety Programme’ (LIPS) developing by the NHS Institute for Innovation and Improvement. The PCT will participate in the 2009 Primary Care Programme that is currently under development.
Strategies for ‘Patient Safety’ and ‘Commissioning for Quality are currently being established.

5.2.3 There is now considerable public concern about health care acquired infections. Primary care contractors have a key role to play in ensuring the highest standards of cleanliness, decontamination and infection control procedures in practice. They should also play a part in early identification of possible infections and evidence-based management. The role of GPs and pharmacists in appropriate prescribing will be key to minimising further resistance in infectious agents and to the appropriate and safe management of established infections.

A robust programme of infection prevention and control visits and audits is established for General practices with an enhanced programme in respect of relevant Locally Enhanced Services. A parallel programme of visits is currently being established for Dental and Optometric practices within a review of capacity and capability to deliver significantly enhanced safety assurance.

5.2.4 Contractors have a particular responsibility as employers to ensure that they employ people who have the right skills for the role, hold the appropriate registration and support staff in developing skills and aptitudes to increase local capacity and capability. As independent businesses they must also ensure they have effective governance processes in place to assure the PCT of competence and capacity as defined by the Health Care Commission and other regulatory bodies.

5.2.5 A key issue is the patient's experience of their care, and patient surveys suggest that patients regard those services as good, in which they feel treated with dignity and respect, and they feel able to raise issues in a consultation and come away understanding the information they have been given (MORI poll).

5.2.6 Services should be relevant to the local population, and given the diversity of demography across the PCT and the impact of globalisation this will be an ongoing challenge for local contractors. The PCT will seek to support contractors with information about different communities and how best to engage them, and will expect contractors to collaborate in adopting new processes and signposting new services as relevant to their patients. Recent experiments with social marketing have shown that targeting specific groups and approaching them in new ways can bring people who have avoided traditional models of care into an effective relationship with health services. These new approaches will be key to tackling inequalities and health improvement.

5.2.7 The PCT has a strong commitment to tackling health inequalities and will monitor service utilisation, health status and intervention outcome, challenging local contractors to ensure that they are contributing to overcoming long-standing inequalities and not contributing to them.

5.2.8 Many contractors, particularly GPs play a key role as micro-commissioners, with referrals into secondary care driving expenditure and variability in access. Given that the PCT works within a limited budget, we shall expect to work with contractors to maximise efficiency quality and safety in service delivery, ensuring that expenditure represents a wise investment for health benefit.

5.2.9 Improving access to health services has been a key theme in health policy over the last decade. Primary care contractors will be expected to play an active role in achieving the PCT's big goal of 'no waiting for the health services our people need'. This will require greater accessibility throughout the day and week, with extended opening hours, reflecting social changes in which people can access other less essential services at times more convenient to themselves.

5.2.10At its most basic level, this is a particular issue for general practitioners. The PCT will address the historic compromised access which has seen patients sharing a single GP with over 3,000 peers when elsewhere in the country it would be less than half that number. The PCT places sufficient value on the personal interaction between patient and doctor to want to ensure that patients

have at least the national average chance of access and the associate minimum average consultation time of 10 minutes.

5.2.11 Technological advances and skills development have meant that much of what traditionally would have required referral to a medical specialist is now undertaken in primary care. The PCT has pioneered innovation in secondary to primary care shift and wishes to see all patients having access to a choice of core general practice provision, at a scale serving around 10,000 patients. This is sufficient to give resilience of cover and continuity of care, to enable the development of specialisation and peer review within practices and to enable the efficient development of a range of attached staff offering an extended range of services at the local level to patients. It is also of a scale which can justify significant public investment into estate and infrastructure. As we understand the appropriate scope and scale of services to support best professional practice in other contractor professions we shall set similar requirements for access and resilience.

5.3 Extending working together for health

5.3.1 Our collaborative programme of clinical re-design and improvement (Working Together for Health – WTfH)has been the subject of academic commentary as a Kaiser Beacon site since 2003 (by Universities of Birmingham, Warwick and Toronto) and has been identified by the University of Toronto as an exemplar of system improvement alongside Jonkopping in Sweden, Veteran’s Administration in the USA, Henry Ford Health System and Inter Mountain Healthcare, USA. More recently we have brought our partnership commitment to commercial relationships and are currently exploring appropriate legal forms to recognise our shared investment of knowledge, expertise and time with UK Pfizer Health Solutions and NHS Direct.

5.3.2 We wish to build on this strength in partnering for re-design, innovation and improvement to our relationships with local contractors. The Working Together for Health programme has been characterised by key principles, which also apply to primary care.

- **Active identification and management of treatment and care to prevent illness and improve quality of life**. Both BENPCT and Solihull CT now perform strongly in the active identification and management of chronic disease in primary care against national averages. The performance of the best must become the norm for local service delivery, with all practices able to perform effectively in identifying patients and ensuring active medical management in primary care, in partnership with health colleagues and crucially, social care focussed on promoting independence and personal improvement in a sense of wellbeing.
- **Promotion of self-care and partnership in care between clinicians and patients.** The evidence is strong that engaging people in understanding and managing their own condition will not only deliver greater independence and better health outcomes but also lead to greater happiness. Our approach to

service delivery is encapsulated in the three phrases: 'Patients as Partners'; 'Promoting Self-Care'; 'Care in the Right Place'.

- **Priority given to enabling people to stay at home.** This includes maximising the integration of care, support and treatment across organisational boundaries to enable people to remain at home as long as this is in their best interests and clinically appropriate, including at the end of life. The bulk of treatment and care will happen, as now, through delivery by peripatetic community-based or primary care staff to maximise flexibility and responsiveness of delivery and minimise unnecessary hospital visits or institutional care. High priority will be given to investment into developing an adequate range of flexible support services to deliver care close to home. It is essential that patients receive the most appropriate treatment at the right time from someone with the right level of skill; and we commit to seeking the most safe, effective and efficient acute hospital provision for those who are seriously ill.
- **Clinical leadership to drive change.** The Working Together for Health philosophy and its principles have proved to be a solid foundation for developing our whole system approach, particularly the partnership between managers and clinicians both within and across organisations. Clinical management across the health economy has been strengthened, clinical service strategies have been developed in partnership and new person-centred services are being delivered, which transcend organisational barriers. We have committed to modelling behaviour characterised by 'Respectful communication'; 'Your success is my success' (and vice versa) and 'A long-term commitment to partnership working'; both at an organisational and an individual level. We are committed to further developing an active cadre of leaders in primary care, able to hold their own with hospital colleagues and engage appropriately as colleagues with PCT and other NHS managers.
- **Use of information technology to support integrated patient care and change management.** As an economy, we seek to maximise the opportunities offered by emerging and available information and assistive technologies. We shall collaborate to make best use of national contracts and local investment to support information sharing and transfer in the interests of patient safety, clinical decision-making and system efficiency. Our economy benefits from a relatively IT literate population, and we shall invest in maximising public and patient access to information (both digital and conventional) which will enable self care, independence and informed use of local services.

5.3.3 During this period we have experimented with new models of care including telephone care management, group interventions for education and treatment and non-medical triage. Where these have been shown to be safe, effective, efficient and acceptable to the patient, they have been rolled out to enable all patients to benefit. Over the next 5 years we expect further experimentation with new models of care to include remote telemonitoring, email / internet consultations, group interventions for assessment and in new settings, and new models of booking and outreach. Clinicians should be the source and natural leaders of many of these developments and the PCT shall seek to work with local champions to experiment, refine and improve services for better health outcome.

As new models of service develop, many will be at the interface between traditional primary care and what would historically have been the domain of specialist medical management. This 'intermediate' tier already exists for a range of chronic diseases and in rehabilitation and is likely to expand. To be safe and efficient, it must actively engage secondary care clinical colleagues in design and must gain their confidence to act as a real substitute for secondary care referral where appropriate. These services will be concentrated into hubs of enhanced services, where primary and secondary care clinicians are able to work alongside each other to deliver integrated care.

5.4 BRISK Processes

5.4.1 In commissioning across the spectrum of services, the PCT has taken bold decisions to re-design for improvement, and to universalise successful pilots to ensure that all local people can access the best in services, and they are sustainable in the long-term. This approach will increasingly bring significant change to the profile and pattern of primary care locally, and we hope that it will increasingly be led by the most creative, competent, committed and entrepreneurial of primary care contractors.

5.4.2 The PCT is committed to developing a core set of processes which support effective and efficient transactions with primary care contractors. This emphasis on core business process improvement will be essential to developing the necessary credibility to underpin increasingly positive relationships. In return, the PCT expects contractors to pay increasing attention to their own organisational efficiency and effectiveness, making best use of the PCT investment to maximise its return as positive patient outcomes.

5.4.3 Knowledge management underpins much of our ability to commission effectively and of contractor ability to target, market and deliver their effective services. The PCT will invest in knowledge management systems which can feed contractors information about their patients, local communities and service performance. In return, the PCT reserves the right to use that information to ensure that local people have equitable access to a consistently high standard of responsiveness and effective services wherever they live in the area PRIME project.

5.4.4 The PCT makes significant investment of public money into primary care and we expect this to deliver a return in improved health status and patient satisfaction. Contractors should work with us to identify and maximise efficiencies in practice which can release resource for re-investment in improved services PRIME project

5.5 Consistently fit for purpose – people, IT, estate

5.5.1 It is essential that we develop the local capacity and capability to secure a local primary care system, which is recognised internationally for its effectiveness, responsiveness and accessibility. We expect contractors to be active participants in training and education both for themselves, their employees and increasingly

as teaching practices of others. Over the next decade, we are likely to see continuing changes in technology and pharmaceuticals which will require new styles and skills within the workforce and we shall actively plan to ensure that our local primary care workforce has the right skills, attitudes and behaviour for future models of care.

5.5.2 Information Technology is already well-adopted across the PCT and actively supporting evidence-based practice, disease management, and effective communications. All contractors are expected to participate in the roll-out of national systems which will facilitate the single patient record and clinical access to information. Contractors are expected to make their own investments as appropriate to maximise the opportunities of digital communications and technology-enabled care.

5.5.3 The Strategic Service Development Plan will set out the key priorities for investment and buildings, with a focus in investment into General Practice. In making this investment (an average of some £5m per building), it is essential that the physical infrastructure supports emerging models of care and delivers a critical mass of improvement with increased emphasis on

- Greater medical capacity and cover
- Extended team working making best use of the range of professional expertise in primary care
- Enhanced range of services, offering access to a variety of community services, both health and support within local settings
- Patient education and group interventions
- Facilities to support professional teaching, learning and research.

In order to offer best value for money, the PCT will increasingly expect to realise benefits of scale, both in relation to service resilience, spreading the burden of management costs and enabling delivery of a more comprehensive range of services and access to more specialised knowledge closer to home. The PCT will increasingly seek to commission single practices serving populations of circa 10,000 with a maximum ratio of 1,500 patients per GP (whole time equivalent).

5.5.4 Other contractors may increasingly seek to co-locate in these developments, or in some cases to undertake their own developments and offer to host GP and other services.

5.5.5 The PCT is keen to explore how to maximise investment into clinical and educational settings and seek other ways of supporting administration and office activities, which may not be NHS owned.

5.5.6 As the PCT develops a strategic approach to investment into intermediate tier services, we shall have to identify appropriate sites which can deliver services on the right scale but accessible to a dispersed population. The PCT currently delivers such services through Partners in Health Centre on the Yardley Green Site, serving some 6 wards in the South of the patch (circa 120,000 population) and Sutton Cottage Hospital will be re-developed to offer a similar range of chronic disease and muskulo-skeletal interventions to the 6 wards in the North of the PCT. Further work is required to develop an appropriate site for the North-

East and potentially for the Southern wards to relieve pressure on Partners in Health. It is unlikely that such centres would serve a population less than 60,000 to operate efficiently and maintain a safe and effective level of specialisation.

6. Investment and Benefits Realisation

6.1 For the current year the PCT is planning to invest £54.4 million on primary care GP services and a further £71.0 million on drugs (mainly GP prescribed). The PCT is also investing £15.3 in Dentistry services and £2.7 million in additional pharmaceutical services for the benefit of the local population. The total investment in all of these services for the current year therefore stands at £143.4 million.

6.2 The Medicines Management team supports the effective use of drugs through a number of means including monitoring of evidence base, addressing reported safety issues, providing advice and updates to prescribers, implementation of NICE technology guidance and identification of cost effective choices. Through a programme to address cost effectiveness issues and realise efficiencies, the team has helped maintain an increase in prescribing costs proportional to the increase in items over the last three years. Continual monitoring and feedback of prescribing data to practitioners supports their continued engagement

Through efficiencies achieved, the increase in prescribing costs in the last three years has been well below the national predicted rise. Although the team will continue to identify annual priorities to achieve both effectiveness and efficiency, as opportunities to reduce costs diminish and newer, more expensive medicines become mainstream, it is inevitable that there will be a higher increase in prescribing costs than in recent years. PCT initiatives to improve primary prevention, as in the Male Life Expectancy programme, more focused care in early disease, as in the Own Health initiative, and development of End of Life care will also add pressures to the prescribing budget. It is therefore likely that in future years, the increase in prescribing costs will be closer to the normal annual increase of between 6 - 8%

Non-medical prescribing is supported through monitoring and feedback and as this activity increases, there will need to be greater input into effective use of medicines through improved communication channels.

6.3 Role of pharmacists in monitoring and advising on prescribing

In addition to the central role of the Senior Prescribing Advisers, a team of Practice Support Pharmacists has been established to work in all GP practices across the PCT to support quality, evidence-based, cost-effective prescribing. Having demonstrated significant progress in achieving prescribing efficiencies in the last two years, and whilst maintaining these, a key priority for both the practice based and clinical pharmacists teams will be to support the

management of long-term conditions and to optimise individual patient therapy through detailed medication review and implementation of the forthcoming NICE guidance on concordance.

Significantly developing the workforce to include pharmacy technicians to complete the more routine medicines audits and actions in practices would facilitate more efficient use of the clinical pharmacists.

6.4 PRIME 'Metrics and Relationships' (and others also) impact on quality assurance , improvement and intelligent commissioning processes.

The PCT will continue to promote and ensure services are delivered in line with national guidance and will maximise opportunities to embed this approach even more robustly as greater clarity on standards is pursued within the national strategic direction on ensuring that quality is at the heart of all we do (High Quality Care for All, 2008). Whilst signed up to national quality and safety metrics the PCT will establish a new strategy 'Commissioning for Quality' in support of the augmentation of national standards with our own quality metrics.

The PCT recognises that a defining characteristic of a high performing organisation is its willingness to self monitor performance and to use performance data generated as a catalyst for learning and a driver for improvement. An ultimate goal is for each of the PCTs service providers to develop their own quality frameworks within which better informed clinicians will be able to drive improvement and change in service delivery where that is indicated.

The PCT is committed to increasingly more meaningful and revealing use of data. This will result the development of robust intelligence enabling the PCT to challenge service providers to deliver the highest possible quality and safety.

In response to the new Care Quality Commission's stronger focus on compliance with regulation requirements for quality and safety the PCT recognises the need to support providers in the identification of and support to improve areas requiring development.

The PCT recognises that clinical practice is constantly evolving and improving and therefore offers new opportunities to improve the quality and safety of services. Within this, innovation remains central to the PCT aspiration to delivering the highest quality, safe services.