

**Practice Based Commissioning
Hallam and South Consortium Plan
2009/2010**

<p>Consortium Name: Hallam and South Consortium Contact Name: Katrina Cleary Designation: Strategic Development Manager Contact Telephone Number: 07811 454101 PBC Clinical Lead: Dr Charles Heatley (Chair)</p>
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Progress against the plan

HASC representatives will meet quarterly with SMMG to discuss progress against the plan (milestones are set out in section 14). The PBC Manager will be responsible for producing a report on progress and recommending to SMMG if further LIS PBC funding should be released.

The key performance indicators against which progress will be monitored are described overleaf.

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 below relate to sections 5-13 in this plan.

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, however, full 5% if total achieved at end of Q4)

The consortium requires clarification and agreement on the following issues in regard to this metric.

1. The historical activity levels against which will form the basis for the performance comparison
2. The mechanism for data collection and validation

The referral activity to be assessed for this purpose should be only that initiated by GP practices within the consortium. It should not include referrals from secondary care, community care, provider services or referrals from the Sheffield City GP Health Centre.

10% Prescribing Spend - paid at the end of Q4 (i.e. cumulative to M12) must remain within financial budget (Consortium Level)

Additional SMMG Reporting Indicators:

5. Organisational Development

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 needs and health inequalities

Indicator: All initiatives benefit at least one ABH(2) health priority in an explicit and measurable way (to be described in the relevant approved Business Case)

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 Business Plan

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.

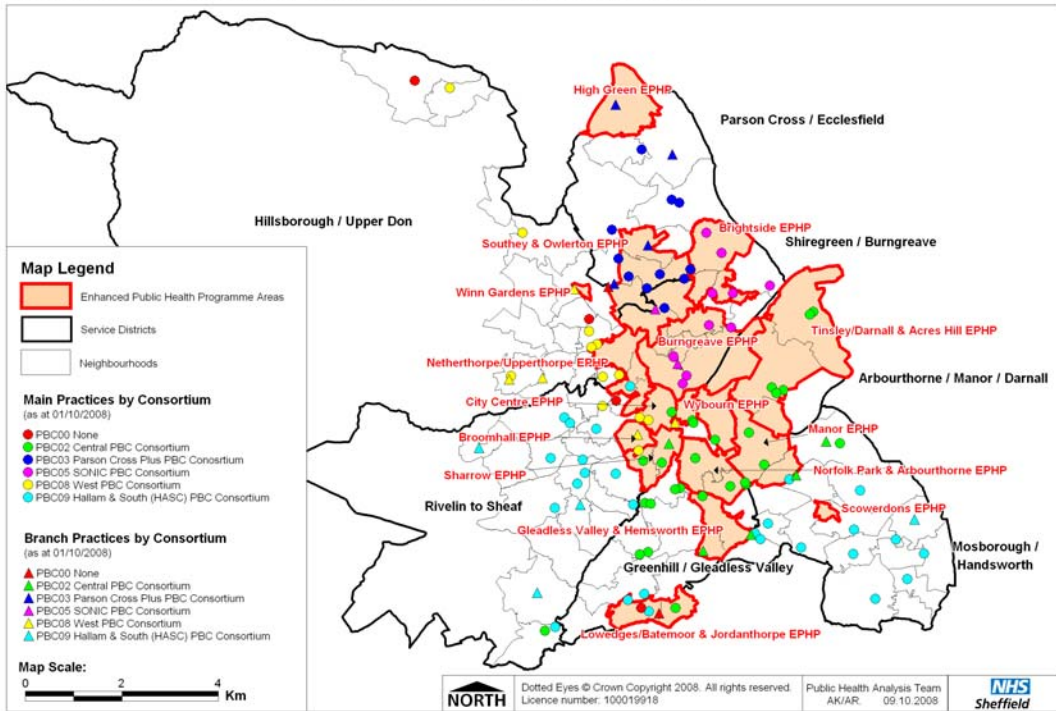
Indicator 1: Evidence of change implemented that has been requested by patients.

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

1. Details of Constituent Practices and Commissioning Leads

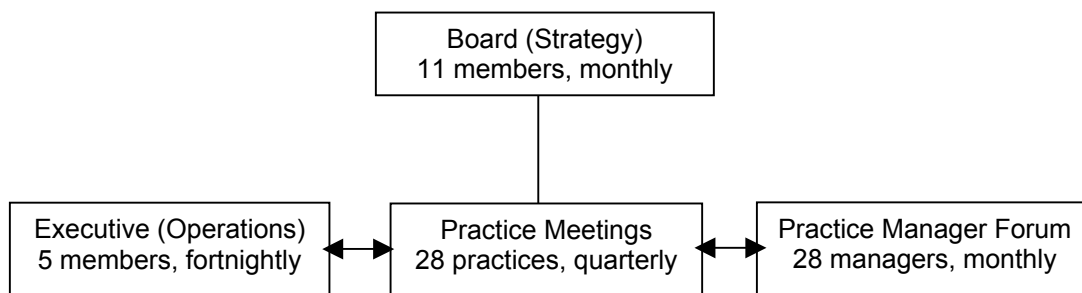
Avenue Medical Practice	Dr Richard J Barnes
Bents Green Surgery	Dr Mark Rogers
Broomhill Surgery	Dr David Savage
Birley Health Centre	Dr Michael Boyle
Carterknowle and Dore Practice	Dr Andy Hilton
Charnock Health Primary Care	Dr Philip Deakin
Crystal Peaks Medical Centre	Dr Scott Davison
Falkland House	Dr Tom Cossham
Far Lane *	Dr Rav Naik
Greystones Medical Centre	Dr Chris Atkins
Hackenthorpe Medical Centre	Dr Cecil DaSilva
Hollies Medical Centre	Dr Vanessa Fisher
Jaunty Springs Health Centre	Dr Alison Fox
Lowedges Medical Centre	Dr David McAllister
Manchester Road Surgery	Dr Andy Marshall
Mosborough Health Centre	Dr Liz Woods
Nethergreen Surgery	Dr Emma Ludlow/Dr Karen Joshi
Old School Medical Centre	Dr James Gray
Owlthorpe Medical Centre	Dr Stephen Rowland
Richmond Medical Centre	Dr Caroline Walton
Rustlings Road Medical Centre	Dr Mandy Sharpe
Selbourne Road Medical Centre	Dr Anil Gill
Sothall Medical Centre	Dr Tim Williams
Stonecroft Medical Centre	Dr Bob Muggleton
Totley Rise	Dr Keiran Pressley
Upperthorpe Medical Centre	Dr Nick Hudson
Westfield Health Centre	Dr Gurcharan Chadha
Woodhouse Medical Centre	Drs Margaret Spinks and Caroline Mitchell
* Far Lane has only recently joined HASC and none of the consortium-level data or graphs in our plan include them as yet.	

Sheffield GP Practices by PBC Consortium (as at 01/10/2008) with EPHP Areas



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.



Our structure is fully described in our Governance Framework but is in brief:

The Board

- The Board comprises 11 members, of which 5 are the Executive Team;
- Normal tenure for Board runs 1st April to 31st March, over 3 years;
- 5 non-executive team members were selected in late 2008 and the further 2 vacancies were filled in January 2009. To maintain continuity, the first Board will run from selection through to 31st March 2012;
- At the end of March each year 1/3 of the Board may step down, if new people come forward for a place on the Board;
- Each Board member has one vote. A quorum will be 7 in attendance including either the Chair or Vice Chair. Decisions will be made by simple majority.

Current membership is as follows:

Executive Team members:

Dr Charles Heatley, Chair and Clinical Lead (Birley Medical Practice)

Dr Eithne Cummins, Clinical Lead (Nethergreen Surgery)

Dr Andy Hilton, Clinical Lead (Carterknowle and Dore Medical Practice)

St John Livesey, Clinical Lead (Avenue Medical Practice)

Katrina Cleary (Strategic Development Manager)

Non-exec members:

Dr Michael Boyle (Birley Medical Practice)

Dr Vicky Holden (Stonecroft Medical Centre)

Sue Nutbrown, Nurse Partner (Mosborough Health Centre)

Chris Kearon, Practice Manager (Birley Medical Practice)

Alan Hancock, Practice Manager (Crystal Peaks Medical Centre)

Heather Leigh (Practice Manager, Old School and Lowedges Practice)

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)

Our values

- To be a patient centred, GP led organisation that drives up the quality of Primary Care
- To collaborate with all stakeholders to ensure the best outcomes for our patients through the commissioning process
- To provide a supportive structure for PBC to flourish in primary care

In summary our aims are to:

- To help shift care outside of the hospital by encouraging clinical engagement in PBC;
- Commission services which are more responsive to the local needs of our member practices and their patients.

We will consider PBC to be working if:

- All of our members are positively engaged in consortium-wide initiatives;
- We see our practices and patients benefitting from service improvements begun last year and outlined in this year's plan;
- Our redesigns evaluate successfully;
- Any savings we achieve are reinvested to drive up quality in primary care.

4. **Organisational Development in 08/09 (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.

Leadership and management development

The key features of our proposed approach are as follows:

- The non-executive team members of the Board have been selected in an open and transparent process in order to ensure that the Board has a wide range of team players within its membership (based on Belbin Team Characteristics).
- We will support NHS Sheffield in identifying appropriate leadership programmes and strive to populate such programmes with HASC current and emerging leaders.
- We believe there is already a wealth of nascent leadership skills and experience among Partners and Managers and that this can often best be enhanced through consortium-based development work. To this end, and to try and develop our capacity, we shall actively engage practice staff in delivering our plan.
- We will support our Practice Managers Forum to further develop its vision for

PBC and 21st century primary care.

- We have strengthened our succession planning by expanding the Board to 11, 1/3 of whom will stand down annually (assuming others come forward).
- We intend to embark on delivering quarterly consortium-wide PLIs to help secure practice engagement, increase awareness of PBC issues and to help with our clinical quality agenda. For this to happen we would ask that the PCT continues to finance Collaborative cover to enable practices to attend these events.

Organisational development

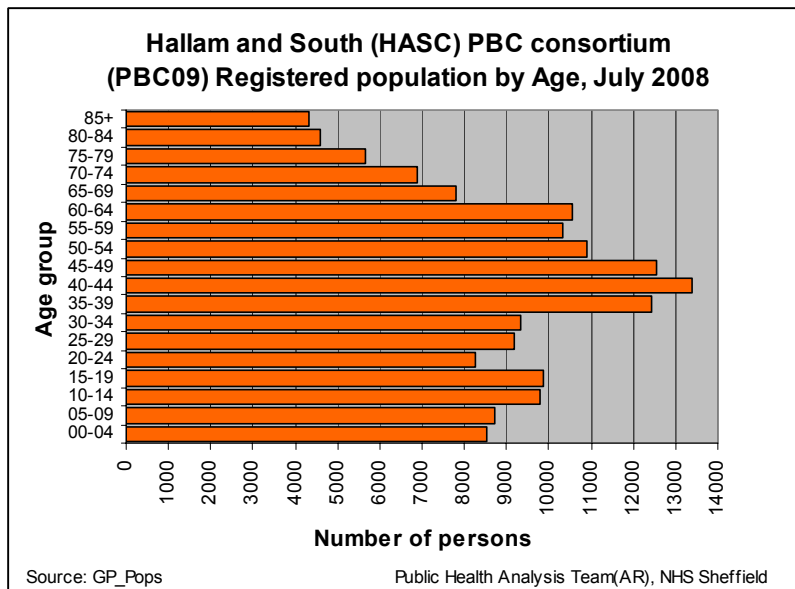
Three years into PBC, it is our view that consortia need to consider how and to what extent they become part of the mainstream NHS in Sheffield. This in part is the reason for our recent merger as it was clear that we need to have sufficient voice, capacity and infrastructure to meet the demands of the future.

- We have agreed a clear structure for our consortium, described in our Governance Framework and we now have to make this a reality in terms of teambuilding, roles and responsibilities.
- We have spent a considerable amount of time and energy in developing an understanding of the challenges and issues facing a nascent provider company hoping to seek NHS body status. We fed our findings back to NHS Sheffield and other consortia. We are clear that if we decide to establish a legal entity that a more robust A&M structure will be required to complement our local governance arrangements.
- Where need arises we will develop our governance structure further (e.g. Local Incentive Schemes (LIS), guidelines, protocols).
- To strengthen practice participation we have agreed our own LIS for Clinical Engagement which describes what support member practices can expect from the Board and what is required at practice level to enable the Board to implement PBC (signing up to the LIS is a condition of consortium membership). Board GPs each offer liaison and support to small group of practices. This is a 1-year LIS which runs from December 2008 and we will review this during the year.
- We intend to support our Strategic Development Manager by recruiting further full-time senior management capacity and by engaging Practice Managers in HASC work wherever possible.
- We will directly and through the Confederation contribute to NHS Sheffield's development programme for PBC.
- We have a proven track record of working in partnership where the agenda requires (NHS Sheffield, other consortia, local authority, university of Sheffield, community optometrists and other primary care practitioners). This approach will continue in 2009/10.

5. Public Health Overview and Needs Assessment (WCC competencies.....)

The consortium will need to demonstrate how it has integrated its constituent population's major public health needs into its strategic aims and annual work plan. In particular the consortium will need to demonstrate that its work plan for the year addresses priorities from the health needs assessment from Public Health.

Our population



The total registered population of HASC as at July 2008 is 163,104. Just under 9% are residents within areas covered by Enhanced Public Health Programme Areas and in this sense ours is not a 'high needs' population.

However we have a slightly older than average population: 9% is aged 75 or more compared to the city average (7.5%), which is just under 14,600 patients. Within this total, almost 4,600 are aged 80 or more and similar numbers aged 85 or more. To prepare for future demand and pressures on local NHS resources, we need to broaden our focus to include the management of management of chronic disease and long term care of older people. This will be the focus of our work.

Older people, COPD

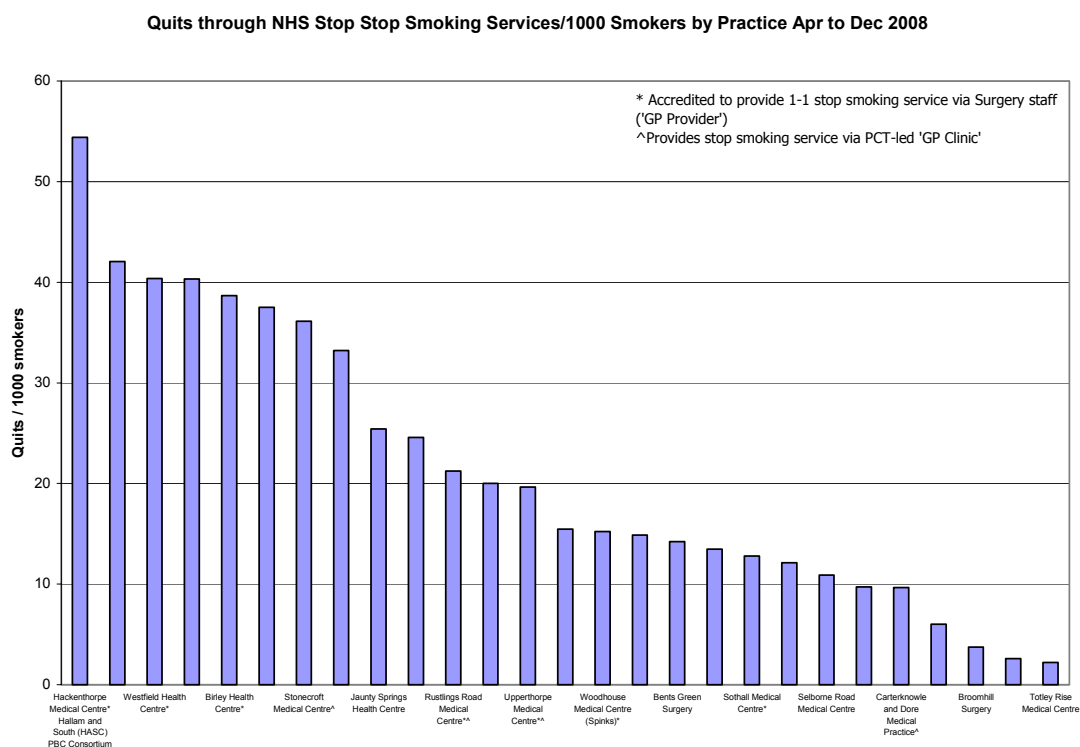
National benchmarking data shows that Sheffield patients are at higher risk of being admitted as a medical emergency. We know from the Balance of Care Report (2004) that 76% of emergency admissions are people aged 65 or more with multiple chronic conditions and 23% of these admissions are avoidable. Review of the data available for our consortium bears this out: around 25% of our total budget is spent on unscheduled care and this element has consistently overspent, even when we have achieved a financial balance overall.

Our major areas of emergency activity above targets set are in relation to respiratory and circulatory conditions and elderly care, although we will need to do tighter analysis to establish the primary diagnosis for these cases especially the elderly. We therefore see gaining control of these emergency admissions as a key action for improving patient access to appropriate primary care. This should in turn have a positive knock-on effect on expenditure – enabling resources to be redirected into primary care and preventive services where NHS investment can be more effective.

Other public health initiatives

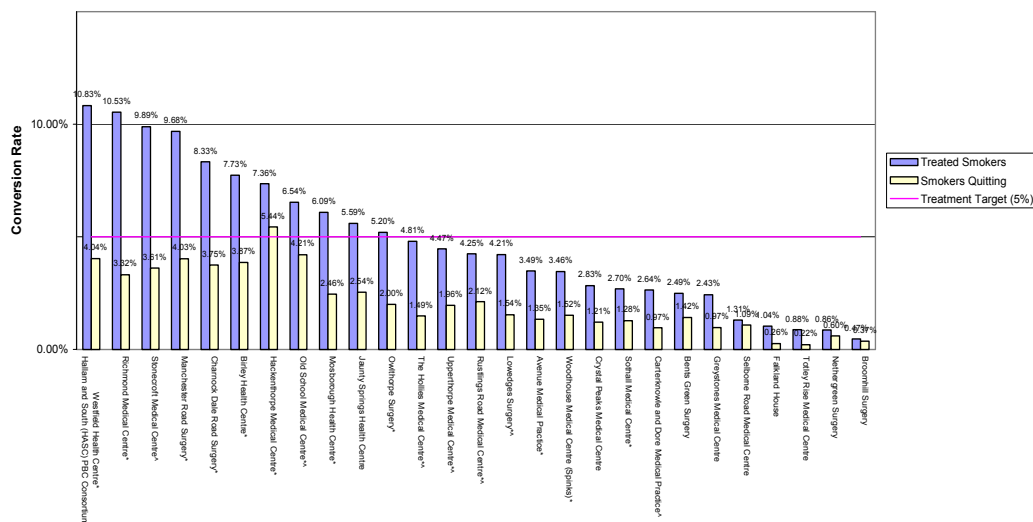
In addition, from a workshop held with Public Health (PH), we have identified potential to promote practical PH input to our practices in the following areas. We will do this by offering each topic market stall space at each quarterly consortium PLI for PH to provide an overview of performance and promote the interventions that can be offered by PH, targeting these at appropriate practices.

Smoking: we will support practices to increase register sizes where these fall below PH estimates of prevalence; improve referral and quit rates (in particular referral to the specialist midwife); and plug gaps in access to a local accredited cessation service. The graph below identifies quit rates and where there is lack of provision:



The graph below shows practice performance against the national target that local services should aim to treat at least 5% of the estimated local population of people who smoke or use tobacco in any form each year.

% Smokers treated and % Smokers quitting through NHS Stop Smoking Services by Practice and Consortium Apr to Dec 2008



Alcohol: we will promote awareness of alcohol issues across the consortium and identify practices with high levels of alcohol use and alcohol-related admissions for additional support from the PH team;

Childhood vaccinations and immunisation, including MMR: we will seek PH support for practices to achieve the 90% DES Childhood Immunisation target for population coverage. The table below summarises cover rates for 1st dose (pertussis) received in children aged 1 year and booster dose received aged 5; and MMR cover rates. Average data is for the year-to-date (Q1 and Q2) but where variation is given this is Q2 only:

	DTa/IPV/Hib cover rates		MMR cover rates		
			Age 5		
	1 st dose age 1	2 nd dose age 5	1 st dose age 2	1st dose	Booster
Sheffield av. YTD	89.4	93.6	83.5	90.9	77
HASC av. YTD	92.0	94.9	85.8	91.7	77.7
HASC variation	63.2-100	66.7-100	50-100	75-100	40.6-100

6. **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).

Budget Setting

Since the inception of PBC we have raised concerns regarding the budget setting process. We remain concerned about the approach to budget setting for 2009/10 and distance from target for HASC in that we are required to deliver, as a minimum, the same health gain for less money year on year with no guidance as to how this can be practically achieved and, unlike the more deprived areas in Sheffield, ABH growth is not specifically allocated to our population.

We are also concerned about the distribution of the PBC risk pool. We made detailed representation to NHS Sheffield last year, making the point that the approach within the PBC Governance Framework gives little incentive to consortia which generated savings. At the time of writing, HASC is participating in the citywide budget setting meetings and discussion is ongoing as to the formula for how 2009-10 indicative budgets should be set and the citywide risk pool managed.

Without being clear on the outcome of these discussions and without knowing our likely budget for 2009/10 it is not possible for us to commit to remaining in budget for 2009/10. What we can say, however, is that we are hopeful that the budget setting process will not penalise our practices so that we can make such a commitment and that our plan reflects real action which, we would anticipate, will manage spend as best we can.

The key elements of our approach to financial management in 2009/10 will be to:

- Encourage the PCT to continue the LIS FUs and review its effectiveness during the year;
- Implement our LIS for Clinical Engagement and review this as above;
- Support practices to gain more control over prescribing costs where appropriate and promote quality prescribing practice as outlined in the prescribing plan for 2009/10.
- Focus on the unscheduled care agenda via the unscheduled care LIS and Anticipatory Care Pilot intended to be launched in early 2009/10

Following the merger, we agreed a Payment Protocol with NHS Sheffield to describe consortium delegated powers and Finance arrangements for payment of the management budget, which NHS Sheffield holds on our behalf.

We are pleased that in the last 2 years our efforts have resulted in FURs which can be reinvested for patient benefit. At the time of writing we are working with our Senior Finance Officer to finalise our approach for planned spend of £500k available to us.

We would wish to encourage the PCT to develop its 'Earned Autonomy' model for performing consortia, which was alluded to in recent correspondence regarding the 2009/10 PBC LIS but which as yet has not been shared.

7. **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

Performance measures: Overall, the actions in our consortium plan will contribute to saving lives and addressing inequalities across the city by:

- Increasing take up of public health services
- Reducing hospital activity (including referrals)
- Reducing avoidable variation in access to and quality of care across our consortium population

More specifically, all of the service and pathway redesigns below are underpinned by service specifications and by financial modelling which predicts the reductions in demand in hospital activity we seek to achieve. The PBC Manager is responsible for ensuring formal 6/12 and annual evaluation reports are made to SMMG.

LES Palpitations: we will extend this to include all practices and launch this to our practices in Q1.

Dermatology: we will provide clinical leadership for the implementation and review of the new service. We see this role as ending in Q1 2009-10.

Ophthalmology: we will provide clinical leadership for PEARS roll out. We see this role as ending in Q1 2009-10.

Gynaecology and Urology: we will provide clinical input to complete the specification and business case for implementation of the women's continence pathway should this be required.

T&O: we will act on the outcome of the chiropractic service within the context of the new back pain pathway. We seek clarity from the PCT as to when this is likely to be in place.

Shoulder pain: we have provided clinical leadership for the development of the pathway, which is near completion. A business case will be submitted in Q1.

8. **Service Redesign and pathway development Proposals for 2009/10 (WCC competencies.....)** Clear plans with milestones need to be expressed for any service redesign/ pathway development work that is planned for the year. Each service redesign/ pathway development timetable needs to be agreed with the relevant NHS Sheffield matrix team to ensure that the individual plan is SMART. In addition the consortia needs to demonstrate how the service redesign/ pathway development will contribute to the achievement of ABH(2) and its own strategic aims.

The service and pathway reforms below are not at a stage where financial modelling has been undertaken. Section 14 of the plan sets out when we anticipate the business cases being developed. Performance measures will be described in:

- The specification for the service
- The finance appendices

Physiotherapy: we remain extremely frustrated by the lack of progress in improving the community NHS physiotherapy available to our patients. Despite having a number of meetings over the last two years in which we have expressed our concerns (timeliness, cost, duplication of GP advice etc.) nothing has been done. We therefore feel we have no option other than to issue notice on our share of the PCT-provided contract and we seek senior commissioning and finance support from

NHS Sheffield to do this properly and to help us take forward our procurement needs. We feel our work to date on the chiropractic pilot, city-wide back pain pathway and our ongoing lead in the pain management service redesign puts us in a good position to take the work forward. However we recognise we need the help and support of senior experienced personnel from NHS Sheffield.

Pain management: as agreed with the PCT and within the PBC confederation we will provide clinical leadership on behalf of city of the pathway development into Pain Management services.

Dementia and falls: we will provide clinical leadership for the pathway work.

EOLC: we propose to be an early adopter to introduce use of EOLC across the consortium and have offered to be a host for the clinical facilitators.

Long term conditions: we will engage with the Planning and Commissioning Group's work to specify the service relating to enhanced diabetes care;

Unscheduled care: See section 10.

9. Referral Management Action Plan for 2008/09 (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)

The consortium's LIS for Clinical Engagement requires practices to submit bi-monthly reports of work undertaken to review GP referrals and to describe any other measures in place regarding management of the PBC budget at practice level.

The Senior Finance Officer and PBC Performance Manager will recommend to the Executive specialties which each practice will be encouraged to focus on, if relevant. To support practices with this, each will be provided with:

- Specialty level data at practice level, showing % movement in GP referrals for the current period compared with the same period last year;
- Overall elective and non-elective budgets, colour-coded as follows:

More than 10% under-target
Between 10% under target and 5% over target
Between 5% and 20% over target
More than 20% over target

Where no specialty is indicated, practices will be asked to report bi-monthly on work undertaken to review GP referrals in general.

We are hopeful that the data provided via the emerging RIS will support us in understanding our practices' referral behaviour more fully.

However, our approach to managing the budget is not restricted to referrals since we are taking active steps to control costs in prescribing, follow ups and non-elective care.

We will directly and through the Confederation contribute to any reasonable approach led by NHS Sheffield to recommend review of 'other' referrals.

10. 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.

Our Unscheduled Care work and Anticipatory Care Pilot is where we will direct the bulk of our focus in 2009/10. This is an ambitious, challenging and exciting initiative which requires us to work in partnership with a range of stakeholders (practices, university of Sheffield, PCT provider arm etc.) and which if successful will significantly improve the quality of care received by our older patients and will, we hope, have a knock-on decrease in our non-elective spend.

The consortium has developed a LIS for Unscheduled Care which will invite all member practices to systematically build 'at risk' registers of patients 75 years and more (excluding care homes, pending the outcome of the Parson Cross LES pilot).

GPs will share the patients they identify as being at risk with their Case Manager for managing/ referring on as normal.

In addition practices will implement care planning for patients on their at risk register which will enable us to test the impact of enhanced GP care co-ordination on reducing avoidable admissions, the remaining practices acting as a control group. We will be piloting EASY-Care assessment and care planning tools. This is a pilot in Anticipatory Care which we are undertaking with the support of the University of Sheffield.

If the pilot evaluates well we will be looking to NHS Sheffield to assist us in implementing this model across the whole consortium.

11. Prescribing Action Plan for 2009/10 (WCC competencies.....)

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

It is our intention for 2009/10 to further increase our focus on Prescribing issues across the consortium.

Engagement

We are keen to further develop a model of joint working between the Consortium Board and the Medicines Management Team (MMT). The jointly agreed prescribing plan can form a significant part of that approach.

We have identified a Board level prescribing lead to work with the medicines management team on Strategic issues and intend to identify other clinical leads to help take forward specific areas of work. In addition to this our Practice liaison GPs will help promote communications to practices to promote key prescribing messages, etc.

Training

We wish the MMT to identify key result areas and designing training that can help to achieve progress within these areas. Training could take the form of formal or informal, small or larger scale events.

The prescribing plan

1. General

a) Practice Prescribing Plans 2009/10

We will encourage our constituent practices to work collaboratively with the MMT in agreeing a practice prescribing plan relating to QOF Medicines Management Indicators 6 & 10 and to engage on all three plan targets throughout the year.

b) Effective working and communication

The key consortia personnel and those MMT members linked to the consortium will meet more frequently to build closer links and to share views and ideas of how the consortium and medicines management team can work more effectively together.

2. Cost Effective Prescribing

a) Identify savings against prescribing to PCT agreed targets

Although many of our practices have made significant savings against targets in previous years there still exists the potential to secure further useful savings against the prescribing budget especially in selected practices. Therefore, a savings target may be agreed that engages the consortium practices to secure further savings against these key prescribing indicator areas.

b) Install Scriptswitch in selected practices

Scriptswitch is designed and marketed to identify prescribing cost savings that prescribers can choose to utilise at the point of prescribing. We understand the PCT is evaluating a recent local pilot on the system and, assuming it evaluates positively, would wish to see the PCT roll this out across all practices.

c) Make savings against the HASC Top 10 Drugs or a selection therein

The top 10 drugs account for a significant proportion of the overall spend on prescribing: in Q2 2008/09 in HASC these were around £1.176 m. Annual costs therefore could total around £4.7m. This accounts for around 20% of the total consortium prescribing budget for 2008/09. A strategy of targeting savings against these top 10 drugs could therefore result in significant savings against the budget.

3. Quality Prescribing

a) Achieve a higher level of engagement with Repeat Dispensing (RD)

The RD service offers a high level of convenience to patients and can also ultimately lead to reduced practice workload. Working with the MMT lead we will scope the potential to reach a higher average level of RD scripts as a percentage of all issues at the end of the financial year. This could include a training component and also target engagement with RD from all consortium practices by the end of the financial year.

Training

A training session could be organised for key practice staff to develop and raise the profile of RD within practices. This could be done via the practice managers' forum or similar. The NHS Sheffield Medicines Management Team lead for RD would develop this training and encourage the participation of all practices perhaps involving a role for key personnel from high performing practices to promote the message and identify effective ways of working.

b) Action sheets

We will ensure that all practices are encouraged to act promptly on the

agreed prescribing actions arising from medicines management action sheets. This will help consortium practices ensure that the targeted area of prescribing is dealt with promptly and appropriately.

c) Clinical audit

Undertake at least one clinical (drug) audit to ensure that prescribing is in line with national guidelines or established best practice.

4. Community pharmacists

We will ask HASC's prescribing lead, MMT lead and the PH team to lead discussions with community pharmacists about how they can help practices:

- deliver targeted public health interventions where there are gaps in provision or capacity (e.g. accredited smoking cessation);
- engage in our RD plans;
- explore the feasibility of community pharmacists providing some community based services, particularly in areas where there is a gap in enhanced service provision.

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

The consortium needs to demonstrate how it will ensure that patient and public engagement is factored into sections 3,5,7,8,9,10,11

The key features of our proposed approach to involving patients are as follows:

- To continue with our subscription to Patient Opinion as a way of seeking our patients' views on acute care. The reports produced by the Patient Opinion website will be discussed at our Board and a practice manager board member will have responsibility in bringing to Board's attention postings of particular interest.
- Each group leading a consortium redesign initiative will identify an appropriate mechanism for involving patients in the work and submit to Board for approval a fully-costed plan for the patient involvement element of this work.
- Our website is ready to go live in March 2009. We expect that this will be a forum for the sharing of data and the exchange of ideas. It will contain pathway information and downloadable referral forms. In time, it will have a public function with information about the consortium for patients, with links to other useful sites.
- We will include in specifications for any new services developed feedback from patients as part of the monitoring of the impact of any pathway or service redesigns..
- As we become more mature in our consortium and governance development we will clearly have to involve patients in a more structured way. If it is identified as necessary in-year then we will give consideration to developing a patient forum.

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

Our objectives remain to:

- Have continued 'buy in' and improved communication with our constituent practices
- Offer education, training and support – particularly within our key priority areas – to enable our practice to provide improved patient care
- Strengthen our relationship with the MMT prescribing lead and identify local actions which each practice could take to manage prescribing more cost-effectively and to improve the quality of prescribing;
- Further improve quality of services by undertaking further service redesign and care pathway development;
- Strengthen our clinical and managerial leadership/capacity to further support service improvement and organisational development;
- Continue to explore meaningful ways in which patients can be engaged in commissioning issues. (Patient Opinion reports to Board)

		2009-10				ABH 2	Contributing to ABH success measures
		Q1	Q2	Q3	Q4		
1	Improve 'buy in' and communication with members						
1.1	Review LIS Clinical Engagement			➤			
1.2	Link Executive GPs to named practices to offer support						
1.3	Launch HASC website	➤					
1.4	Continue monthly Practice Manager Forum	➤	➤	➤	➤		
2	Offer education, training in our priority work areas						
2.1	Continuously update protocols etc on website	➤	➤	➤	➤		
2.2	Run quarterly consortium PLIs (subject to PCT resourcing)	➤	➤	➤	➤		
3	Strengthen relationship with NHS Sheffield Prescribing						
3.1	Agree signed up prescribing plan 2009/10	➤					
3.2	Seek decision from PCT regarding Scriptswitch	➤					
4	Manage demand						
4.1	See continuation of LIS Clinical Engagement from PCT	➤				12. Planned care	To reduce referral rates to lower quartile performance.
4.2	Review findings of practices' bi-monthly reports at Exec	➤	➤	➤	➤		
4.5	Agree plans for reinvestment of FUR	➤					
5	Public Health Actions	➤					
5.1	Support practices with smoking cessation uptake	➤	➤	➤	➤	4. Tobacco control and smoking	To increase % of smokers quitting aiming towards 5% national target. To reduce the number of mothers 'smoking at delivery' and aiming towards 1% reduction year on year.
5.2	Support practices with Childhood Imms uptake		➤	➤	➤	7. Children and young people	To increase the proportion of children who complete MMR in line with national targets.
5.3	Raise awareness alcohol issues and treatments		➤	➤	➤	6. Drugs and alcohol	To reduce the rate of hospital admissions per 100,000 for alcohol related harm year on year.
6	Provide clinical leadership to pathway/service redesign						
6.1	Implement LIS Unscheduled Care/Anticipatory Care Pilot	➤				15. Unscheduled Care	To reduce emergency admissions year on year compared to 2006/7 baseline To reduce COPD emergency admissions year on year compared to the 2006/7 baseline
6.2	6/12 review LIS/Anticipatory Care Pilot			➤			

6.3	Finalise women's continence pathway	➤				12. Planned care	To reduce referral rates to lower quartile performance.
6.4	Implement LES Palpitations	➤				12. Planned care	To reduce referral rates to lower quartile performance.
6.5	6/12 review LES Palpitations			➤			
6.6	Recommendations re future chiropractic pilot (subject to PCT clarity on Back Pain Pathway)	➤				12. Planned care	To reduce referral rates to lower quartile performance.
6.7	Agree with Procurement process for physiotherapy review	➤				12. Planned care	To reduce referral rates to lower quartile performance.
6.8	Support service spec for enhanced diabetic care			➤		5. Diabetes Personalisation and LTCs	To increase the percentage of people screened for diabetic retinopathy to 100% compared to 2007-8 baseline. To improve diabetes controlled blood sugar (patients with HbA1c>7.5%) compared to 2007-8 baseline. To maintain low standardised 28-day readmission rates.
6.9	Commence pain management pathway			➤		12. Planned care	To reduce referral rates to lower quartile performance.
6.10	Wind up clinical input to dermatology and PEARS reform	➤				12. Planned care	To reduce referral rates to lower quartile performance.
6.11	Complete shoulder pain pathway and submit bus. Case.	➤				12. Planned care	To reduce referral rates to lower quartile performance.
6.12	EOLC actions TBC with NHS Sheffield lead.	➤				15. Unscheduled Care	To reduce emergency admissions year on year compared to 2006/7 baseline
6.13	Dementia input TBC with NHS Sheffield lead	➤					
7	Strengthen clinical and managerial leadership capacity						
7.1	Organise facilitated team building for Exec and Board	➤		➤			
8	Engage patients in commissioning issues						
8.1	Review Patient Opinion findings at Board		➤	➤	➤		
9	Develop our relationship with co-commissioners						
9.1	Meet regularly with PCT 'matrix group'	➤	➤	➤	➤		