practice advice from central NHS agencies, often based on the pressing need to reduce costs and augment effectiveness. This approach doesn't necessarily include consideration of more qualitative approaches that look at individual patient experiences. Services, in this respect, are described as processes/operations and less as experiences.

3. Clinicians participating in PBC discussions may recognise the significance of their roles in wider change interventions, but these processes seem to be detached from daily discussions and negotiations about service improvements and re-design at practice level where daily issues of patient-staff interactions and service provision are dealt with. GPs, nurses, district matrons, etc. don't necessarily see themselves as contributing to design processes and don't recognise, accept, or have the time to consider, their involvement in broader issues of patient engagement or wider issues such as public health management. In this respect it is a matter of perspective and perception of roles, power, control and visibility.

In this process of formalisation of the role of clinicians in the commissioning and envisioning of new services we therefore advocate, on one side, the importance of making the existing 'design' processes at practice and PBC levels more explicit, visible and shared and, on the other side, creating a synergy between more 'evidence based' approaches with 'experience based' ones and also leveraging clinicians' tacit knowledge about their patients and territories. In doing so we acknowledge the potential role of service design skills and tools such as storytelling, scenarios and outside in and visionary approach as described in the following section.

The role of Service Design

What emerges from the description is the level of pressure, complexity and amount of interlinked problems clinicians need to deal with and how many stakeholders are directly or indirectly involved in the decision making process. Clinicians face the difficulty in negotiating priorities among several issues, and PCT structures demand business cases which evaluate in advance the impact of the service redesign proposals. Given this level of uncertainty and complexity clinicians look for evidence based solutions and datasets that can support their decisions as well as managerial and financial skills to create sustainable models. We have seen how PCTs have provided, or will provide, this support through training, consultancy and by introducing new professional roles into PBC.

What is not mentioned, as part of these support packages, are skills and methods related to user involvement, to make tacit knowledge explicit and usable during designing processes as well as related to the capacity to imagine and visualise radically new solutions. Tom Pickering, Business Manager of Lancaster PBC, recognised how the richness of knowledge doctors have about their clients ('1 millions of visits every year') and local community often remains implicit or only manifested as a general concern; he suggested that this makes it difficult then to evaluate if the concern is coming from a real need of users or from a personal interest of GPs (or a mix of both). The richness of their experience doesn't remain unused, but it is *ill-captured, not shared or exchanged,* reducing the power and influence they could bring into discussion tables as well as in the shaping of common visions.

The power of storytelling has been proved (Erickson, 1996; Bate and Robert, 2007) to be a relevant resource for design, to generate ideas and improvements and to challenge fundamental assumptions. Our questions are therefore: how can clinicians tacit knowledge be accessed during day-to-day activity and brought meaningfully into PBC meetings? How can it be used in a complementary way with more quantitative data? And how it can be

integrated in a systematic approach to generate ideas, set up priorities or generate business models?

PCTs are now required to make arrangements to involve users in planning, developing and delivering health services (DH, 2008). PBC groups, however, are not under any obligation, but still it is considered as 'a powerful tool for redesigning services, for providing innovative care and for making the best use of our resources. Most importantly, […] will help to deliver an NHS more responsive to patient's needs' (Hutton 2005). All PBC groups we interviewed are producing innovations at different levels, but it is not clear to us still how these ideas are generated and what are the sources of information they use. Both Stockport and Wigan seem to have developed ways to engage local communities and third parties to their commissioning activities as it has been integrated into their governance model. Lancaster PBC misses a clear plan for user involvement that perhaps reflects their less structured governance model. We argue that this is not necessarily a limitation as Lancaster PBC seems to have a strong commitment to the community and a belief in a bottom-up approach that manifests in its looser connection with PCT. We therefore argue that, given the richness of links with the community and of the knowledge of clinicians and community servers (i.e. district nurses and community matrons), it could be valuable to explore how clinicians could better make use of this knowledge in commissioning activities. The applicability and relevance of tool kits for 'creative thinking' (developed by NHSi 2007, Thinking Differently) and methodologies for EBD might be explored with PBC groups to investigate how these may be adapted in practice.

At the same time the case studies have shown how time needed to reach agreements among different stakeholders is often under estimated. This is amplified when the role and position of the PCT is not clear, or when contrasting interests reduce willingness to collaborate. A good driver for convergence is again the generation of a narrative, a vision or, in design terms, the building of a scenario (Carroll, 2000). Scenarios and storytelling are often interconnected methodologies that have the powerful potential to facilitate convergence on distant futures and in complex projects if employed in a participatory approach (Jegou, forthcoming; Raijmakers, forthcoming). The NHS North West has been applying scenario building to provide directions and inspirations to their Local Authorities (NHS North West, 2008); this process lasted one year based on 107 interviews and five scenarios building workshops, focusing on future healthcare landscapes. The same approach could be used at a smaller scale to support convergence and direction.

Considering the call for systematic approaches to innovation, our last question is about the degree to which the commissioning process is based on incremental changes arising from emerging concerns, as opposed to a process driven by a wider strategy. Again Stockport and Ashton PBC groups (as much as we could see) seem to have developed (or have been developing) a structured approach to innovation. Lancaster PBC has developed a common vision for 'a continuous expansion of capacity, personnel and skills of the Primary Care Health Team to manage as much care as possible within that team' (Lancaster PBC Business Plan, 2009/2010), but apparently a less structured approach to innovation. Both have strengths and weaknesses. While the unstructured approach can be viewed as a strength, as it can provide the space to work more closely with the local community in a more flexible way, it still requires coordination, methods and techniques to facilitate that.

Service Design consultants have been said to "view the service as a fluid arrangement of human and non-human artefacts, rather than a fixed intangible entity" by elaborating new 'value propositions' that unsettle existing configurations and generate new potentials for businesses (Kimbell, 2009). Service Designers have their own sets of methods that they constantly adapt to the situation and they have an outsider perspective. We ask how much

people within the system, can maintain that openness of imagination, without falling into existing situations or battling against conflicts of interests. And how much providing tools and a more structured approach to innovation can really increase the capacity to look at things in different ways. Service Design studios such as Engine or IDEO are famous for the development of interactive games that support organisations to reflect on their practice and think in different ways. This link between insider and outsider perspectives and their possible interconnection could be explored as well.

What next?

This paper has presented some first insights into PBC framework as it has been implemented in North West of UK. We started posing and answering key questions about the way PBC has been implemented to commission and co-design new services at a local level, showing the diversity of models of governance, support and collaboration.

The development of an effective mode of collaboration between PCT and PBC groups and among different stakeholders within the PBC groups themselves that could balance issues of control, resources and skills is still a big challenge. It seems that highly structured and PCT driven solutions are more effective, but probably weaken local control and real participation by clinicians.

A recent report by the King's Fund (2009) illustrates ongoing problems with practical application of PBC at local level where business cases are taking around 25 weeks to gain approval from the PCT (when guidelines state 8 weeks), then a further 25 weeks to actually become practice. Fifty two percent of PBC clinicians nationally said that they did not feel that their PCTs are making a real effort to engage them at decision-making level.

At the same time clinicians, because of limited managerial skills, resources and time, ask for support and for a clear vision from PCT to be able to deliver what they are asked to. In North Lancashire PCT, Jim Gardner, Medical Director of North Lancashire PCT, admits that, 'GPs have been disappointed that PCTs have often not seemed as willing to help and sort it out as they can ... it's about practicalities, about all the other things that are going on in the system. All the targets in fact, that as a health economy we have to achieve ... and they get in the way of some of this other redesign stuff that colleagues would like to do.'

This difficulty of balancing roles and contributions is mirrored by the low percentage of practices that think PBC has improved patient care; in quarterly results published by DoH the percentage of practices who think that PCB has not improved patient care sits at around 31% consistently, only around 16% believe patient care has improved.

From the Service Design point of view, we believe clinicians could benefit from using service design tools and service design can benefit by learning how to take the synergy between evidence based medicine and experience based design more seriously. Clinicians would benefit from expressing and using their knowledge about their communities in more designerly ways. Clinicians and PCTs consider statistical data as the main source for motivating and imagining services, missing out an extremely rich source of knowledge that comes from daily work of doctors and nurses. Modes to engage patients and to record and communicate their understanding and experiences should be integrated into commissioning activities and training packages to compliment organisational development approaches. This would help to improve GP's role in the negotiations processes and result in better quality briefs for new services.

The Design in Practice team are involved at two levels within North Lancashire PCT, working with the Lancaster PBC group and, specifically, with Coastal Medical Group in Morecambe. The focus of the current research will be the exploration of modes of connection between practitioners and patients (particularly those from typically disenfranchised groups) as well as how to acknowledge, communicate and bring into commissioning groups existing knowledge and daily experience of clinicians and community carers such as district nurses and community matrons. We will explore how these insights into patients needs might be integrated into practice development at GP level, and into commissioning of services at PBC level as well as how they might generate radical visions for the future of health services.

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