

Pharmacy PBC Week Virtual Expert Panel
Questions and Answers compiled

Question 1

My PCT has 5 different cluster groups with 5 commissioning leads all with their own plans and perceived needs. Do you believe that the public will be receiving mixed messages from Community Pharmacy when the needs of the different cluster groups will all differ and one service may be available in one area but across the road it may not be available because it falls into another cluster groups patch. In the long term it will be doing Pharmacy no favours at all. Where is the continuity of service in the eyes of the public? How is Pbc going to address this potential imbalance in the provision of services?

Peter Johnstone – Liverpool Health Care PBC Consortium

In your position I would be having a word with patient representative groups, and winding them up to ask questions about equity of services and how robust the needs assessment process and consultation was.

Done properly, different clusters can appropriately provide different services, especially if there is no geographical overlap. These clusters are presumably commissioning for their own populations, but the could commission across the whole PCT, or they could view their service as a pilot which can be rolled out across the city once the bugs have been ironed out, which is what we are doing.

The key to this question lies in the hands of the patients. A queue of unhappy patients will soon change people's plans

Mike Holden – Hampshire and Isle of White LPC

I think there is still some lack of clarity about PBC amongst CPs. At the end of the day the needs of most areas are very similar with some differentiation resulting from demographics and deprivation. We must also remember that PCTs remain the ultimate commissioner and are held accountable for delivery of services to meet the needs of their patients, who the provider is may vary and will be dependent on capability, capacity, effectiveness, cost-effectiveness, access, location etc.

Patient power could be an important issue and hence Peter is right re accessing PPIFs etc. It is also important to challenge, if necessary, the governance, contestability and equity of the commissioning strategy and process at all levels.

Tim Jones – Commissioning consultant

One of the contradictions inherent in PBC is that for it to work it must lead to differential provision and access. PCTs are tasked with 'holding the ring' and are very much struggling with the this. Differential provision is appropriate in some instances for example where one cluster is centered around a hospital and another is at some distance leading to much greater patient travel. Inevitably there will be places where the difference is stark. As a commissioner I am comfortable with this.

In the event of any really significant service differences which could lead to differences in morbidity or mortality then the PCT must address this by commissioning the service across the whole patch. While I don't disagree with comments above I think that this issue is overstated

Ash Soni – Community Pharmacist

This in some ways is no different to the provision of different services in different PCTs. Ultimately decisions should be made on patient need. However, as a first step most PBC

groups will pick pet subject areas that they feel confident about. It is important for pharmacy to engage with whoever but be prepared to explain to patients why there are differences between different groups. Pharmacy being disengaged will not change the services that PBC is looking to deliver but I agree that patients are the key to changing variation in service and pharmacy should not aim to take responsibility. Ultimately we are the providers not the commissioners.

Michelle Webster - Improvement Foundation

What priorities are set out in the PCTs LDP? These priorities should be addressed by the Practice Based Commissioners, regardless of how many clusters there are.

Mo Dewji – Clinical Director for Primary Care Contracting

There needs to be clear communication between everyone. Clusters ensure local sensitivity rather than bringing inequalities, especially if the funding is set fairly. Use the debate as a way of engaging patients and encouraging public participation. Make meetings/minutes open to the public and this transparency avoids any confusion or public perception of collusion.

Question 2

I am an LPC member and a member of its PBC subgroup. We are having great difficulty in getting representation on anything to do with PBC, especially representation on the PBC board. The chair of the PBC board (a local GP) is anti-pharmacy and we are struggling to get to grips with PBC issues. What should I do?

Mike Holden

Suggest using the CP Strategic Commissioning Tests (see NPA Summer Flyer) as leverage – these are must do's for PCTs and have come down from DH. Building relationships with commissioners in PCTs and PBCGs is not a quick win; perhaps a business case built on reduced waste or unplanned admissions/attendances would be a way in. Getting existing CP services embedded in redesigned care pathways is another – it does not cost them anything to optimise existing services funded through the global sum, just a mindset change.

Ash Soni – Community pharmacist in London

This is tough. Ultimately there is a need to build relationships and the route may be to find other more sympathetic GPs who can influence the decision making process. Also talk to the PCT about how they are performance managing activity and the open transparent system for all providers to bid.

Tim Jones

This is the issue at the heart of PBC and there are no easy solutions. PCTs are finding it difficult to engage GPs in PBC and so turn a blind eye to shortcomings on stakeholder engagement. I expect that your PBC collaborative has established itself as legal entity and will have a degree of freedom to invite whom it chooses. Your tactics will need to be tailored to the local situation but some generic ideas include:

- Attach yourself to workstreams/project groups as a professional advisor looking at specific issues e.g. unscheduled care (admissions from nursing homes)
- Find and cultivate relationships with other GPs who are influential
- Leverage access via the PCT on their workgroups – many PCTs will keep control of big service redesign projects

None of this will get you a seat at the table in the current climate but it will start to build relationships and demonstrate the value of collaborative approaches

Michelle Webster (Improvement Foundation) & Mo Dewji (Clinical Director for Primary Care Contracting)

There is no absolute rule that states that there has to be pharmacy representation on the board. There are multiple entry points to PCT, such as meeting with the exec team, discussions with the Non Exec Chair/NED. Presentations detailing the improved patient pathways that address local priorities.

Question 3

I own an independent pharmacy and our patients have shown interest in weight management programmes if they were run in house. Which organisations should I contact ahead of setting up such services and is there any grant money available to start the project, other than from PBC?

Mike Holden

DH does have some direct funding and all PCTs/local authorities have reasonably large budgets often held within public health pooled budgets to try and tackle obesity, particularly in children. The Coventry model is interesting and the early data is promising. There is always the option for a single independent or group of pharmacies in a locality to bid for such services, particularly if they are in a deprived area and could be linked to GMS QoF requirements on BMI which GPs are not too keen on. Could also be linked to a more holistic healthy lifestyle risk assessment which brings in diet, exercise (step-o-meter initiative?) and smoking cessation plus risk screening for vascular disease (hypertension, CHD and diabetes)

Ash Soni – Community pharmacists in London

Picking up on Mike I think you should talk to John Goes in Coventry as they have a DH funded pilot running and he will be able to point you in the right direction. My advice is always try and find someone providing a service as they will have done a lot of groundwork and we should all learn to share learning.

Tim Jones

As a commissioner I am concerned that the evidence base for clinically effective interventions in this area is not strong and the costs are potentially quite high. PCTs are not enthusiastic about developing these services without a clearer directive to do so. All contracts, whether a pilot or an established service would come via the PCT, not practice based commissioners. I am not aware of any other sources of public funding although pharmaceutical companies may be interested in supporting bids. To move forward you need to test with your PCT commissioners whether this is something they would be interested in. If not then don't waste your time with the public sector. I also suggest that you look at the Euroaction study which is likely to set the future course for weight management in the context of coronary disease

Michelle Webster (Improvement Foundation) & Mo Dewji (Clinical Director for Primary Care Contracting)

Look at what resources are available locally. Define the priority more specifically and refer it to the LDP. Get patients involved formally. Look at the whole resource pool

rather than just the financial resources. Capital grants are easier to access than revenue. Look at external sources of funding.

Question 4

Dear virtual experts. First up, it is probably the most significant address of PbC I have seen from a pharmacy perspective in a long time. The idea of a week devoted to PbC is great, and I hope it liberates movement and change. Well done. How are you going to measure the campaign's success? It just so happens I am meeting with one of my local GPs to discuss some reciprocal work in return for clinical tutor independent prescriber guidance provided over the first half of the year. It will be at this meeting I hope to unveil their service plans etc. I was wondering if I could ask what would you suggest I include in my preparation for this meeting? My goal is to use this reciprocal work to drive deeper engagement and fuel the relationship started. My IP skills I intend to promote but what other pointers can you give me?

Peter Johnstone – Liverpool Health Care PBC Consortium:

Before embarking, you need to have thought through a business case. It doesn't need to be presented at the first meeting, but you need to have it clear in your head before you open discussions.

What service do you want to provide and what evidence is there that it will be successful

What is the benefit of this to GPs and patients (workload, income, convenience)

What outcomes will be improved – these need to be measurable – reduced hospital admissions, reduced days off sick

What will this cost them

What are the risks and what will you do to manage them

Mike Holden – Hampshire and Isle of White LPC:

I would add that needs assessment must pre-empt all activity. Too much commissioning has been, and still often is, based on what providers want to deliver not what is needed.

CPs are often guilty of this basic omission in the commissioning cycle. So my recommendation is to do some research before the meeting, look for service gaps or high cost areas in referral and unplanned admissions. Most PCTs/PBCGs are looking for support in reducing prescribing costs, waste and unplanned attendance/admissions.

Anything that can deliver some of this in a cost-effective manner will normally hit the spot – try targeted MURs, Repeat Dispensing and interventions on effective and cost-effective prescribing (preferably without shooting Cat M funding in the foot. Same goes for QoF shortfall – check out where offering improved access through CPs can make a difference with risk assessment, screening, monitoring, inhaler check etc.

Tim Jones – Commissioning consultant:

I think you are taking the right approach. Competing with GPs or attempting to substitute for them is not proving to be very productive. The name of the game is minimizing costs through better management or timely intervention in order to keep people out of hospital. Pharmacists have a lot to offer in this area.

You need to understand the local provider and commissioner aspects of PBC and develop engagement in exactly

Ash Soni – Community Pharmacist, London

I think all the other suggestions are right. This is all about creating partnerships which then deliver through a health care team to meet the needs of a local population. The

most important aspect is being proactive in the process and not just waiting for it to happen to you. In developing the partnership ask the GPs which areas they have concerns about and where they believe the patient pathway could be improved and then make suggestions on where you fit into the modified pathway.

Michelle Webster – Improvement Foundation

What added benefits to current and proposed care pathways can pharmacy provide? 'Set out your stall' and tell the PBC group what services you could provide or have the potential to provide. How can you help them achieve the priorities, as set out in the LDP?

Question 5

One of our PCTs has indicated that they are planning to move all their funding for Pharmacy Local Enhanced Services into PBC clusters. The PCT plans to hold no budgets itself. Apparently the clusters would be instructed from the outset that there are some "must do's" which would enable the commissioners (who, incidentally, attend LPC open-session meetings) to ensure that those LES currently commissioned (Smoking Cessation, EHC and several others) will continue. The PCT believes there are a number of advantages:

- it signals to all providers a clear way forward for commissioning (i.e. PBC clusters identify service needs and commissioners commission)
- it deals with contestability issues, because expressions of interest can be made by any suitably qualified providers
- it halts any activity of PBC clusters where GPs are considering commissioning from themselves (it is definitely going on, apparently!)
- it will enable a transparent, level playing field

It also occurs to me that this simple move it will also enable the PCT to 'tick all the boxes' with regard to the 'downward pressure' on it to engage with CP and move forward with PBC at the same time.

Has anyone else any experience of this, or any views?

Mike Holden – Hampshire and Isle of White LPC

I suppose that there are some potential advantages and risks for CP with this move, but have no experience of it locally. I assume that Global Sum funding for GMS and CPCF will remain at PCT level? It is vital for all contracted providers that the PCT ensures that a level playing field, a transparent governance and commissioning framework and equity, plurality and contestability are all in place with appropriate challenge pathways should anyone of these be seen to fail by any party. Within PBC the ultimate commissioner remains the PCT and accountability very much sits with the senior managers and the PCT Board.

Tim Jones – Commissioning consultant

Logic of this move is in accord with guidance on PBC and with the general thrust of commissioning policy. The services commissioned in this way are part of care pathways and all commissioning should be made along these pathways – that is how we improve care and how we get a clear picture of how resources are used. To understand the impact/risks it is helpful to make the distinction between purchasing and commissioning. The former is a stage in the commissioning process. PCTs will make decisions about purchasing and changes should only be made by PCTs.

Michelle Webster – Improvement Foundation

The ultimate aim is to get clusters to be the most effective commissioners they can be and if by giving them the budget this helps then it is the right way forward. Communication is the the key if it is to succeed. If LPC is attending and meetings are public then transparency has been achieved; all stakeholders must feel they can influence the eventual decisions.

Peter Johnstone - Liverpool Health Care PBC Consortium

I think this delegation is a good thing as it allows engagement at a local level, rather than trying to negotiate with a megalithic bureaucracy. There is potential for different clusters to want different services, but run with the early adopters, demonstrate quality and cost effectiveness and the others will want a piece of the action.

Question 6

I am the Chair of an LPC. We are actively seeking new funding streams and have, this evening, sought the views of 40 of our Pharmacist and staff colleagues in a meeting to discuss the provision of future services locally mainly via PBC.

My concern is perhaps one suited to the realms of paranoia and imagination.

My LPC colleagues have expressed a concern that the new Chair of the newly formed CMC group (which of course has replaced the old PEC) is **also** on the Board of a company who themselves are bidding locally for contracts. The CMC chair will of course be able to influence the bids as he sits on the commissioning committee.

I do not in any way shape or form wish to imply that the obvious conflict of interest which might arise will ever happen in reality. I can only assume that all steps will be taken to demonstrate total fairness and transparency - which I am sure will happen.

My question is – are there protocols and controls in place which will demonstrate with openness and transparency the independence of the Commissioning groups as they are formed and then go about their work?

I look forward to your opinion.

Mike Holden – Southampton and Isle of White LPC

whilst there will always be some grey areas with potential conflicts of interest between commissioning and provision and so called chinese walls, I believe that this goes beyond the boundary of acceptability. In our area this formal dual role is not permitted and 1-2 have resigned for one of their posts where conflicts of this nature have arisen. The DH guidelines are there and should be enforced or situations formally challenged through the appropriate route where they arise.

Tim Jones – Commissioning consultant

This is a problem that is raised in a number of forms across the whole country. Make no mistake – the problem is a real one and PBC collaboratives can marshal many arguments as to why newly commissioned services should be given to primary care providers without recourse to a proper competition. They have a very powerful hand to play and PCTs may be inclined to acquiesce with the idea that they can address and value for money issues when the contracts come up for renewal.

There are plenty of grounds to challenge this situation although you need to ask yourself whether this approach will yield the result you seek.

On the other hand I think it is a mistake for the pharmacy profession and for LPCs to do anything that frames the debate as one between different professions. PCTs should be interested in good quality providers for clinical services and not in the notion of a fair share out between different interest groups. Pharmacists need to start seeing the NHS market in terms of provider opportunities, not professional opportunities.

Michelle Webster – Improvement Foundation

There are safeguards suggested in the PBC guidance on avoiding conflict of interest issues and PCT boards can call on PEC members from nearby PCT's to help in the process. The *provision* of care must only be a *secondary* call, after effective commissioning with the commissioning process driving the whole agenda – the local delivery plan (LDP) and its interpretation is key. Meetings of the new PEC held in public with minutes available to all can ensure transparency. The SHA can be called on if there are any issues of impropriety.

Peter Johnstone - Liverpool Health Care PBC Consortium

Ultimately the Commissioning is done by the PCT, not the PBC and the PCT must have governance arrangements in place that ensure transparency and probity. If the CMC chair (or any CMC personnel) are on the commissioning committee then the PCT has failed in its duty and will get badly mauled in court.