

**Practice Based Commissioning
Consortium Plan
2009/2011**

Consortium Name: **North Sheffield Consortium for Health
Commissioning Plan 2009-11**

Contact Names: Simon Kirby/Grainne Landowski
Designation: Project Leaders

Contact Telephone Numbers: 0114 257 3197/07710 677357

1. Details of Constituent Practices and Commissioning Leads		
	<i>GP</i>	<i>Practice Manager</i>
Barnsley Rd Surgery	Dr Anil Grover	Janette Burgar
Bluebell Medical Centre	Dr Jess Tweney	Christine Hitchmough
Buchanan Rd Surgery	Dr Helen Stockdale	Michelle Richards
Burncross Surgery	Dr Eugene Rybinski	Martyn Smith
Burngreave Surgery	Dr Bryan Hopwood	Karen Green
Dunninc Road Surgery	Dr Dilip Chatterjee	Duncan Miller
Ecclesfield Group Practice	Dr Richard Oliver	Simon Kirby
Elm Lane Surgery	Dr Des Keating	Margaret Turner
Firth Park Surgery	Dr Leigh Sorsbie	Julian Stevens
Foxhill Medical Centre	Dr Amanda Rosario	Mandy Neville
Grenoside Surgery	Dr Mark Durling	Anita Warner
Health Care Surgery	Dr Heather Charlton	Louise Bodsworth
Mill Rd Surgery	Dr Mandy Gamsu	Angi Hartley
Norwood Medical Centre	Dr Susie Lupton	Sam Grundy
Page Hall Medical Centre	Dr Margaret Ainger	Jan Jude
Pitsmoor Surgery	Dr Trish Edney	David Emmas
Sheffield Medical Centre	Dr Chi Nwafor	Julie King
Shiregreen Medical Centre	Dr Ted Turner	Victoria Allen
Southey Medical Centre	Dr Navnit Patel	Janet Scott
Upwell Street	Dr Jackie Burton	Johanne Shirt
Wincobank Medical Centre	Dr Ilyes Tabani	Tyronn Tate

2. Internal Governance Framework

The consortium constitution (see Appendix 1) describes arrangements for joining, leaving, winding up, meetings and voting.

A steering group will set agendas and monitor progress with work streams, meeting fortnightly.

The steering group will call upon other practice managers, as and when required, to provide essential support to the direction of travel of the group and these will help implement the plan via monthly practice manager meetings.

Practices will be incentivised to both participate and help the consortium achieve its objectives. Funds from the LIS will be released on successful completion of our quarterly reviews with NHS Sheffield.

A lead GP and Practice Manager from each practice will be invited to represent the practice at consortium Board meetings.

The consortium is also committed to joint working with other consortia, Sheffield City Council and other partner agencies to improve services for Sheffield people. We also acknowledge the role of the Sheffield PBC Confederation as a collective representative view for citywide PBC issues.

Specifically, we will actively engage with the following clinical groups:

Optometry

The consortium has been impressed by the PEARS scheme that had been piloted in WEST and Hallam consortia, and has already started to seek local optometry interest in delivering a similar scheme in our area. Through links with the LOC we will also seek early implementation of the developing Children's Eye Screening programme (contact: Lynda Liddament NHS Sheffield)

Pharmacy

Many of the schemes mentioned can and should be delivered through pharmacy sites. The consortium has agreed links with two local pharmacists via the LPC and will continue to invite them to consortium board meetings and support the delivery of pharmacy led services. The citywide prescription optimisation scheme was successfully piloted in the Parson Cross area and we see this as a well thought out scheme which we can use to maximum advantage. (leads: Simon Kirby, Lynn Murrie and James Wood (Lloyds Pharmacy)

Dentistry

Accounts for a high number of referrals, and as yet we have struggled to identify a link with local dentists. We now have a named dentist and plan to have early discussion with him about closer working (leads: Simon Kirby &

Stephanie Holmes)

Note - A PLI event planned for Mid May will bring together a mix of partners from across the PBC health economy to scope out how local partnerships can be improved

3. Strategic Aims of the consortium

NHS Sheffield's Strategic Plan 'Achieving Balanced Health (2)' sets out to improve the health and well being of the city. Notably in Sheffield there are significant health inequalities. With that in mind ABH (2) sets out two ambitious goals – to:

- save 400 lives by 2012
- lead, develop and sustain the NHS

The PCT aims to release £40m from secondary care in order to support delivery of care in the community.

ABH (2) reflects the national and regional policy context on focussing on quality which was outlined in the recent publications 'High Quality Care for All' and 'Health Ambitions' which was part of last year's next stage review of the NHS by Lord Darzi.

As a co-commissioner of services North Sheffield consortium's aims will support the delivery of ABH (2).

The aims of the consortium are to improve local health and well being in the wider north Sheffield area and to commission high quality health services, targeted on reducing health inequalities. We are merging two consortia that have a track record of close working which will enable greater clinical and managerial engagement in the development of pathway work across larger areas of the city. We will do this by:

- Encouraging joint working across practices, the local health community, Sheffield City Council and the voluntary sector.
- Helping the above gain greater understanding of NHS usage and finance.
- Involving local clinicians, Adult Services and Children and Young People's Services in joint planning and commissioning more care outside hospital.
- Improving the patient's experience of health services, wherever provided.
- Creating stable working arrangements to minimise clinical and financial risk, in order to provide efficient services within an affordable framework.
- Sharing specialist skills across the consortium to facilitate inter-practice referrals and reduce hospital use.
- Build on relationships and engagement with pharmacists, dentists and

optometrists (as outlined in section 2)

4. Organisational Development in 09/11

The consortium will be an unincorporated association with its own bank account. We have plans to look at becoming a legal entity in order to explore future commissioning and providing options. Our organisational development objectives for 2009-11 are to:

- Enable the steering group to lead work streams to increase the pace of service change.
- Encourage member practices to lead work on behalf of the consortium with additional time being reimbursed from the consortium Local Incentive Scheme.
- We will participate in the citywide PLI scheme aiming to provide multi-disciplinary initiatives which will provide support for citywide and practice-based initiatives.
- Develop the relationship with the new Confederation of Sheffield PBC consortia.
- Ensure that the business case for Pulmonary Rehabilitation for patients with COPD is implemented across the city.
- Explore the scope for developing collective plans to tackle non-elective admissions.
- Continue to represent the interests and views of member practices and to work with the PCT to influence and shape commissioning strategies.
- Provide on-going management by the steering group to ensure succession planning is undertaken to minimise risk and disruption to service change proposals
- Maximise opportunities within QOF to ensure appropriate patients receive care and reduce variation across the practices (eg heart failure management, diabetes)
- Develop the consortium activity to reflect the WCC competencies
- Develop future co-commissioning clinical leadership through commitment to the PBC leadership development programme
- Develop processes to improve project management approaches across all consortium initiatives

5. Public Health overview and needs assessment

Public Health Profile

The North Sheffield Consortium for Health covers a population with 22.5% living in poverty (receipt of income support). Poverty increases deaths and those from CHD, respiratory disease are significantly higher in the south of the

consortium. Many of the neighbourhoods covered by the practices are part of the Enhanced Public Health Programme (EPHP) which is an initiative focussing on the most deprived neighbourhoods. (see below)

Population Mix

There are 6% people from the Asian/British Asian community living mainly in the south of the consortium. This compares with the Sheffield average of 4.6%. The higher proportion of BME groups in some practices presents additional challenges, with some practices having in excess of 50% of their population from BME communities.

Mortality

Mortality rates reflect the higher levels of deprivation in the consortium. The areas which are significantly higher than the Sheffield average all cause mortality. These are Cancer, Circulatory and Respiratory disease. Chronic disease levels are higher than the Sheffield average, with in excess of 6,000 people known to have CHD, and more than 5,500 known to have diabetes. The consortium's population has twice the national prevalence of COPD.

Our *Health Profile* shows three areas where our non-elective hospital admission rates are in the top 20% for the city – residents admitted from residential and nursing homes; patients with COPD and with CHD.

Chronic Disease (inc CVD)

The majority of practices have higher than average prevalence of chronic disease, most of which is captured on practice disease registers. Participation in National Service Framework audits for CHD and diabetes indicate that most patients are appropriately managed. However there remains scope for improvement, in particular around the provision and support for behaviour change (exercise, BMI recording and advice giving).

We have concerns that there is a high prevalence of Cardiovascular disease in the area. This is reflected in the high emergency hospital admission rate where CVD is the primary diagnosis. Clearly we need to have a better understanding of how these are linked. We will be working with the PCT's Information and Public Health team to gain better understanding of these relationships.

QOF Info

QMAS data shows practices claimed maximum payment against the QOF measured parameters. However there is considerable variation in terms of achievement and exemption reporting between the practices compared both with city and national averages. In order to reduce variation, improve quality and access across practices it is important to ensure all patients are offered and receive management of their chronic disease that is evidenced based and in line with good practice guidelines.

Mental Health

Highest prevalence of depression at 8.6% is reported in the north of Sheffield. The city average is 6.9%. Areas with the highest reported prevalence include Firth Park (12.2%) and Southey Green (10.1%). Mental health is often associated with other co-morbidities.

Smoking

The proportion of people smoking is higher than the average for the city, with 25,758 smokers in the consortium. These include smoking in pregnancy.

Overweight and obesity

Sheffield has the highest level of adult obesity and the lowest levels of physical activity of the eight English Core Cities. Our most recent data shows that 22% of adults in Sheffield are obese and 34% overweight and that the proportion of children who are obese increased between 2006/7 and 2007/8 from 14.8% to 17.5% at Y6 and from 6.9% to 8.1% in Reception Year.

There are an estimated eight thousand adults in Sheffield with a BMI over 40, with 80 of these having a BMI over 50. There are 360 deaths per year in Sheffield which can be attributed to obesity.

There is a higher prevalence of obesity and overweight among lower socio economic groups (especially women) and the prevalence of obesity and overweight increases with age.

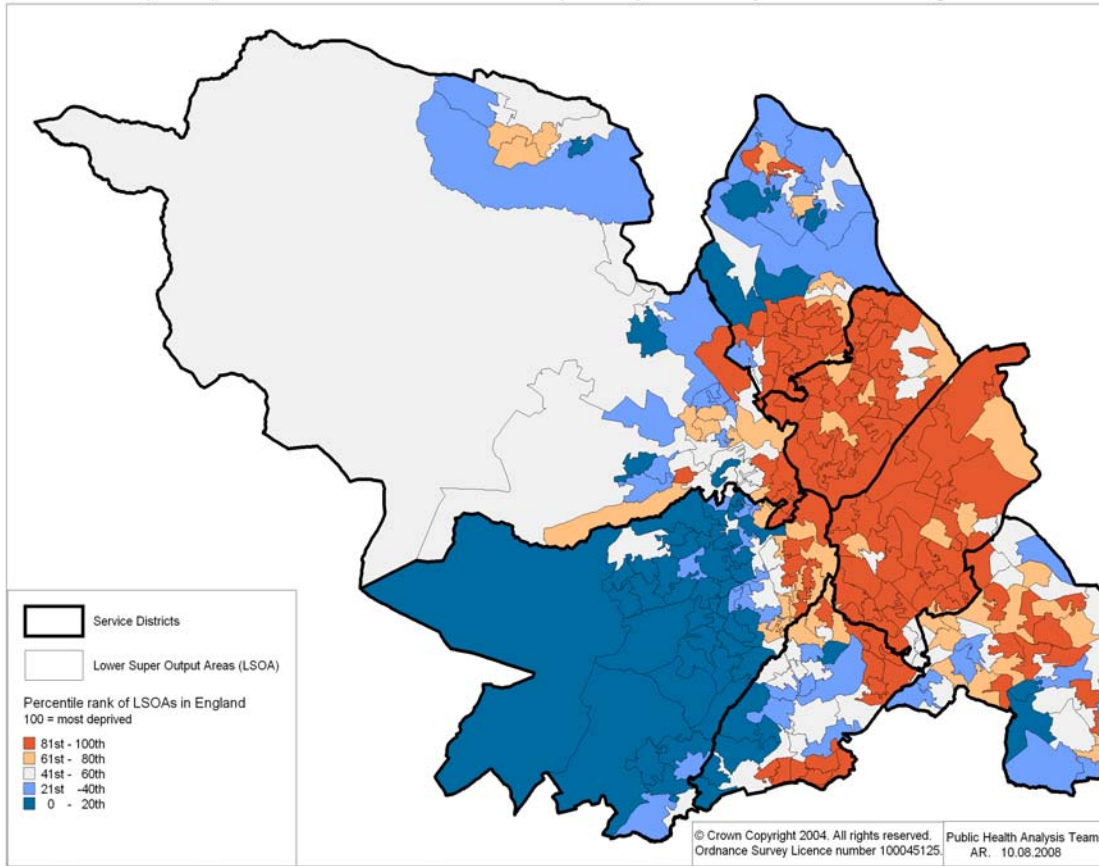
Alcohol

Of the PBC consortia (as at Oct 08), the south of the North PBC has the highest alcohol-attributable mortality rates (ref Alcohol HNA 2009 NHS Sheffield). Projected figures in the annual number of Alcohol Specific Admissions for Sheffield are increasing. Overall between 2003/04 and 2007/08 there has been a 77.8% increase in the number of admissions from 993 to 1766. If this trend continues, by 2011/12 there may be about 2,500 alcohol specific admissions. In addition admission rates for alcohol related conditions for 2003/04 to 2007/08, range from 795 admissions per 100,000 in Hallam and South PBC Consortium to 1216 admissions per 100,000 in North Sheffield PBC Consortium.

Additional Public Health information

There is a range of evidence that illustrates the above points for further information. Please see the PCTs strategic plan (ABH2), the Joint Strategic Needs Assessment and the Director of Public Health report 2008. In order to demonstrate the link of poor public health and deprivation - the diagram below illustrates the high levels of deprivation in north Sheffield.

Index of Multiple Deprivation 2007. Sheffield Lower Super Output Areas by value rank in England



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, 4 of which fall in the North Sheffield consortium area – Burngreave, Flower/Stubbin/Brushes, High Green, Southey and Owlerton.

The 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.

Examples

SOAR Healthy Living Theme Group; Stop Smoking Service; Children’s Centre Project:

Older Person’s Activity Worker; Drug project, enhanced counselling with local practices and a cervical screening programme; Funding from Burngreave New Deal for Communities; A food health trainer is already in post delivering 5 a

day messages to local groups and organisations health training courses; a women's health network; an advocacy service; culturally appropriate mental health support workers and healthy walk schemes.

Our service redesign proposals are aimed at supporting improving the public health of the consortium's population through our service change projects (see sections 7 & 8). Our proposal & plan recognise that there are numerous competing needs for our population and therefore competing priorities exist for submission into the plan. On that basis, we discussed the following criteria when outlining our priorities for our plan. The prioritisation criteria included:

- **fit with national priorities**
- **fit with local priorities**
- **patient benefit**
- **clinical benefit**
- **stakeholder buy in**
- **estates**
- **workforce**
- **financial benefit**

6. Financial management arrangements

Practices work as a consortium and have agreed to the 2.5% risk pool for hospital spend and 2.5% pool for prescribing.

Progress on 2008 - 09 indicative budget

The steering group has concerns about simplistic performance indices and incentives that do not take into account overall performance in the context of the populations served. Performance should be measured against both actual and Fair Shares budgets until the latter are fully implemented. GP referrals should be referenced against hospital spend actually incurred as a result of the referral and for clinical appropriateness according to the various standards being developed across the city. Ranking practices using overspend on historical budgets has had a dis-incentivising effect on those practices serving needy populations with a lower than average historic spend. This meant that those consortia were not eligible to make savings.

North Consortium

Forecast Outturn for the Year Ending 31.03.09 as at 31.12.08

	Variances		
	Parson X	Sonic	Total Var
	(+)Over/ (-)Under	(+)Over/ (-)Under	(+)Over/ (-)Under
	£'000	£'000	£'000
OP FA	471.6	318.1	789.7
OP FU	427.5	249.9	677.4
OP Procedures	106.2	28.9	135.1
EL IP	935.3	289.2	1,224.5
NEL IP	297.1	1,254.2	1,551.3
A&E	303.1	385.3	688.4
Mental Hlth	0.0	0.0	0.0
Prescribing	-133.1	66.7	-66.4
Comm Services	-3.9	-3.3	-7.2
P/Care Enhanced Services	-7.7	-3.4	-11.1
Fair Share Adjustment	-79.2	-234.8	-314.0
Total Variance (excl. RP)	2,316.8	2,350.8	4,667.6
Risk Pool (RP)	-1,903.4	-1,748.2	-3,651.6
Total Variance (inc RP)	413.4	602.6	1,016.0

We are committed to work within our overall PBC financial budget and work with the PCT to address areas where savings can be made. We have set up an Activity and Finance group and we aim to meet on a monthly basis to identify any outliers and tackle these at practice level.

We have actively taken part in the PBC budget setting meetings. In particular, looking at the Fair Shares and Pace of Change debate. The Consortium have made it clear that they would welcome a speedier move to Fair Shares which would enable us to work within a more achievable target. This would serve to motivate practices into making real changes with a possibility of freeing up resources to aid service redesign at a local level

The budget for 09/10 is not expected until the end of April 09.

The steering group recommends that this year the 100% element of the LIS paid on submission of the consortium plan is pooled.

Parson Cross has its own bank account and the steering group proposes that any remaining funds from the 2008-09 SONIC LIS be transferred into this account for future use of the consortium. The account will be transferred into the new names of the consortium with revised signatories agreed.

The steering group will consist of four GPs and two managers who will be paid retainer fees from the consortium LIS for their commitment. This will be at a rate of £75 for each GP hour and £25 for the manager. Each GP will commit to one GP session per week, with the two managerial leads making up a full time equivalent.

Other parties (e.g pharmacists) brought in to carry out work for the consortium will be paid an hourly rate equivalent to cover reasonable locum expenses, totalling no more than £75 per hour.

Each practice will receive an incentive payment for participation in consortium plan, tied into successfully achieving the quarterly reviews with the NHS Sheffield. Because of their list size Burncross have a weighted vote of 2:1 and will therefore receive double the incentive payment.

The remaining LIS will be used for individual clinical project work as described later in this plan.

Savings

The consortium will pool all savings made on the indicative budget. We are proposing that all remaining Parson Cross/SONIC LIS monies from 2008/09 and FURs are pooled from 1st April for use of the merged consortium.

With regard to any freed up resources in the 2009-10 year, these will also be pooled and used towards consortium agreed aims. These aims will depend upon the amount of money available. The consortium is committed to local service provision aimed at reducing the inequalities evident in our area.

7. Ongoing Service Redesign and pathway developments from 08/09 Plans

LES Care Homes

Project Aim: To improve proactive care for patients in care homes in order to reduce non elective admissions to hospital

Citywide or Consortium Specific: Consortium (PX)

Timescale: April 08 - March 10, Evaluation – in year and in 2010

Project Team: Alison Hobbs (Pitsmoor) and Andrew McCoye (Ecclesfield)

Delivered Benefits & Measures of success:

- Reduced emergency admissions
- Reduced length of stay
- Improved end of life care
- Support for care home staff
- Initial evaluation shows percentage reduction in number of admissions of care homes when compared to same period in previous year

Contribution to following ABH Measures:

- *To reduce excess bed days per admission from baseline of Jan 2007 - Dec 2007*
- *To reduce the percent non elective admissions from baseline of Jan-Dec 2007*

(note - as per PCT 2007 Baseline)

Diabetic Management

Project 1

Project Aim: Initiation of insulin in a community setting

Citywide or Consortium Specific: Consortium (Sonic)

Timescale: Launch April 08,

Project Team: Hugh McCullough

Delivered Benefits and Measures of Success:

- Increased knowledge of insulin therapy for primary care professionals
- Community scheme
- Reduced hospital costs
- More timely access to insulin treatment

Project 2

Project Aim: Ongoing management in the community of patients established on insulin.

Citywide or Consortium Specific: Consortium (Sonic initially)

Timescale: April 09, Ongoing

Project Team: Hugh McCullough

Delivered Benefits and Measures of Success:

- Better management of patients on insulin following project 1
- Improve knowledge for primary care professionals
- Reduce hospital outpatient activity

Contribution to following ABH Measures:

- *To reduce referral rates to lower quartile performance.*

COPD and CVD

Project Aim: Working with the Public Health development nurse team to case find patients with COPD and/or CVD, improve the management of and signpost to appropriate services inc. EOL

Citywide or Consortium Specific: citywide scheme

Timescale:

Launch April 08

Evaluated March 2010

Made available for citywide use from Dec 08

Project Team: Amanda Rosario, Mandy Neville, Sue Thackary

Delivered Benefits and Measures of Success:

- Improved patient confidence in self management
- Reduced emergency hospital admissions

Contribution to following ABH Measures:

- *To improve CHD mortality 3 year pooled average compared to the baseline of 2004-2006*
- *To continue the reduction of premature (Under 75 years) circulatory deaths to 40% below 1995/97 by 2010. Rate in 2007 was 81.7% per 100,000 which was 50% below 1995/97*
- *To reduce hospital admissions for COPD by 5% by 2010/11*

Trauma & Orthopaedics (Swollen Knee)

Project Aim: To clarify the patient pathway for knee conditions

Citywide or Consortium Specific: Citywide initiative

Timescale: Oct 08 – aiming completion for July 09

Consortium leads: Anil Grover, David Barron

Delivered Benefits and Measures of Success:

- Clarity of patient journey
- Appropriate use of rheumatology/physiotherapy/orthopaedics
- Reduced hospital outpatient activity

Contribution to following ABH Measures:

- *To reduce referral rates to lower quartile performance.*

Anticoagulation Monitoring

Project Aim: To ensure community availability for anticoagulation services for all patients in north Sheffield

Citywide or Consortium Specific: Consortium

Timescale: Oct 08 – June 09

Project Team: Richard Oliver, James Wood, Lynn Murrie

Delivered Benefits and Measures of Success:

- Reduction in hospital anticoag clinic appointments
- Community provision of warfarin monitoring

Contribution to following ABH Measures:

- *To continue the reduction of premature (Under 75 years) circulatory deaths to 40% below 1995/97 by 2010. Rate in 2007 was 81.7% per 100,000 which was 50% below 1995/97*

Community Phlebotomy

Project Aim: To provide increased availability and accessibility of phlebotomy services for patients in north Sheffield

Citywide or Consortium Specific: Consortium

Timescale: May 09 – May 10

Consortium lead: Grainne Landowski

Delivered Benefits and Measures of Success:

- Extra daily collection by phlebotomist will enable practice staff to stay within the practice
- Improved patient satisfaction as a result of home visits
- Reduction in hospital follow up rates

Contribution to following ABH Measures:

- *To reduce referral rates to lower quartile performance*

Capital Developments

The merged consortium has three capital development proposals at various stages. The consortium continues to liaise with the PCT's LIFT and Capital Programme Manager John Rannigan.

The Foxhill scheme is for a single practice to relocate from premises judged to be not fit for purpose and will incorporate a healthy living ethos with full engagement of the local community.

Mandy Neville (Foxhill Medical Centre)

The Bluebell development will represent a very significant improvement in terms of disabled access and environmental quality for healthcare. There will be ten consulting doctor/nurse rooms, dedicated physiotherapy, counselling and minor surgery rooms and a large area upstairs (with disabled access) that can be used as a 30 x 24 sq metre meeting room, or divided to make 2 smaller rooms available to the local community/PCT. The layout/room allocation and room function has now been agreed and detailed final plans are awaited. Building is expected to start early 2010.

Christine Hitchmough (Bluebell Medical Centre)

Palgrave Road Surgery, Southey Green Medical Centre, Buchanan Road, Wadsley Bridge, and Ecclesfield branch have been involved in a multi practice Primary Care resource centre supported by the LIFT scheme. During this next financial year, we will be working with the practices and NHS Sheffield to agree a specification and timescale for completion of this project. We aim that this centre will provide a range of services over and above traditional primary care and this may incorporate other practices within the consortium being able to offer services from this site.

Simon Kirby (Consortium Managerial Lead)

8. Service redesign and pathway development proposals for 2009/11

The projects below set out to deliver:

- Improvements in public health
- Reductions in hospital activity (inc referrals)
- Improvement of the health and well-being of our consortium's population
- Delivery of the quality agenda in north Sheffield

Overall, the projects continue to build on the consortium's work of saving lives and addressing inequalities.

Note - as the projects enter their 'design phase' and are scoped out in more detail the consortium aims to undertake robust predictive modelling which states what reductions in demand these projects will achieve. However, at this time the projects are not yet sufficiently scoped out to provide the data which would provide specific performance metrics (eg reduce admissions by 10% within 6 months)

Portfolio 1: North Sheffield Consortium Specific Projects

Obesity

Project Aim: Reduce health risks associated with being overweight and promote healthier lifestyles. We are exploring ways in which we can access larger groups of the population including the use of community pharmacists.

Citywide or Consortium Specific: Consortium

Timescale:

PPI consultation (March 09)

Project Design/ Procurement/Business Cases (April-May)

Pilot start/finish June 09 – June 10.

An evaluation to be held March 2010 for possible roll out.

Project Team & Stakeholders: Amanda Rosario, Mandy Neville, Simon Kirby, Lynda Liddament, Garry McCulloch, James Wood

Expected Benefits:

- Increase physical activity and reduction in sedentary behaviour for selected patient cohort
- Improve nutritional intake
- Improve emotional well-being
- Improve weight loss

Contribution to following ABH Measures:

- *To improve CHD mortality 3 year pooled average compared to the baseline of 2004-2006*
- *To improve diabetes controlled blood sugar (patients with HbA1c>7.5%) compared with 2007-8 baseline*

Learning Disabilities

Project Aim: To screen patients (over 18yrs) with learning disabilities for their healthcare needs with specific reference to those that may be especially disadvantaged such as those that are house bound or have elderly carers. The consortium will support schemes in line with the Direct Enhanced Service and will encourage practices to participate.

Citywide or Consortium Specific: Consortium

Timescale:

April – June 09: Design programme (inc) establish need & patient cohorts

July/August 09: Procurement/Business Cases

September 09: Start Project

Project Team & Stakeholders: Jess Tweney, Grainne Landowski, Claire Richardson, Lynda Liddament

Expected Benefits:

- Better health for people with learning disabilities
- Better support for carers
- Equality of service
- Improve better access to care for those traditionally disadvantaged
- Better communication between patients with learning disabilities and practices/the NHS

Contribution to following ABH Measures:

- To increase in proportion of adults with learning disabilities in settled accommodation.
- To increase in proportion of adults with learning disabilities in employment.

Unscheduled Care

Project Aim: Reduce attendances at A&E through improved education off an identified patient cohort group of North Sheffield consortium and appropriate use of clinical admission avoidance schemes.

Citywide or Consortium Specific: Consortium

Timescale:

April-June 09– Project Design

July/August 09– Project Start

Project Team & Stakeholders: Trish Edney, Heather Charlton, Mark Durling, David Brinkley, Shelley Jackson, Dave Barron

Expected Benefits:

- Patient education and confidence
- Reduction in A/E attendances

Contribution to following ABH Measures:

- To reduce excess bed days per admission from baseline of Jan 2007 - Dec 2007
- To reduce the percent admissions of non elective admissions from baseline of Jan-Dec 2007

(note - as per PCT 2007 Baseline)

ENT

Project Aim: Develop referral analysis in order to inform the business case. Assess and, if appropriate, set up an ear toileting nurse led service

Citywide or Consortium Specific: Consortium

Timescale:

Project Design June-Sep 09

Project Start – October 09

Project Team & Stakeholders Richard Oliver, Wijdan Issa, Chi Nwafor, Sandra Emerson, Lynda Liddament

Expected Benefits:

- Improved management of minor ear conditions
- Reduce ENT outpatient appointments and A&E attendances

Contribution to following ABH Measure:

- To reduce referral rates to lower quartile performance.

Please note: the above projects were scoped out by the sixty members of North Sheffield Consortium at a Practice Learning Initiative in February 2008. Depending on progress with the above projects, the consortium will scope out the following areas for service development to be worked on this year in a future PLI: Mental Health, Alcohol Services, and Provider Services.

Portfolio 2: CITYWIDE Projects where North Sheffield is leading

Physio

Project Aim: North Sheffield consortium leading the commission of new community physio as soon as PCT rules allow us.

Citywide or Consortium Specific: Citywide

Consortium leads: Drs Mark Durling, Jackie Burton, Ted Turner

Timescale:

Scoping Started March 09. Decommissioning implications. Aim for new service to be commissioned from 2010/11

Stakeholders: All consortia & PCT

Expected Benefits:

- Seamless transition between physio and specialist physio services
- Increased patient satisfaction
- Equal access and optimum provision of physio for all GP Practices
- Value for money
- Reduction in secondary care referrals

Contribution to following ABH Measure:

- To reduce referral rates to lower quartile performance.

Stroke

Project Aim: Improve detection and prevention of stroke. Primary screening for BP, atifillbrillation and smoking will be carried out in line with the stroke strategy. Practices will be encouraged and supported in warfarin initiation.
Citywide or Consortium Specific: City Wide with North Sheffield leading
Consortium leads: Richard Oliver,
Timescale: Launch in April (preparation work currently underway)
Stakeholders: All consortia, GPs, PCT and local community groups (e.g. SOAR)

Expected Benefits:

- Leading to a reduction in number of stroke cases
- Patients will be able to access community led anticoagulation services
- Promote better primary care management and training of hypertension
- Improve our relationship with local community groups
- Indirect benefit to improve smoking cessation rates
- Promote better primary care and training in relation to anticoagulation

Contribution to following ABH Measure:

- To reduce stroke deaths within 30 days compared to the baseline of April 2005 - March 2006

Rheumatology (Inflammatory Arthritis)

Project Aim: Review and redefine pathway for Inflammatory Arthritis
Citywide or Consortium Specific: Citywide with North Sheffield consortia leading

Consortium lead: Carl Edgill

Timescale: On Going. Business Plan to completed end of June 09

Stakeholders: All Consortia, GPs, and PCT

Expected Benefits:

- Reducing hospital referrals and follow ups
- Retaining patients in primary care
- Improve quality of care
- Improve relationships between GPs and Rheumatologists

Contribution to following ABH Measure:

- To reduce referral rates to lower quartile performance

Chlamydia screening

Project Aim: The consortium will work with practices and pharmacies to improve the screening and management of at risk groups for Chlamydia

Citywide or consortium specific: Consortium

Timescale: Three months

Consortia leads: Trish Edney, James Wood, Lynn Murrie

Benefits:

- Population screening – reduce prevalence of disease
- Reduction in future infertility

- Reduction in pelvic inflammatory disease
- Reduction in other complications associated with Chlamydia disease

Contribution to following ABH Measure:

- To increase the percentage of under 25s receiving chlamydia screening.

Gynaecology – Female Incontinence

Project Aim: Improving detection and management of female incontinence

Citywide or Consortium specific: Citywide led by us and HASC and North Sheffield

Timescale: 4-5 months to complete business plan and procurement

Project Leader: Trish Edney

Expected Benefits:

- Clarity of pathway
- Community-led service

Contribution to following ABH Measures:

- To reduce referral rates to lower quartile performance.
- To reduce inpatient average length of stay. Indicative data: H87 FNOF Jan-Dec 2007

Portfolio 3: Projects taking place within other consortia which North Sheffield will aim to adopt.

Foot & Ankle (led by HASC). There is a PLI event in July, promoting Foot And Ankle, Knee, Back, and Shoulder following which the consortium will aim to implement the pathway.

Urology (led by West), lower urinary tract symptoms and haematuria.

The adoption decision will be based on how the successful the pathways are.

9. Referral Management action plan for 2009/10

The table below shows the referral position for Parson Cross and SONIC Consortia against the citywide position as at December 2008. The table shows that Parson Cross and SONIC were 15.9% and 15.3% above indicative level for GP referrals compared with all Consortia. However, looking at total referrals shows that both Consortia have a smaller variance (-3% and +13.1%) than the citywide position (+14.8%).

April - December 2008	Parson Cross	SONIC	All Consortia
GP Referrals Indicative Level	10454	8541	80252
GP Referrals Actual	12115	9844	91028
GP Referrals Variance	1661	1303	10776
GP Referrals Variance %	+15.9	+15.3	+13.4
Other Referrals Indicative Level	7597	6230	55323
Other Referrals Actual	8519	6864	64629
Other Referrals Variance	922	634	9306
Other Referrals Variance %	+12.1	+10.2	+16.8
Total Referrals Indicative Level	18051	14771	135575
Total Referrals Actual	20634	16708	155657
Total Referrals Variance	2583	1937	20082
Total Referrals Variance %	+14.3	+13.1	+14.8

Source: PBC Contract Monitoring System

Referrals will be assessed and reviewed on a monthly basis via the practice managers group. The steering group remains committed to play an active role in supporting the delivery of the PCT financial plan.

The consortium recognises that it is classed as a 'high referrer'. However initial data analysis suggests that the cost of these referrals is below the city average. During the year we plan to seek better understanding of this relationship. The consortium area covers populations with high disease prevalence, high levels of social deprivation and high levels of BME groups, which we feel support a higher level of secondary care uptake. The move towards fair share allocations will provide financial support for the consequences of caring for these populations.

Goals/measures for referral management:

- The practices will engage with the RIS and make full use of the reports provided.
- This data will be shared in un-anonymised format between the practices. We will share referrals data at practice manager meetings so that
 - 1) position against plan can be tracked
 - 2) each practice can see where referral rate is 'ranked' compared with other Sheffield practices
- We will identify areas that require further investigation across the

consortium and where this is indicated will identify and support a clinical lead for this work.

- We will ask practices to undertake audits in specialties where the consortium perceives there to be a problem and will use this information to support further redesign. In order to have consistent data collection the steering group will agree an audit template to be used.

10. Action plans for Demand Management of non-practice initiated activity, in particular non elective admissions

The consortium needs to identify clear priorities and measures for successful management of non-elective admissions. The consortium will also undertake a review of consultant-to-consultant referral activity and seek to understand ways of working with this.

Plan to reduce non- elective admissions is based on successful implementation of the following projects which have been previously prioritised:

- Unscheduled Care Consortium Project
- Stroke
- COPD and CVD
- Diabetes Management
- LES Care Homes

The benefits for undertaking these projects in line with reducing the demand on secondary care services are set out above in the appropriate sections.

By reducing demand for secondary care services, North Sheffield Consortium can contribute to the delivery of generating £40m worth as savings as identified in Achieving Balanced Health

Furthermore, as the projects enter their 'design phase' and are scoped out in more detail the consortium aims to undertake robust predictive modelling which states what reductions in demand these projects will achieve. However, at this time the projects are not yet sufficiently scoped out to provide the data which would provide specific performance metrics (eg reduce admissions by 10% within 6 months)

11. Prescribing action plan for 2009/10

Richard Crosby will be the Medicine Management Team link for the consortium and will be supported by Dr Eugene Rybinski. We will continue to receive quarterly reports on effective prescribing and will encourage practices to fully adopt recommendations which make better use of our prescribing resource.

The Medicines Management Team will continue to provide written quarterly reports ahead of consortium meetings. Each of the practices will have an attached Medicines Management Team member who will support the practice in meeting its prescribing targets.

The consortium will continue to engage with the Medicines Management Team audits to promote safe and effective prescribing. Where the Medicines Management Team carries out audits within practices the practice will give due consideration to the results.

The consortium will actively engage in medicines 6 and 10 of the QOF both to ensure all practices receive appropriate payment but also as a method of improving prescribing and patient care.

The consortium will continue to make excellent progress on repeat dispensing, in order to free reception and doctor time, and also to make services more convenient to patients.

Dr Eugene Rybinski (Burncross Surgery) & Richard Crosby

12. Public and Patient Engagement

For all service redesign proposals outlined in this plan, we will undertake patient and public engagement activities and communicate to ensure PBC is shaped by the views of the local population. This will be critical if we are to realise our improvement aims as a co-commissioner and will begin in the early stages of design phase of each project.

We recognise the importance of public and patient engagement. Parson Cross has had initial discussions with the SOAR group who are keen to support and work with the merged consortium. We will continue dialogue and invite representatives to our board meetings. The PCT PPI department through the internal matrix function, supports the development of the Consortium. We are also aware of the developing role of Community Assemblies and aim to be involved.

- We are working with Adult Services, Care Home Managers and Sheffield Carers Centre to raise awareness of the LES Care Homes and will work with the Reference Groups attached to specific homes to regularly review progress and gain feedback from residents and stakeholders.
- Patient feedback is a standard part of the progress monitoring for the COPD Pulmonary Rehabilitation programme. We will agree a specification for this service with providers and invite them to present feedback to the consortium.
- The clinical areas identified in Sections 7 and 8 will be tested with patient representatives

- We will also see to establish input from *Patient Opinion* and a local PPE group representative of the local community

Simon Kirby & Grainne Landowski (Consortium Managerial leads)

13. Summary of objectives

Please see Section 14

Our objectives are outlined and integrated in section 4-12. In summary they are:

- deliver our service redesign project proposals to the timelines specified in sections 7 & 8
- manage the referral activity as set out in section 9
- ensure all our commissioning activities are consistent with the World Class Commissioning Competencies and ABH (2)
- ensure our organisational development continues and enables our PBC activities to mature and evolve
- ensure all our service redesign proposals are financially viable, robust and sustainable for the local NHS
- ensure all our service redesign projects compliment the city wide non-elective strategies
- ensure we continue to work and improve relationships with local communities

Please see Appendix A for plan of services

Performance Area (Objective) & Milestones	Progress reviewed at:			
	Q1	Q2	Q3	Q4
11. Stroke (Detection and prevention)				
- Finalise Scope and Specification	✓			
- Launch Project		✓		
12. Chlamydia Screening				
- Project Design	✓	✓		
- Begin Project		✓		
13. Female Incontinence				
- Complete Business Plan and Service Spec	✓			
- Procure new service		✓		
14. Referral Management				
- Referrals assessed and reviewed on a monthly basis	✓	✓	✓	✓
- Engage with the RIS and make full use of RIS reports	✓	✓	✓	✓
- Identify areas requiring further investigation and support a clinical lead	✓	✓	✓	✓
- Steering Group to agree a Referrals Audit template	✓			
- Practices to undertake referral audits when requested by the Consortium	✓	✓	✓	✓
15. LES Care Homes				
- Evaluation March 2010				✓
16. Demand Management				
- Undertake a review of consultant-to-consultant referrals	✓	✓	✓	✓
- Review progress of the following projects: - Unscheduled Care, Stroke, COPD & CVD, Diabetes Management and LES Care Homes	✓	✓	✓	✓
17. Practice reporting				
- Practices to provide quarterly assessment reports to the Consortium	✓	✓	✓	✓
18. Prescribing				
- Regular analysis of the Prescribing budget	✓	✓	✓	✓
- Review of quarterly repeat dispensing reports	✓	✓	✓	✓
- Report on audit progress within practices	✓	✓	✓	✓
- QOF Progress, medicines 6 and 10	✓	✓	✓	✓
19. Public & Patient Engagement	✓	✓	✓	✓
- Evidence of engaging the local population				

Note – further quarterly objectives past Q1 will be defined as the projects listed above are scoped out and developed.

Appendix 1

Constitution of the Sheffield North PBC Consortium

1 Name

1.1 The name of the organisation shall be the Sheffield North PBC Consortium.

2 Aims

2.1 The aims of the consortium are to improve local health and well being in the North Sheffield area, to maintain the strengths of general practice in this area, to commission high quality health services, targeted on reducing health inequalities. We will do this by:

- A commitment to addressing the causes of health inequality within the local area
- Improving the quality of services and staff
- Encouraging joint working across practices, the local health community, Sheffield City Council, and the voluntary sector
- Helping the above gain greater understanding of NHS usage and finance;
- Improving the patient's experience of health services, wherever provided;
- Creating stable working arrangements to minimise clinical and financial risk, in order to provide efficient services within an affordable framework.
- Developing relationships with local people

3 Powers

3.1 To achieve its aims the consortium may:

- Organise training and events;
- Work with consortia across Sheffield and other organisations to exchange information and advice and to redesign clinical pathways;
- Work with other organisations which will help it fulfil its aims;
- Manage any PCT seconded staff for work undertaken on its behalf;

4 Board

- 4.1 The consortium Board is made up of one nominated GP, practice nurse, and practice manager from each practice.
- 4.2 The Board will be considered quorate when at least two thirds of practices are represented by at least one member.
- 4.3 The consortium board shall elect the members of the steering group annually, the first vote being no less than twelve months after the launch of the consortium

5 Membership

- 5.1 New practices may join the consortium, subject to two thirds of all practices already in the consortium agreeing to this.
- 5.2 A local practice may join which is:
 - Interested in helping the consortium achieve its aims;
 - Willing to abide by the rules of the consortium.
- 5.3 Practices who wish to join will need to commit to the consortium 'pot' their indicative share of the LIS.
- 5.4 A practice choosing to leave will give at least three months' notice of its intention to do so.
- 5.5 All practices in the consortium will take responsibility for commissioning services in accordance with the budgets that have been allocated to them.
- 5.6 All practices participating in the consortium are expected to:
 - Send at least one member to a minimum of 4 PLI meetings scheduled in 2009/10.
 - Send another practice representative if any of the three members cannot attend
 - Share referral data and prescribing data, electronically.
 - Share specialist skills within the consortium.
 - Maintain an open mind with regard to how services might be developed
 - Maintain a willingness to appreciate that PBC is a shared agenda between Practices
 - Share information about the development of PBC within the consortium.

- Respond to requests for information from the consortium
 - Respond to requests for practice agreement/disagreement with proposed decisions
- 5.7 Consortium Board members will be the nominated leads for each practice and have responsibility for ensuring that all practice staff and GPs are informed of the outcome of each consortium meeting. They also have responsibility for ensuring that the views of those practice teams are fed up to the consortium Steering Group.

6 Steering Group

- 6.1 A Steering Group of not less than four and not more than eight individuals elected at the May 2009 PLI shall administer the consortium.
- 6.2 The Steering Group may also nominate a Treasurer. In the absence of a Treasurer the Steering Group will appoint a member to hold responsibility for consortium financial arrangements.
- 6.3 The Steering Group shall meet no less than monthly.
- 6.4 The Steering Group will be considered quorate when at least two thirds of members are present.
- 6.5 At least the Chair or Vice Chair must be present for the Steering Group to make a decision.
- 6.6 Where a member of the Steering Group fails to attend three consecutive meetings without good reason then the Chair will discuss with the individual how best to secure attendance, making fair and reasonable allowance for any difficulties he or she may have.
- 6.7 The Steering Group may appoint any other member of the consortium as a Steering Group member to fill a vacancy, provided that the maximum prescribed is not exceeded.
- 6.8 The Steering Group shall have the power to remove an individual from the Steering Group for good and proper reason.
- 6.9 The Steering Group may appoint subgroups to lead clinical redesigns and such other work as it deems necessary.

7 Duties of the Officers

7.1 The Chair will:

- Chair meetings of the Steering Group and the consortium;
- Represent the consortium at meetings to which it has been invited;
- Act as the spokesperson of the consortium where necessary.

7.2 The duties of the Vice Chair are to

- fulfil the duties of the Chair in his or her absence
- or to jointly undertake these duties as both agree appropriate.

7.3 The Treasurer, or steering group member with designated responsibility for consortium financial arrangements, will:

- Keep proper accounts of monies received and paid out on behalf of the consortium, including presenting written updates to the Steering Group and consortium meetings at least quarterly.

8 Budgetary management and finance

8.1 The consortium will work to achieve financial balance. However where practices fail to do so, for a variety of good reasons, support will be provided by the Steering Group, taking reasonable account of the practice's difficulties.

8.2 The consortium anticipates some practices will achieve a reduction in expenditure through reductions in elective and non-elective activity. This will offset practices that over perform, leading to an overall balanced position for the consortium. In this way, the consortium will share financial 'risks'.

8.3 The Steering Group will meet as reasonably required with the PCT to discuss consortium activity and finance reports.

8.4 All monies received by or on behalf of the consortium will be used to further the aims of the consortium and for no other purpose. The Steering Group may authorise reasonable out of pocket expenses including locum cover, cover for Practice Manager time, travel, childcare and meal costs to practices. Members will be asked to provide appropriate evidence of expenses incurred.

8.5 It is envisaged that the reorganisation of services will free up funding for new primary care services to be created. Any savings will be retained by the consortium and PCT and a 70%/30% share respectively

- 8.6 All savings/freed up resources will be spent on patient care or for the benefit of patients and will not be subsumed into regular practice income.
- 8.7 Where practices in the consortium wish to pool some or all of their indicative budgets, the consortium will confirm this in writing to the PCT.
- 8.8 Any business plan for any service redesign will identify, where applicable, where savings will be made within the available budget in order to reinvestment in national and local priorities.
- 8.9 Reimbursements of time working for the consortium

There will be reimbursement for attendance at general consortium Board and Steering Group meetings. Reimbursement for time spent on other consortium business will be agreed in advance at the consortium Board meeting. For example reimbursements will be made for people working in sub-groups to develop new models of service. Reimbursements can be used to compensate the practice for time lost or to fund locum or partner cover.

Each Steering member will be paid for work done, a minimum of one session per week.

The following rates will apply:
£75 per hour for GP
£25 per hour for Practice Manager
£20 per hour for Practice Nurse

Claims need to be submitted to the treasurer within 30 days

Claimants will need to provide evidence of what they did and when (i.e. reports for Board, locum receipts) so that the Treasurer can then apply to the PCT to draw down from the LIS. Practices can only claim for work they did which was first approved by the consortium and therefore supports the consortium aims.

X money will be paid to practices that send a PM to monthly Practice Manager meetings where at least 50% of the agenda relates to PBC business.

9 Consortium Board Meetings

- 9.1 The consortium board will meet 4 times a year before or after the quarterly consortium PLI.
- 9.2 Each practice will nominate two named representatives to attend, at least one of whom must be a GP partner and, normally, the Practice Manager.
- 9.3 Each practice will have one vote, except for those practices whose list size exceeds twice the national average
- 9.4 A majority decision will be final.
- 9.5 Voting will be by show of hands at meetings. If there is a tied vote the Chair shall have a second vote.
- 9.6 The aims of the consortium can only be achieved by the regular participation of practices in meetings. Where a practice is not represented without good reason then the Chair will discuss with the practice how best to secure attendance, making fair and reasonable allowance for any difficulties the practice may have.

10 Extraordinary General Meetings

- 10.1 An Extraordinary General Meeting (EGM) may be called for, in writing:
 - By the Steering Group or
 - By the partners or practice-employed staff of five practices (who need not be the named representatives) to discuss an urgent matter.
- 10.2 The Chair will give practices and other interested parties at least 14 days notice of any EGM with notice of the business to be discussed.

11 Alterations to the Constitution, changes to membership and dissolution

- 11.1 Any changes to this Constitution; or decisions to expel practices from the consortium or allow new practices to join; or dissolution of the consortium will require the agreement of two thirds of all practices already in the consortium.¹
- 11.2 Any practice wishing to leave the consortium is free to do so. Their share of the LIS remains with the PCT. If those practice members have been charged by the consortium to do work and have claimed for that time then they are expected to submit the results of that work to the Board so that it can be continued.
- 11.3 In the event of winding up, any assets remaining shall be given to Sheffield PCT or its successor.

12 Dispute

- 12.1 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 Steering Group will specify in writing the actions that the practice is required to take and the timescale for these to be implemented. The consortium will afford the practice all due information and assistance.
- 12.2 If agreement and resolution cannot be reached through this mechanism, or if there is no improvement within 3 months (or the timescale specified, if less) then the matter will be brought to a consortium meeting for full discussion.
- 12.3 The consortium will normally offer up to a further 3 months for improvements to be achieved (which will again be specified in writing). If after 6 months, the practice has not put into effect the changes required by the consortium, the consortium may, as a last resort, propose the expulsion of the practice. Expulsion 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 of the consortium; or compromised its independence or corporate integrity.

¹ Any practice facing expulsion will still be entitled to a vote as an existing member of the consortium.

12.4 In the event of any dispute that cannot be resolved through the arrangements described here, practices reserve the right to apply to Sheffield PCT for arbitration. The consortium will work with the PCT, under any such disputes procedures as the PCT considers appropriate.

13 Adoption of the Constitution.

The persons whose signatures and practice names appear at the bottom of this document are the members' named representatives and will nominate the Steering Group referred to in this constitution.

This Constitution was adopted on xxx .

Constituent practices and leads		
	GP	Practice Manager
Barnsley Rd Surgery	Dr Anil Grover	Janette Bugar
Bluebell	Dr Jess Tweney	Christine Hitchmough
Buchanan Rd Surgery	Dr Helen Stockdale	Michelle Richards
Burncross Surgery	Dr Eugene Rybinksi	Martyn Smith
Burngreave	Dr Bryan Hopwood	Karen Green
Dunninc Road	Dr Shrivass Keini	Duncan Miller
Ecclesfield Group Practice	Dr Richard Oliver	Simon Kirby
Elm Lane Surgery	Dr Des Keating	Margaret Turner
Firth Park	Dr Leigh Sorsbie	Julian Stevens
Foxhill Medical Centre	Dr Amanda Rosario	Mandy Neville
Grenoside Surgery	Dr Mark Durling	Anita Warner
Health Care Surgery	Dr Heather Charlton	Louise Bodsworth
Mill Rd Surgery		Angi Hartley
Norwood Medical Centre	Dr Susie Lupton	Sam Grundy
Page Hall	Dr Margaret Ainger	Jan Jude
Pitsmoor	Dr Trish Edney	David Emmas
Sheffield Medical Centre	Dr Chi Nwafor	Julie King
Shiregreen	Dr Ted Turner	Victoria Allen
Southey Medical Centre	Dr Navnit Patel	Janet Scott
Upwell Street	Dr Jackie Burton	Johanne Shirt
Wincobank	Dr Illyes Tabani	Tyronn Tate