

**Practice Based Commissioning
Consortium Plan
2009 – 2010**

This template is to assist practices in developing a practice based commissioning plan. This submission will form the first element of a three year period. There will be in-year opportunities to refresh the plan in addition to half year and annual reviews. The plan should be drawn up in the context of the Sheffield PCT Practice Based Commissioning Incentive Scheme and Governance Framework: Local Enhanced Service Agreement 2008 – 09.

Agreement of the plan by the PCT will trigger the award of the first element of incentive payment.

The plan should be supported by the development of a work programme including measurable outcomes and milestones that will provide evidence to release the second element of the PBC incentive payment.

Progress against the plan will be measured through a programme of monthly support meetings between the consortia and PBC Locality Manager and half-year and annual reviews with PCT Senior and Executive Officers in attendance. Consortia will be expected to complete an annual self-assessment audit evidencing progress and practice engagement.

Consortium Name:

Central Sheffield PBC Consortium

Contact Name: **Paul Wike, Michelle Wilde**
Designation: **Primary Care Lead Managers**

Contact Telephone Number: **2766786**

PBC Clinical Lead:	Dr MG Read	Dovercourt Surgery
	Dr K O'Connor	Heeley Green Surgery
	Dr T Hooson	Northern Ave Surgery
	Dr O Hart	Sloan Practice

Please Type in the text boxes and the boxes will expand

1. Details of Constituent Practices and Commissioning Leads	
Practice:	Commissioning Lead:
See Appendix No.1	

2. Internal Governance Framework (WCC competencies.....)
i.e. Consortium Constitution, voting rights, leaving the consortium, joining the consortium, meetings etc. The consortium should provide evidence of signed off terms of reference. The consortium should consider formally engaging with community pharmacists, optometrists and dentists. The consortium should (ideally) formally acknowledge the role of the Sheffield PBC Confederation as a collective representative view for city wide PBC issues.

Practice PBC Leads

Each Practice has appointed a clinical and non-clinical PBC lead who can be any member of the Practice. Practice PBC Leads will meet formally, usually monthly unless in exceptional circumstances, to review and advise upon commissioning activities.

Practice PBC Leads will be the point of contact for the Steering Group in the delivery of Consortium PBC Plans, and in bringing written requests for service redesign to the Steering Group from the Practice.

The Management Steering Group

The affairs of the Consortium will be managed by the Management Steering Group, which will consist of voting members, namely Practice representatives and appointed non-voting members.

However, Tina Cooke, Central Sheffield PBC PEC Representative attends the meetings along with PCT representatives from Strategy, Performance Management and Finance.

There will be one clinical and one non-clinical representative from each of the 27 Practices within the Consortium. Each Practice has one vote.

For changes to service redesign, a minimum of 80% Practices will be required, for a change in the inter-Practice agreement, 90% Practices will be required.

At a meeting held Wednesday, 5th July 2006 a vote was taken which unanimously agreed that each Practice would have one management and one clinical representative on the Steering Group – irrespective of the size of the Group.

However, a pool of GPs and managers are available who can represent the core group when dealing with other Health and Social Care organisations.

A smaller group of Central representatives meet on a regular basis to develop future strategies for the Consortium with regards to services changes and redesign and changes to clinical pathways

Non-voting members will be representatives from Commissioning, Finance, Public Health, MMS and Community Pharmacy, Information and IT and other stakeholders when required.

These members will be present for discussion relevant to their expertise or by invitation to specific discussions.

Central Consortium is willing to work and engage with all other healthcare professionals in an effort to ensure the patient experience is enhanced; the Consortium will work with other professionals to implement innovative solutions to problems. As an example, some Practices are using pharmacy consulting rooms to expand estates capacity.

Governance and the Consortium

The Consortium will adhere to all local and national governance guidance. The Consortium will uphold their independence and objectivity. All service redesigns and commissioning proposals will have to be ratified by the PCT who will impose ethical rigour and appropriate governance procedures. Central Consortium will work within the city-wide PBC Governance Framework.

Where Practices and Practice staff are undertaking work for the Consortium, they will be expected to act in a professional manner and with the utmost integrity.

Any financial claims for work undertaken must show a clear audit trail of payment and receipt, ensuring transparency in all transactions for Consortium work.

Membership Dispute Resolution

If the actions of a Practice are outside its agreement with the Consortium or risk the effectiveness or financial security of the Consortium it will be asked to meet with the Steering Group to discuss the issues and agree a way forward.

The Consortium will afford the Practice all due information and assistance in these circumstances.

If agreement and resolution cannot be reached through this mechanism, and given a reasonable length of time for any changes by the Practice to become effective, the Steering Group may, as a last resort, propose the expulsion of the Practice from the Consortium.

Expulsion from the Consortium would only be proposed in serious circumstances, for example, where the continuing activities of the Practice resulted in gross inequity in the availability of services or distribution of resources across the member Practices, or threatened the clinical or financial effectiveness or compromised its independence or corporate integrity.

As a last resort, the Steering Group may propose the expulsion of a Practice. Such a proposal will require the agreement of a simple majority of member practices in a closed ballot to be ratified. The decision of such a vote will be final.

A dispute, which parties cannot resolve, will be referred to the NHS Dispute Resolution Procedure.

Freed Up Resources

The Steering Group, for future service redesign, will allocate resources freed up by PBC activities of the Consortium across the locality and on a priority basis to meet health inequalities.

Health inequalities will be identified with the input of Public Health and will address any needs assessment work that has been completed.

Practices, other clinicians and other health professionals and local residents may suggest appropriate service redesigns and developments.

The share of freed resources will be 70% for the Consortium and 30% for the PCT, as stated in the national Guidance. However, the Consortium is below 'fair share' budget allocation compared to some other Sheffield Consortia who are not only above 'fair share' budget allocation but are also overspending on their commissioning budgets. Currently, the Consortium is 2.5% below 'fair share' budget which equates to £2.5mills.

Because of this, the Consortium would wish to secure the total amount of any savings that are available.

Risk Pool

If Practices disagree with the allocation of savings from PBC, they will be encouraged to discuss this with the Steering Group, which will have a duty to ensure fair, transparent and agreed allocation of freed resources within the regulatory framework.

Dissolution of the Consortium

The Consortium may be wound up at any time by a simple majority of its member Practices. On dissolution, the indicative PBC Budgets would revert to the Practices that would then need to undertake all their PBC activities in direct negotiation with the PCT.

Leaving the Consortium

Any Practice can opt to leave the Consortium at the end of a financial year by giving three months' written notice. Their indicative PBC Budget would then revert to the Practice for it to decide its future in commissioning in discussion with the PCT directly.

Review Meetings

Consortium representatives will attend regular meetings with PCT staff to discuss issues around finance, referrals and activity and information and IT issues.

3. Strategic Aims of the Consortium (WCC competencies.....)

The consortium should provide clear strategic goals that align to ABH (2). In addition the consortium should demonstrate clearly how its strategy has been developed with input from its constituent members, wider stakeholders and the patient population it represents. In particular the consortium is encouraged to think about strategic links with other contracted primary care providers (ie Optoms, pharmacists and dentists)

The strength of the Consortium lies within the Practices in the area working together to achieve the following aims:

- Ensuring that local clinicians inform and direct the services to be commissioned
- Creating a common approach to PBC which aims to reduce health inequalities and improve service availability and quality across the locality
- Minimising financial and clinical risk through its strength and stability
- Providing information, guidance and support for practices in the management of the PBC activities which will still be required at practice level
- Via the Consortium Steering Group and Practice PBC Leads, developing a body of PBC knowledge and expertise in primary care clinicians for the benefit of all parties.
- The Consortium will demonstrate effective partnership working within their commissioning proposals; input will be sought from patients and the public, NHS Sheffield, Sheffield Foundation Trusts, Voluntary and Community Sector organisations and the City Council agencies
- The Consortium will seek to share skill, knowledge and/or appropriate resources for the benefit of the registered population
- The Consortium will fully engage in PPI (Patient and Public Involvement) and services will be reviewed and developed in partnership with clinicians, Providers and service users
- The Consortium will maintain close working relationships with Provider Trusts.
- All commissioning activity involving the use of public funds must be seen to be in the public interest and be transparent – this will require not only potential conflicts of interest to be identified, declared and resolved in advance by commissioners, but that adequate audit trails are established

Central Sheffield Consortium Specific Aims and Objectives for 09/10

As in the past, all Practices in Central are given the opportunity the input into the future strategy of the Consortium.

This is achieved in several ways:

- Weekly Manager meetings
- Joint Manager and Clinician meetings
- Central Strategy Group
- Individual Practice visits by Central representatives
- By Email

- where all views are canvassed on PBC and Primary Care and input is sought into the future strategies and policies of the Consortium

Central representative have undertaken presentations to the LMC and the LPC. It is

envisaged that the already good links with Pharmacists and Dentists will continue and grow. A Community Pharmacist is a member of the Joint Meeting and work has been ongoing with several dentists who are keen to open a dental surgery within Central Consortium. However, a more structured meeting schedule will be developed and implemented to allow more integrated and collaborative working to take place with pharmacists, dentists and optometrists. This will be developed throughout this period, in an effort to fully engage these different disciplines of healthcare providers.

Central Consortium will also work towards:

- Moving Secondary Care activity into Primary Care
- Increasing access for patients to diagnostics tests and analysis
- Utilise service redesigns and freed up resources to implement Consortium-specific services which will be cost-effective, of high quality and patient focused.
- Public Health – working NHS Sheffield Public Health staff to get the maximum form the Public Health Enhanced Programmes within the Consortium
- Increasingly involve patients and the public in service redesigns and the commissioning cycle
- Work towards being a World Class Commissioner
- Explore the use of Integrated Care Programme and Organisations to deliver a holistic, seamless service for patients – utilising increased vertical integration with other organisations as a means of achieving this.
- Continued marketing of Central Sheffield PBC Consortium - including various marketing initiatives; for example, the website, newsletters, leaflets and posters, continued work with HR Media
- Develop as an organisation
- Engage with other PBC Consortia in the Sheffield Confederation and be involved in citywide PBC initiatives

Contribution to ABH(2)

Alongside NHS Sheffield's goals and vision, as stated in the document, Achieving Balanced Health (2), Central Consortium will work in collaboration with NHS Sheffield in an effort to achieve the goals stated in ABH2:

- An increase life expectancy for the people of Sheffield - we aim to 'save 400lives' by 2012 – by ensuring that 400 fewer people in Sheffield die under the age of 75 in the years between 2007- 2011, compared with the 2006 rates
- A reduction of the gap in life expectancy which exists in the city between the healthiest and the least healthy
- A increase in the quality and personalisation of services
- Financial viability for services in the long term

Additionally, service redesigns and investment of freed up resources around COPD, Unscheduled Care, ENT, Diabetes, D-Dimers and Mental Health have been identified by the Consortium to ensure ABH2 goals are achieved.

4. Reporting metrics for LIS payments

In pursuance of linkage to the NHS Sheffield strategic objectives as articulated in ABH(2) and evidence of clear accountability arrangements for the use of resources, the consortium is expected to demonstrate achievement across a range of parameters.

Detailed below is the apportionment of LIS payments and the reporting indicators to which the consortium is signed up, the achievement of which will trigger LIS quarterly payments

PBC Consortium Plans 2009/2010 - SMMG Performance Metrics (Quarterly Reporting)

LIS Part A Payment (50%) - Approved Consortium Plan 2009/2010

LIS Part B Payment (50%) Comprising:

30% Delivery of key service redesigns identified within Consortia plan. Achievement criteria listed
10% Referral Activity and Out-patient Follow-Up Spend below pre-set targets (Consortium Level)
(5% Referrals Activity Target, 5% OPFU Spend Target- Quarterly Payment Release Non-cumulative,
10% Prescribing Spend - paid at the end of Q4 (i.e. cumulative to M12) must remain within financial

Additional SMMG Reporting Indicators:

The Consortium makes progress in leadership capability, leadership capacity and succession planning
Indicator: Agreed Consortium Development & Succession Plan.

6. Public Health Overview and Needs Assessment

Service redesign and pathway development plans incorporate a full and robust impact assessment on health
Indicator: All initiatives benefit at least one ABH(2) health priority in an explicit and measurable way

7. Financial Management Arrangements

The Consortium remain within pre-agreed quarterly targets

Indicator 1: Referral Activity below pre-set targets.

Indicator 2: Out-patient Follow-Up Spend below pre-set targets.

8. Ongoing Service Redesign and Pathway Developments from 2008/09 Plan

Ongoing developments are within the agreed milestones set

Indicator: Delivery of benefits as set out in Business Case(s) post implementation

9. Service Redesign and Pathway Development Proposals for Current 2009/10 Plan

New proposals are within the agreed milestones set

Indicator: Production of Business Cases according to the timescales as set out in the Consortium

10. Referral Management Action Plan for 2008/09

Referrals both from GPs and other sources to be reviewed and acted upon on a monthly basis

Indicator 1: Referral activity levels below previous year's comparable quarter (working day basis)

Indicator 2: Referrals reviewed at relevant monthly Consortium meetings

Indicator 3: Evidence of regular review of referrals using 'real-time' RIS data.

11. Actions Plans for Demand Management of Non-Practice Initiated Activity

Non-elective activity to be reviewed and acted upon on a monthly basis

Indicator: Non-elective admissions below previous year's comparable quarter

12. Prescribing Action Plan 2009/10

Indicator: Prescribing spend must remain within financial budget - reported at the end of Q4

13. Public and Patient Engagement

Service redesign and pathway development plans include evidence of patient support, including consultation with patients and users.

Indicator 1: Evidence of change implemented that has been requested by patients.

Indicator 2: Evidence of patient involvement in implementation of initiatives.

5. Organisational Development in 09/10 (WCC competencies.....)

The consortium should have a clearly stated OD plan, which identifies specifically how it will develop its leadership capability and capacity. The consortium should also demonstrate how it will manage succession planning

Organisation Development Strategy

Introduction

Central PBC Consortium is a group of GPs, Nurses and Practice Managers from 27 practices in the centre of Sheffield who are working together to improve the quality and delivery of services for our patients and to reduce health inequalities across the city.

Vision

The members of the Consortium aim to develop new and better solutions to improve the quality and levels of care within their local communities and give patients better access to the health care services they need.

The Consortium will work together to develop best practice and best value health care services which reflects and meets the needs of local people.

Development Goals

1. Develop a culture for learning and development of individuals and as a learning organisation.

Objectives

- Nurture learning opportunities to develop a culture for innovation and ability to adapt to changing circumstances and strive to continually improve.
- Develop a culture for valuing individual contributions.
- Provide interactive learning activities for members of the Consortium to engage in and learn from.
- Increased engagement with patients, public and other stakeholders to develop feedback opportunities for enhancing learning.
- Promote the importance of team learning and opportunities for creative and collaborative working across traditional boundaries.

This work will be ongoing and will be measured by facilitating learning events and workshops.

2. Continue to develop the Organisational structure

Objectives

- Development of a shared common vision amongst members of the Consortium
- Improve work processes within the Consortium.
- Enhance communications and involvement with relevant stakeholders in strategic development to develop increased levels of commitment.
- Continue to develop effective marketing and awareness of Consortium activities.

This work will be ongoing and will be measured by the amount of Consortium-Practice contact and level of service marketing and advertisement.

Continued work with HR Media.

3. Improve the quality of services provided for patients

Objectives

- Encourage the benchmarking and development of best practice to work towards improving the standard and quality of services delivered improving the equity of access and quality for patients.
- Develop evaluation and service improvement strategies to ensure critical analysis and establish 'reality' in the development and direction of the Consortium.

This work will be ongoing and measured by the number of audit and evaluation reports produced.

4. Develop management capabilities and human resource provision

Objectives

- Develop a skill matrix of Primary Care staff and available resource pool.
- Offer training and developmental opportunities for leadership training and team development for the Managerial and Clinical leads within the Consortium.
- Review opportunities for external resource provision.

This work will be ongoing and will be measured by the compiling of a skills matrix and the take-up of clinical and managerial development opportunities.

Succession and Capacity Planning

Central Consortium recognises the need to enhance the commissioning and leadership skills of managers and clinicians, especially younger GPs. The Consortium will work with NHS Sheffield colleagues to identify and develop managers and clinicians and access resources being offered by NHS Sheffield.

Capacity of managers within the Consortium has been identified as an issue; however, this is being addressed with another two managers becoming more involved in PBC work.

It is also envisaged that the Consortium will fully utilise NHS Sheffield staff aligned to the Consortium in this period.

Lead members of the Consortium have identified individual learning needs and it is proposed to develop and implement a training and development programme to address these needs;

Possible subject areas:

- Change Management – M Wilde
- Health Economics – P Wike
- Contracting and Negotiation Skills – M Read
- Leadership – K O'Connor
- Organisational and Strategic Planning – O Hart
- Contract Financial Management – P Wike, T Hooson
- Marketing – C Nicol, S Turner, O Hart
- Public Health issues and Health Inequalities – P Wike, J Chauderna

Also, Central will access the NHS PBC Development Framework that is being developed and facilitated by NHS Sheffield

A skills and capacity audit has been undertaken within Consortium and from this, 2 Primary Care managers are to increase their time working for the Consortium and a Secondary Care manager is to work 1 day per week implementing the Community Diabetes Team.

Alongside this, Consortium managers are to work more closely in this period with allocated NHS Sheffield managers and staff to form a larger Consortium 'management resources team'.

This will include NHS Sheffield staff from Strategy, Finance, Performance Management, Public Health and Health Informatics.

6. Public Health Overview and Needs Assessment

Public Health Commentary and Priorities

Public Health Profile

The Central Consortia practices cover a population in the centre and South East of the city. There are a high number of households living in a poverty postcode 40.8% compared to 27.7% in Sheffield. Many of the neighbourhoods covered by the practices are part of the Enhanced Public Health Programme which is an initiative focussing on the most deprived neighbourhoods. (see below) There are 7.7% from the Asian/ British Asian community compared with the Sheffield average of 4.0 %. Some practices have more than 20% Asian/British Asian patients. The higher proportion of BME groups in the practice will present additional challenges.

Other public health indicators are at a higher level including conceptions to females aged < 18 and also mothers recorded as smoking at delivery but this varies across the Consortium neighbourhoods. The consortia population also have a lower rate of mothers intending to breast feed at delivery.

Mortality rates reflect the higher levels of deprivation in the Central Consortia population the areas which are significantly higher than the Sheffield average include - All cause Circulatory disease, Cancer deaths, Circulatory disease and Respiratory disease. The QOF data indicates higher prevalence of stroke and TIA, COPD and Mental Health. Smoking prevalence recoded within a disease group indicates higher rates of smoking in patients with CHD, Hypertension and Asthma.

Priorities:

- **Central Consortium Public Health Group** will provide the strategic lead with regard to public health interventions and the public health role of the consortium

- **Public Health Data**

The consortium will need to demonstrate how it has integrated its constituent population's major public health needs into its strategic aims, annual work plan and business cases. In order to achieve this the consortium will develop further understanding about utilising public health data.

- **Communication** Provide up to date and appropriate information about public health interventions including the Active Programmes, Enhanced Public Health Programmes and health promotion campaigns. This information will be included on the consortium website and other information will be available at practice level.

- **Active Programmes**

Achieve development and support for the Active Programmes including effective referral systems and communication with practices. The Active Programmes are:

1. Desmond – Diabetes education and self management for ongoing and newly diagnosed and BME groups
2. Cardiac Rehabilitation
3. Respiratory Rehabilitation
4. Physical Activity Referral Scheme – which is part of the pathway for the rehabilitation schemes

- **Enhanced Public Health Programmes**

The EPHPs are planned to galvanise services and stakeholders to prioritise resources and attention to areas where health is poorest. The EPHPs are focused on 15 geographical neighbourhood clusters in Sheffield, these programmes are intended to lead to a substantial improvement in health in the areas covered, through a three-tiered approach

- Tackling the wider determinants of health – housing, environment, regeneration and employment
- Promoting health lifestyles – increasing physical activity, stopping smoking
- Increasing uptake of appropriate health services – to increase access by the most at risk individuals to treatment and care and primary and secondary prevention.

Objectives:

- Identify practices with the most patients from EPHP areas.
- Develop a systematic approach for developing links between EPHP and practices. This will enable earlier identification, treatment and care to those most at risk. Develop referral systems for community interventions for primary and secondary prevention including social prescribing.
- Utilise community venues for provision of services such as screening.
- Link practices with the new Health Champions Scheme and the Phase 1 health trainers scheme when established. This will enable support for patients to access public health interventions.

- **Smoking**

Practices will aim to treat at least 5% of their smoker population annually – treatment is defined as a patient setting a quit date.

Provision of stop smoking advice and support

Practices to continue to routinely ask about smoking and record patients' smoking status, Practices to provide effective advice to smokers and arrange for smokers wishing to quit to receive stop smoking support. Support programmes will comprise an offer of both weekly counselling plus relevant medication. Practices will aim to treat at least 5% of their smoker population annually.

Smoking in pregnancy:

The Consortium acknowledges that in general terms smoking is the single biggest modifiable risk factor in pregnancy. Practices will endeavour to ensure that smoking status is checked at the earliest opportunity in every pregnancy and that smokers are strongly advised to stop, and referred to a midwife trained in smoking cessation.

Smoking status of registered patients:

Having accurate and up-to-date electronic patient records and registers are essential to the provision of systematic and structured healthcare. As the biggest modifiable risk factor for chronic ill health and death – and the single biggest cause of health inequalities – the Consortium recognises the importance of practices maintaining high rates of smoking status recording of patients aged 16 years and over (ref. QOF Records 22).

7.Financial Management Arrangements (WCC competencies.....)

The consortium will need to present a clear financial plan that confirms how it will manage its indicative budget. With regard to FUR's the consortium will need to identify priority areas for usage and in particular provide reassurance that previous years savings will be committed appropriately within the two year deadline. The financial plan will be measured against pre agreed quarterly targets for each consortium (reflecting that historical budgets will affect the level to which savings can be made)

Financial Management:

The Consortium is committed to working with NHS Sheffield to ensure budgetary balance. Regular finance meetings will take place with NHS Sheffield Finance to ascertain the financial position of the consortium, on a monthly basis. Trends and forecasts will be discussed and any potential overspends will be identified to allow the Consortium make meaningful and timely decisions to address any potential slip from financial target. Finance and activity data will be shared with constituent Practices to highlight any individual Practice issues.

There will be individual pieces of work that will be commissioned from individual staff or from Practices; this will be agreed by the Management Steering Group prior to the work starting.

Any reimbursement for work undertaken for the Consortium will require a clear and transparent audit trail; the Consortium will work closely with PCT Finance staff to ensure transparency.

All claims submitted by Practices will be countersigned by another manager and signed by the NHS Sheffield Primary Care Asst Director prior to submission to NHS Sheffield Finance.

PBC LIS funds will be pooled, and distributed when possible, and the NHS Sheffield will hold these funds for Consortium Practices as in the past 3 years.

A computerised record of PBC Local Incentive Scheme spend will be kept.

The Consortium would like to continue with a 2.5% risk pool allocation.

Predicted LIS Spend -

Locums for back fill	£50,000
GP pay for outside working hours	£35,000
Management	£75,000
Refreshments/Venues/Misc	£5,000
HR Media	£15,000
Prescribing Advisor	£5,000
Total	£185,000
Carried over from 08/09 – held in reserve	£100,000

Freed Up Resources

In period 2009/10, the Consortium will have to spend £600,000, this will allocated:

MH Service – recruitment for 2 CPNs is underway to	£60,000	This will allow patients of the pilot
Generic Support Workers – after a recent meeting	£150,000	This will give Community Nurses
Community COPD Service – it has been decided to	£150,000	This service will increase access to
Pharmacy provision – possible investment in	£150,000	Implementing ScriptSwitch across

		quality of prescribing.
Reserve	£90,000	This reserve will be used to address any potential financial overspend due to the implementation of HRG4 coding.
Total	£600,000	
2008/09 Underspend	£750,000	A proportion of this will be used to address any potential financial risks through the implementation of HRG4 coding. The remainder will be invested in patient services 2010/11

8. Ongoing Service Redesign and pathway developments from 08/09 Plans (WCC competencies.....)

Clear plans with milestones need to be expressed for any service redesign/ pathway development work that is carrying over from the previous year

The Consortium, when undertaking service redesign, will work with NHS Sheffield and be mindful of citywide work being undertaken in an effort to reduce duplication.

Consortium specific service redesigns -

- **COPD** - service will be expanded and will be specific to Central Consortium utilising the Met Office Alerts Service
- **Diagnostics** - expansion of collaborative work with STH, possible expansion of MRI service
- **Prescribing** - ongoing work with Practices and the MMS Team
- **Diabetes** – implementation of approved business case
- **ENT**
Business Plan submitted to PCT, April 2008, this is a resubmission. The service will be nurse-led, community-based and will be cost-effective

Clinical Sub Groups will continue to undertake Service redesigns.

**9. Service Redesign and pathway development Proposals for 09/10
(WCC competencies.....)**

See Appendix 3

- **Un-Scheduled Care** - ongoing and use of freed up resources to implement a service that is responsive to patient needs by using a Health and Social Care Co-ordinator and engaging with all stakeholders working with all agencies including the Voluntary and Community Sector, Benefits Advice and Patient Advocates – utilising Generic Support Workers
- **D Dimers** – implementation of DVT test in Primary Care
- **Physiotherapy Services** – implementation of a Consortium specific service using freed up resources
- **Primary Based Gastroenterology Service** – in collaboration with STH

Involvement in City wide service redesigns-

- **Back Pain**
Involved in citywide service redesign around a rationalised Back Pain Service. Coordinate and deliver an implementation strategy – May 09
Evaluation of service – November 09
- **Mental Health**
Involved in citywide service redesign pilot around implementing a Primary Care based MH service which will be disseminated citywide when successful
- **Unscheduled / Intermediate Care**
Ongoing work on citywide aspects of unscheduled care

10. Referral Management Action Plan for (WCC competencies.....)

The consortium needs to identify clear priorities and measures for successful referral management. The plan needs to be agreed with the relevant NHS Sheffield matrix team. The plan should include reference to non practice initiated referrals (This could be managed via the Confederation and with the support of NHS Sheffield)

Activity

A Local Incentive Scheme was introduced in October 2008 where Practices from Central were asked to commit to looking at the appropriateness of referrals and ways of reducing referrals. All Practices signed up to the LIS and ongoing evaluation of the LIS is underway, if the LIS proves to be successful this will be carried forward for period 2009/2010.

Collaborative work will continue with all Directorates of NHS Sheffield to effectively monitor the rate of referrals and number of referrals being made. Monthly meetings with Performance and Strategy ensure that this information is disseminated to Practices so they can see their rates of referral against other Practices within the Consortium and Sheffield as a whole. However, there needs to be more Practice specific information on referrals made available from Health Informatics and Performance so effective management of referrals can be undertaken.

Representatives from the Consortium monitor activity and referrals, this Group continues to liaise and work with Practices, Health Informatics and Secondary Care to ensure validity of data:

- This Group will identify and monitor areas of concern highlighted by Practices and the NHS Sheffield
- Reviews Consortium referrals activity monthly
- Continues to target over activity
- Part of the citywide Information Group

Elective Referrals

The Consortium will continue to monitor referrals, including indicative referral profiles identified by the PCT.

This Group will continue to work with Practices in a structured way to address referral management, the aims of the Group are:

- Improve the understanding of commissioning data available from HIS
- Show Practices how to access the data
- Help Practices to understand their own data in more detail
- Agree areas of interest that may benefit from further investigation by either NHS Sheffield or the Consortium

Monitoring of referrals will be undertaken in several ways; for example,

- In-Practice peer review of referrals where each referral is agreed amongst Partners and best practice shared between GPs and Cluster Practices,
- Single handed GPs will be given the option of working with a neighbouring Practice to agree referrals
- Continued work with Practice typists and secretaries ensuring they are aware of locality based services
- Referrals triage when service redesigns permit
- Systematic audits will be undertaken, both in-Practice and Consortium-wide, where reductions in a specific speciality do not occur
- Ongoing service developments to reduce Secondary Care referrals
- Market local services effectively to encourage maximum uptake and appropriate use of service
- Monitor uptake of Locality Based Services
- Identify appropriate Read Codes to capture referral data of local services, working in partnership with Health Informatics

Ongoing agreement is required with the NHS Sheffield to address inaccurate data and the effect this will have on decision-making process and service redesign and ultimately financial balance.

‘Other’ Referrals

35% of all referrals made to Secondary Care and other Providers are made by non GPs, this is a major issue for the Consortium as Practices have no control over these referrals. Preliminary work undertaken by NHS Sheffield Performance has identified an issue but the origin of these referrals has still not been determined.

Possible referrers could be; Health Visitors, District Nurses, Community Matrons and Midwives, Intensive Case Managers, Dentists, Opticians and Orthodontists.

Unless, and until, these referring clinicians are identified, it will be difficult for the Consortium to effect any change in current referral patterns, however, Central will work with NHS Sheffield colleagues to have a unified approach to addressing the problem.

Non-GP referrals are an issue within Central Consortium. Within this period, work will be undertaken, working with NHS Sheffield colleagues to effectively identify where these non-GP referrals are instigated.

A Primary Care manager will be allocated to work with NHS Sheffield colleagues to ascertain the scope, size and solution to this issue.

Even though the Referral Information Scheme has been imposed on the Consortium, the Consortium will use the RIS to validate and verify GP referrals made against activity charged.

11. Action plans for Demand Management of non-practice initiated activity, in particular non elective admissions (WCC competencies.....)

The consortium needs to identify clear priorities and measures for successful management of non elective admissions. In particular the plan needs to ensure that it the following strategies (unscheduled care, primary care, LTC's and end of life) The plan needs to be agreed with the relevant NHS Sheffield matrix team

Non-Elective Referrals and activity -

Consortium Practices will continue to Community Matrons, Intensive Case Managers, District Nurses, the Intermediate Care Team and Rapid Response Nurses and the CART teams in an effort to reduce the amount of non-elective admissions, a major and ongoing issue for the Consortium.

Addressing non-elective activity is a priority for the Consortium

Out-of-Hours, A&E for both adults and children and emergency admissions are all areas where the Consortium sees potential to rationalise services, make them more integrated and deliver them in a community setting.

A Clinical Sub Group has been set up and issues around the current service and any potential service redesign will be shared with other citywide initiatives to ensure value for money and minimise duplication of work.

A meeting has been held with representatives of NHS Sheffield Provider Services to fact-find and information gather in an effort to identify any potential gaps in the current services or gaps between the services.

The Consortium intends to work with all stakeholders and agencies to ensure that the existing resource is deployed effectively to benefit patients and reduced unscheduled care admissions.

There has been considerable investment in Community Nursing services, especially in DNs, ICMs, and CMS – the Consortium wants to work with all these elements of the service to enhance patient care and ensure housebound patients receive comparable care compared to ambulant patients.

The Consortium is to invest some freed-up resources to introduce Generic Support Workers to further enhance patient care and reduce the number of unscheduled care admissions.

Ongoing work with D Mason, Unscheduled Care Service and Specification Manager, will continue in an effort to reduce non-elective admissions. Issues around length of stay, early discharge, lack of Social Services funding for care packages and end of life care will be considered when addressing unscheduled care activity.

12. Prescribing Action Plan for 2009/10

The consortium needs to develop a robust prescribing action plan, with clear milestones and performance measures to demonstrate effectiveness

Central Sheffield Consortium Prescribing & Medicines Management

Aims

- To promote high quality, cost effective, evidence-based prescribing.
- To effectively manage prescribing resources without affecting the quality of prescribing.
- To minimise the risks to patients associated with medicine taking.
- To deliver national and local priorities on prescribing.

Objectives

- 1. To hold regular Consortium Prescribing Subgroup meetings to progress prescribing and medicines management issues across the consortium**
- 2. The consortium prescribing subgroup will work to 'champion' prescribing and medicines management issues across the consortium**
- 3. Promote evidence based cost effective prescribing**

The consortium prescribing subgroup will work with the PCT Medicines Management team to:

Identify which practices are heading for an overspend on their drugs budget

Ensure that all practices in the consortium have acted in areas in which savings can be made without detriment to patients.

To identify other therapeutic areas where prescribing may differ compared to local or national practice.

To identify other areas where further savings could be achieved through simple schemes e.g. wound management prescriptions, use of a dietician to review sip feeds

4. Maintain and update the Scriptswitch profile database

Work with Practices so that Scriptswitch software is configured to show the most cost effective evidence based product to be presented at the point of prescribing

5. Involvement/Support of schemes to improve medicines management systems and processes within practices

Pilot the 'practice medicines managers' scheme' within one practice and spread good practice across the consortium.

The consortium prescribing subgroup will work closely with new members of the consortium to improve medicines management within their practices.

6. Helping patients to get the best use of their medicines

Improving the methods by which patients receive medicines by:

- Ensuring practices have robust, efficient repeat prescribing systems in place i.e. training of new receptionist staff on repeat prescribing systems, development of repeat prescribing policies.
- Greater involvement in repeat dispensing schemes
- Supporting Introduction of electronic prescribing
- Supporting use of minor ailment scheme

7. Education

To run regular education meetings on prescribing issues across the consortium for prescribers

To create a web-page that the consortium prescribing subgroup can populate so that information messages to be prescribers and practices can be easily disseminated.

Challenges and Potential Risks

Effective systems and processes need to be in place to support the consortium in delivering the above objectives. Some challenges include:

Difficulties influencing and implementing change in prescribing behaviour across the consortium and ensuring practices keep within allocated prescribing budgets.

Maintaining the Scriptswitch profiles on a regular basis presents a huge workload challenge for the consortium prescribing subgroup.

Better engagement and support from the PCT in the following areas is crucial:

- Medicines management support to all practices within the consortium.
- Early organisation of meetings and provision of prescribing plan for achievement of QoF medicines management targets.
- Regular timely provision of prescribing data analysis by the medicines management team so changes in prescribing costs can be identified early
- Support from the PCT to progress any schemes identified as beneficial.

13. Public and Patient Engagement (WCC competencies.....)

The consortium needs to demonstrate how it will ensure that patient and public engagement is factored into sections 3,6,8,9,10,11,12

Several Practices within the Consortium have Patient Representative Groups and Patient Forums, especially for specific diseases, for example, Diabetes and COPD.

The Consortium has built on this experience and will work with an external organisation, HR Media to formulate an effective strategy for engaging with the local population to ensure their views are considered when issues around service redesign and the implementation of new services are decided upon. A Sub Group have been set up and has met several times with patients in an effort to ascertain their views on commissioning and what they perceive as local priorities in an effort to formulate service redesign and potential investment. This has been especially successful around ENT and Diabetes service redesign proposals.

The NHS Sheffield PPI Manager, the Expert Patient Programme and Better Outcomes for Patients will also be used to enable and empower patients to input into the commissioning process.

The Consortium is keen to work with all stakeholders, especially local voluntary and community groups, local council Area Panels and Primary Care employed and attached staff.

A website has been set up; www.sheffieldhealth.co.uk, and working with HR Media we have specific support around Media and Public Relations, PR Meetings, Press Release production and Media Distribution.

The Consortium can also access expertise around Event Management and Health and Public Health campaigns.

HR Media will also work with the Consortium on Web and E-media opportunities, including e-newsletters

13. Summary of objectives (WCC competencies.....)

The objectives from the consortium should be clearly developed from sections 4 -12 and can be integrated within each section

See Appendix No.3

14. Measuring Progress of the plan (WCC competencies.....)

Key milestones and performance measures for each objective need to be stated to ensure release of the second component of the PBC LIS

What	When
<i>Submission of business case for a Primary Care based Gastroenterology Service</i>	<i>Quarter 2</i>
<i>Implementation of a Primary Care based MH Service</i>	<i>Quarter 2</i>
<i>Implementation and evaluation of the effectiveness of ScriptSwitch across all Practices</i>	<i>Quarter 2</i>
<i>Submission of business case for a Community COPD Service</i>	<i>Quarter 3</i>

Central Sheffield PBC Consortium – Section 13 Summary of Objectives – Appendix No.3

ENT	Objective	Timescale	Lead	Key Performance Indicator
<p><i>To implement a Primary Care based ENT Service</i></p> <p><i>ABH(2) linkages:-</i> Local Initiative 11-planned care</p>	Plan agreed	November 08		
	Variation to Plan – movement to a Consultant-led service	February 09	Central / STH / NHS Sheffield	<i>Reduce referrals below current levels</i>
	Agree variation to Plan	February 09		<i>Increased cost-effectiveness compared to existing service</i>
	Introduce referral criteria for clinicians and agree start date	March 09	Central / NHS Sheffield	
	Market service prior to start	April 09	Central	<i>Move patient care closer to home – a local and national priority</i>
	Audit and monitoring of activity – analyse referral and diagnoses	October 09	Central	
		April 2010	Central / STH / NHS Sheffield	<i>Improve access to services and reduce DNAs</i>
	Work with other Sheffield Consortia to implement citywide service-expand service		Central / STH / NHS Sheffield	

Central Sheffield PBC Consortium – Section 13 Summary of Objectives

PATIENT AND PUBLIC INVOLVEMENT	Objective	Timescale	Lead	Key Performance Indicator
<p><i>To develop a Consortium Patient and Public Involvement Strategy</i></p>	<p>To work with Patient and Public Sub Group/ HR Media company and develop a strategy for patient and public involvement.</p>	<p>May 09</p>	<p>Central / HR Media / NHS Sheffield</p>	<p><i>Produce a strategy</i></p>
	<p>Produce newsletters for marketing services, informing patients of health issues – both local and national.</p>	<p>Monthly</p>	<p>Central / HR Media</p>	<p><i>Continue to interact with patients, the public and the local media</i></p>
	<p>Involve patient user groups in service redesign for the consortium.</p>	<p>Ongoing</p>	<p>Central / HR Media / NHS Sheffield</p>	<p><i>Produce marketing material</i></p>
	<p>Produce promotional literature/ marketing of new/existing services/ health campaigns for patients</p>	<p>Quarterly</p>	<p>Central / HR Media</p>	
	<p>Produce promotional literature/ marketing of new/existing services/ health campaigns for patients</p>	<p>June 09</p>	<p>Central / HR Media</p>	
	<p>Continue development of Website for patient and public use</p>		<p>Central / HR Media</p>	

Central Sheffield PBC Consortium – Section 13 Summary of Objectives

COPD	Objective	Timescale	Lead	Key Performance Indicator
<p><i>Expand the current Primary Care COPD Service</i></p> <p><i>ABH(2) linkages:-</i></p> <p>Local priority 2-Chronic respiratory disease</p> <p>Local initiative 12- Planned care 15- Unscheduled care</p>	<p>COPD Operational Group set up.</p> <p>Prevalence and Incidence of COPD disease identified at Practice level.</p> <p>Support for practices identified.</p> <p>Recruit staff</p> <p>Resource input into Practices.</p> <p>Evaluation and monitoring of input into Practices, especially around Unscheduled Care.</p>	<p>February 09</p> <p>February 09</p> <p>March 09</p> <p>June 09</p> <p>July 09</p> <p>October 09 – March 10</p>	<p>Central / NHS Sheffield Public Health and Provider Services</p> <p>Central / NHS Sheffield Public Health and Provider Services</p> <p>Central / NHS Sheffield Public Health and Provider Services</p> <p>Central / Provider Services</p> <p>Central / NHS Sheffield Public Health and Provider Services</p> <p>Central</p>	<p><i>Reduce referrals below current levels</i></p> <p><i>Increased cost-effectiveness compared to existing service</i></p> <p><i>Move patient care closer to home – a local and national priority</i></p> <p><i>Improve access to services and reduce DNAs</i></p>

Central Sheffield PBC Consortium – Section 13 Summary of Objectives

DIABETES	Objective	Timescale	Lead	Key Performance Indicator
<p><i>To implement a Community Diabetes Service</i></p> <p><i>ABH(2) linkages:-</i></p> <p>Local priority 5- Diabetes</p> <p>Local initiative 12- Planned care</p>	<p>Work with Secondary Care to organise and implement service.</p> <p>Address operational issues.</p> <p>Implement service</p> <p>Evaluate and monitoring Primary Care service.</p>	<p>February / March 09</p> <p>March 09</p> <p>April 09</p> <p>October 09 – March 2010</p>	<p>Central / Secondary Care</p> <p>Central / Secondary Care</p> <p>Central / Secondary Care</p> <p>Central / NHS Sheffield</p>	<p><i>Reduce referrals below current levels</i></p> <p><i>Increased cost-effectiveness compared to existing service</i></p> <p><i>Move patient care closer to home – a local and national priority</i></p> <p><i>Improve access to services and reduce DNAs</i></p>

Central Sheffield PBC Consortium – Section 13 Summary of Objectives

MENTAL HEALTH	Objective	Timescale	Lead	Key Performance Indicator	
<p><i>To implement a Primary Care based Mental Health service – a pilot for the City.</i></p> <p><i>ABH(2) linkages:-</i></p> <p>Local priority 9- Mental health</p> <p>Local initiative 12- Planned care 15- Unscheduled care</p>	Recruit staff	April 09	Central / NHS Sheffield	<i>Implement the service</i>	
	Induction	May 09			
	Start service.	June 09	Central		
	Address operational issues	Ongoing	Central		<i>Evaluate the service</i>
	Evaluate service at 6 months, 9 months and 12 months.	Ongoing	Central / NHS Sheffield		<i>Disseminate the findings</i>
	Compile report regarding difficulties of service.	March 2010	Central / NHS Sheffield		<i>Recommend future development</i>
	Disseminate.		Central / SCT / NHS Sheffield		

Central Sheffield PBC Consortium – Section 13 Summary of Objectives

UNSCHEDULED CARE	Objective	Timescale	Lead	Key Performance Indicator
<p><i>Working with NHS Sheffield Public Health and Provider Services</i> - <i>Expand the capacity of Community Nursing capacity around unscheduled care admissions</i></p> <p><i>ABH(2) linkages:-</i></p> <p>Local initiative 15- Unscheduled care</p>	<p>Fact-finding and information gathering workshop to identify any gaps in service provision</p> <p>Recruit Generic Support Workers</p> <p>Identify unscheduled care nursing resource</p> <p>Align nursing resources to clusters within Central Consortium</p> <p>Audit and evaluated enhanced service provision</p>	<p>January 09</p> <p>April 09</p> <p>May 09</p> <p>June 09</p> <p>Ongoing</p>	<p>Central / NHS Sheffield</p> <p>Central / Provider Services</p> <p>Central / Provider Services</p> <p>Central/ Provider Services / NHS Sheffield</p>	<p><i>Reduce referrals below current levels</i></p> <p><i>Increased cost-effectiveness compared to existing service</i></p> <p><i>Move patient care closer to home – a local and national priority</i></p> <p><i>Improve access to services and reduce DNAs</i></p>

Central Sheffield PBC Consortium – Section 13 Summary of Objectives

D DIMERS	Objective	Timescale	Lead	Key Performance Indicator
<p><i>To implement a Primary Care based DVT Service utilising the D Dimers test</i></p> <p><i>ABH(2) linkages:-</i></p> <p>Local initiative 12- Planned care 15- Unscheduled care</p>	Plan to be submitted	March 09	Central / NHS Sheffield	<i>Reduce referrals below current levels</i>
	Quality Control and governance to be agreed	March 09		
	Tests to be obtained	April 09	Central / NHS Sheffield	<i>Increased cost-effectiveness compared to existing service</i>
	Agree protocol and training for Primary Care clinicians	April 09	Central	<i>Move patient care closer to home – a local and national priority</i>
	Market service prior to start	October 09	Central	
	Audit and monitoring of activity – analyse referral and diagnoses	April 2010	Central	
	Work with other Sheffield Consortia to implement citywide service Expand service			Central / NHS Sheffield

Central Sheffield PBC Consortium – Section 13 Summary of Objectives

PRIMARY CARE BASED GASTROENTEROLOGY SERVICE	Objective	Timescale	Lead	Key Performance Indicator
<p><i>To implement a Primary Care based Gastroenterology Service</i></p> <p><i>ABH(2) linkages:-</i></p> <p>Local initiative 12- Planned care 15- Unscheduled care</p>	<p>Agree activity and finance</p> <p>Develop patient pathway</p> <p>Audit of referrals for 2 months</p> <p>Plan and set up the clinic and design a referral protocol and pathway.</p> <p>Clinic to start</p> <p>Audit and evaluation</p>	<p>April 09</p> <p>April 09</p> <p>May 09</p> <p>June 09</p> <p>July 09</p> <p>Ongoing</p>	<p>Central / STH / NHS Sheffield</p> <p>Central / STH</p> <p>Central</p> <p>Central / STH</p> <p>Central / STH / NHS Sheffield</p> <p>Central / STH / NHS Sheffield</p>	<p><i>Reduce referrals below current levels</i></p> <p><i>Increased cost-effectiveness compared to existing service</i></p> <p><i>Move patient care closer to home – a local and national priority</i></p> <p><i>Improve access to services and reduce DNAs</i></p>