

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

This template is designed to ensure that the development of your practice based commissioning plan provides a clear and robust link to the commissioning cycle for health care in Sheffield. In particular the template is intended to allow your consortium the opportunity to shape the commissioning intentions for the patients within your constituent population and, where appropriate, across the city. The template is also designed to support the move towards World Class Commissioning (WCC) within Sheffield and deliberately encourages your consortium to demonstrate key competencies. The template cross references to specific and relevant WCC competencies

There will be in-year opportunities to refresh your plan, particularly with regard to the development of new ideas around service development and performance management. Your plan should be drawn up in the context of NHS Sheffield's Practice Based Commissioning Local Incentive Scheme (LIS) and Governance Framework. Agreement of your plan with NHS Sheffield will trigger the award of the first element of incentive payment for the beginning of the new financial year.

Your plan should be supported by the development of a work programme, which includes measurable outcomes and milestones that will provide evidence for the release of the second element of the PBC (LIS) payment. Milestone payment points will be agreed with your consortia at the start of the year.

Progress against the plan will be measured by a programme of monthly support meetings between the consortia managerial leads and the matrix teams. In addition there will be formal quarterly reviews between the consortium and NHS Sheffield, chaired by an executive officer. Consortia will be expected to complete an annual self assessment audit evidencing progress and practice engagement.

Consortium Name: **Sheffield West PBC LLP**

**Contact Name: Elizabeth Sedgwick**  
**Designation: Business Manager**

**Contact Telephone Number: 0845 122 3331**

**PBC Clinical Lead: Dr John Poyser**

## 1. Details of Constituent Practices and Commissioning Leads

<b>Practice Details</b>	<b>Clinical Lead</b>	<b>Manager</b>
Deepcar Medical Centre 241-245 Manchester Road, Deepcar S36 2QZ Tel: 0845 124 6243	Dr K Davis	Sue Lambert
Devonshire Green Medical Centre 126 Devonshire Street S3 7SF Tel 0845 122 7721	Dr G Pettinger	Anthony Fisher
Porter Brook Medical Centre 9 Sunderland Street S11 8HN Tel 0845 124 5567	Dr A Mackie	Susie Uprichard
University Health Service 53 Gell Street S3 7QP Tel 0114 222 2100	Dr M Jakubovic	Chris Franklin
Walkley House Medical Centre 23 Greenhow Street S6 3TN Tel 0845 122 2524	Dr J Stephenson	Sandra Poore
The Crookes Practice 203 School Road S10 1GN Tel 0845 120 4201	Dr M Billington	Martyn Heeley
Tramways Medical Centre 54 Holme Lane S6 4JQ Tel 0845 126 6411	Dr A Bradley	Diane Dickinson
Oughtibridge Surgery Church St, Oughtibridge S35 0FW Tel 0845 125 5001	Dr T Moorhead	Paul Roberts
Harold Street Medical Centre 2 Harold Street S6 3QW Tel 0845 122 6566	Dr N Patrick	Lynda Clarke
Fairlawns 621 Middlewood Road, S6 1TT Tel 0845 122 3331	Dr J Poyser	Sue Sharpe
Stannington Medical Centre Uppergate Road S6 6BX Tel 0845 124 1041	Dr D Shurmer	Sharon Thompson
Dykes Hall Medical Centre 156 Dykes Hall Road S6 4GQ Tel 0845 121 0223	Dr S Thomas	Fiona Walker

## **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.*

### **Consortium Status**

The West PBC consortium remains the only legally constituted PBC group within Sheffield. The group is comprised of twelve practices who were within the aegis of the Sheffield West Primary Care Group and the Sheffield West PCT. Thus there is a history of collaborative working in this group of practices which goes back to 1997. The twelve constituent practices are responsible for the delivery of primary care in the west of the city in an area covered largely by the S6, S3, S10, S35 and S36 postal codes plus much of the City centre and extending up the Don Valley to Deepcar. The registered population is approximately 110,000 including approximately 35000 students who attend both University General Practices.

The West PBC Consortium was formed formally in September 2006 as a loose working group of practices who had each signed a memorandum of association. By the middle of 2007 the Consortium had realised that there was insufficient organisational solidity to enable the achievement of key objectives and that the Consortium needed to develop into an entity with its own legal status. Following a number of organisational development meetings the Consortium agreed to pursue status of a Limited Liability Partnership. The LLP was incorporated in March 2008.

### **Organisational Structure**

The functional structure of the LLP remains identical to the Consortium which preceded it. There is an Executive Committee which leads the LLP and comprises three General Practitioners, one of whom is the designated Clinical Lead. There are also three Practice Managers and a non exec member. The Executive Team meet monthly.

The Executive reports to the Council which comprise two delegates from each practice, one being a clinician and one being a manager. Council meetings are held bi monthly unless need demands otherwise. Practices have agreed to ensure representation at meetings.

In 2008, the Consortium successfully appointed a Business Manager. The manager works closely with the Executive Committee and reports to the Council.

The Consortium engages with all stakeholder groups as and when appropriate, including, secondary care clinicians, independent contractors (optoms, dentist and pharmacist) and representatives from community, voluntary and statutory bodies. It is the intention to integrate further with these groups through the local Community Assemblies and the Sheffield Links project. The support team at NHS Sheffield is essential to the success of

PBC.

### **Joining the consortium**

The Consortium is willing to consider requests from non-consortium practices to join the Consortium. Request will be formally considered by the members of the West PBC consortium LLP and practices admitted only through the unanimous agreement of the members. The joining practice will be bound by and work to the West PBC plan

### **Leaving the consortium**

- Any practice wishing to leave the consortium should give 3 calendar months notice in writing to the LLP members.
- In exceptional circumstances a consortium practice may be asked to leave the consortium. Such circumstances would include actions contrary to the spirit of the consortium, thus seriously compromising the consortium's ability to achieve its clinical or financial goals. Such action would only be taken with the unanimous agreement of the LLP membership.

The budgetary implications for practices joining or leaving the consortium will be handled in adherence to the agreed 'PBC governance framework'

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

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

The principle aims of the West PBC consortium LLP are to deliver Practice Based Commissioning in alignment with the strategic goals of Achieving Balanced Health 2, including moving care closer to home, addressing inequalities, improving health and ensuring best value. The main areas to deliver this vision are:

1. To further develop the LLP as a robust commissioning entity with the intention of becoming a service provider,
2. To improve the quality and value of the services commissioned for the served population, delivering closer to home when possible.
3. Utilise the skill set unique to our consortium and to deliver both clinical and management training programmes within those identified clinical areas to enhance GP knowledge and further develop the strategic direction of the consortium.
4. Achieve Financial Balance but continue to challenge the basis on which the budgets were set. Aim towards fair budgets, participating in the City wide work towards this goal.
5. To tackle the current escalating levels of non practice initiated activity/unscheduled care, finding alternative pathways where appropriate
6. To utilise verifiable data in a constructive manner and challenge inaccurate data.
7. To develop stronger partnerships with statutory community and voluntary sector stakeholders and work to engage more closely with patients, carers and other independent contractors.

#### 4. Reporting metrics for LIS payments

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

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

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

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

##### LIS Part B Payment (50%) Comprising:

**30% Delivery of key service redesigns identified within Consortia plan. Achievement criteria listed 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
3. 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.**

**5. Organisational Development in 08/09 (WCC competencies.....)**

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

The LLP continues to grow in strength with determination in the collaborative working between members and its relationship with other stakeholders. The foundations stones set during the development of the West PBC has enabled the group to move forward and work together in a cohesive manner which can only be constructive in the improvement of patient services.

**Organisation and Aims of West PBC Consortium LLP**

The appointment of a Business Manager has provided a key link between practices and members of the consortium to achieve objectives. The Business Manager is developing a closer working relationship with the PCT support team following involvement in the Matrix meetings.

**Commissioning**

The principle reason for the existence of the West PBC Consortium LLP is to assist member practices in achieving success in Practice Based Commissioning. This will be measured in terms of the innovative service redesign which can be achieved as well as improving the patient experience across Primary and Secondary Care

**Service Redesign**

The West PBC Consortium LLP aims to improve the quality of care as well as the patient experience by collaborating with clinicians and managers across all service providers to ensure that services deliver the most appropriate level of care by the most appropriate provider at the most appropriate time and in the most appropriate setting.

The areas identified for further development in 2009/10 will involve working groups of interested clinicians with a timetable of meetings and actions to be taken. Each clinical area has an identified lead GP and a target date for completion. The Consortium expects to increase its level of engagement with the PCT, further taking up the capacity offered through closer working with the matrix team.

Particularly where new services are to implemented within a community setting the

consortium will ensure that the information and training is delivered in both an appropriate and timely manner.

### **Financial Management**

The West PBC Consortium LLP aims to achieve financial balance within its commissioning budget. The new service redesign initiatives will utilise the 'Invest to Save' model as it is recognised that there is little room for manoeuvre within the current budget setting methodology.

The consortium will hold and manage the budget on behalf of the constituent practices. The indicative budget is continually monitored with any outlying areas investigated further and appropriate action taken where possible.

An internal financial Budget for the next three years has been agreed to ensure the administration and management function of the PBC continues. Achievement of new LIS payments is over and above planned expenditure and may lead to increased capacity being developed by the Consortium.

### **Engagement of Clinicians**

None of the aims of the West PBC Consortium LLP can be met without the full and enthusiastic involvement of all clinicians. The West PBC Consortium LLP aims to be inclusive in the way it works to maximise the engagement of its stakeholder clinicians. Reimbursement of GP time when engaged on specific PBC business has been agreed.

### **Public Consultation**

Public Consultation is very important. The local community's perceptions of service redesign and the reasons for it require being accurate if it is to be popular and sensitive to the needs of patients. The West PBC Consortium LLP will maintain good relationships with local interest groups, local user groups and patients at practice level to ensure that public consultation is of the best possible quality. The West PBC has developed its public participation strategy which will be implemented in 2009/10. A website with an area for the public to use and comment will also be available in 2009/10.

### **Education**

The Consortium has a history of providing educational support for GPs and their teams and to be responsive to training needs of constituent members.

West PBC Consortium LLP intends to continue and strengthen its educational activities to improve the skills of the workforces in member practices. Through the PLI, training events for both clinical and strategic management will be provided for constituent members to further consortium development.

### **Inter Practice Collaboration**

There is a history of collaborative working in the member practices which dates back to the Sheffield West PCG. The West PBC Consortium LLP will continue that tradition, strengthen it and improve the cohesion of the practices in the consortium. The West has re introduced the Practice Managers group to provide support and information to the member practices for both Primary Care and Practice Based Commissioning matters. The development of the website will be a further tool for Practices to access information about current projects, workgroups and the Business Plan.

### **External Relationships**

The West PBC Consortium LLP will strengthen its existing relationships with the PCT and other Consortia as well as develop new relationships and strategic alliances with other related agencies, independent contractors and organisations. This will include community, voluntary and statutory bodies. The Business Manager for the West attends the City Business Managers group. The West PBC is working with the City Confederation. Membership of national professional organisations which provide support to PBC groups has also taken place. The West PBC is a member of the NHS Alliance and the NAPC.

### **Succession Planning**

The consortium recognises the need to enhance the commissioning and leadership skills of younger doctors. The consortium will, in partnership with the PCT, identify interested and enthusiastic GPs and nurses and encourage them to access the leadership training resources being offered by the PCT. The consortium intends to continue its own organisational development throughout 2009-10 by taking advantage of the available practice level PLI sessions provided by the PCT.

NHS Sheffield has made a further commitment to fund the City Wide Development Framework for Consortia, which is an investment for the future and the consortium plans to fully utilise its allocation of these resources.

### **6. 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*

The consortium has a diverse population with differing needs. There are areas of extreme deprivation and low life expectancy, pockets of high ethnic and minority groups, a significant number of students and other areas of elderly middle class. The Consortium will:

- Take the lead on the City wide alcohol strategy, aiming to complete within twelve months.
- Engage in enhanced Public Health programme activities where appropriate and to evaluate possibility of joint working.
- Continue to support city wide initiatives to improve vaccine uptake
- Tackle Obesity – through the further development of its Weight Management Business case. The protocol and work plan is established but it is unclear which route to take or how this will be funded. There is an expectation that a decision will have been taken by the end of Quarter one.
- Continue the ongoing work to reduce prevalence of smoking.
- Utilise Public Health Data appropriately, including benchmark data available from Yorkshire Public Health Observatory.

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

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

The consortium will hold and manage the budget on behalf of the constituent practices. The indicative budget is continually monitored with any outlying areas investigated further and appropriate action taken where possible. Using data available and the most cost effective use of management time, Practices have agreed to check and confirm the High Cost in patient procedures (minimum procedure cost £5000) On average this is five patients per practice.

The LIS payments through the PBC incentive scheme will continue to be paid directly in to the consortium LLP bank account. These monies will be used for the continued development of a robust management structure and continued involvement of clinicians.

The West Consortium continues to push for fairer budget setting with an increased allowance for the student population. The historical budget setting has affected the consortium ability to make savings due to the initial low budget per capita. However, the development of plans using 'Invest to save' methodology should enable the consortium to better manage potential overspends. The PEARS scheme is a good example of this strategy in action. Our Gynaecology redesign should be able to use similar techniques to achieve our redesign goals.

The consortium has significant concerns about the implications of the PCTs planned approach to fair shares in respect of the student population and the potential problems these practices may have with the impact of QOF 2009/10 changes. The West PBC supports the member practices in their efforts to negotiate a local resolution with the PCT.

### Contract Monitoring – Quality Issues

Concerns have been raised by the GPs within the consortium that the contracts with secondary care are all about quantity with quality coming a poor second.

Specific concerns include

- Discharging the patient too early without appropriate care package being in place.
- No discharge summary
- Incorrect discharge information letters
- Patients regularly discharged without drugs

These often lead to patients being readmitted, particularly elderly vulnerable being discharged in time for the weekend.

The consortium intends to introduce a quality monitoring system, reporting centrally, to identify areas in need of development for the benefit of the patient. This will provide the evidence determine required improvements

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

*Clear plans with milestones need to be expressed for any service redesign/ pathway development work that is carrying over from the previous year  
The consortium will actively participate in service redesign initiatives.*

The major successes in 2008/09 will continue:

Urology pathway redesign – to be rolled out across the city, date to be confirmed by NHS Sheffield.

Continuation of ongoing DMARD management and Anticoagulation Service.

PEARS – Optometry Service, rolled out across the city- Future enhancements to the service to be determined. Six months service evaluation.

Maximal Stress Test ECG service – continuation of existing service with expansion of capacity.

Eating disorder service – continuation and funding of existing service. Any reduction of provision in either will result in increased referrals to secondary care. Robert Carter is pursuing funding streams for continuation.

Continuation and delivery of:

West Referral Management scheme

West Patient participation group

Further refinements will continue throughout 2009/2010.

Implementation of QUTE pilot scheme: PBC data validation system, between primary and secondary care to be piloted in UHS. Expected to take up to eighteen months.

#### **9. 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*

#### **Appendix One**

#### **Business Case/Service redesign**

Five Main Clinical Areas for further development across the consortium in Business Plan 2009/10. These will use principles of invest to save, providing care closer to home, using robust, clinically sound care pathways. Redesigning services to utilise resources more efficiently, these are all contributing to the achievement of ABH 2.

### **1. Gynaecology**

Enhanced level of diagnostic assessment & treatment in primary care – pipelle. Low cost procedure can be carried out in community setting, closer to home. Financially viable, saving the cost of outpatient appointment. Menorrhagia pathway redesign – to discriminate between potential uterine cancer and heavy bleeding.

### **2. Cardiology (Heart Disease – ABH2)**

Further enhancement to service already developed by Dr O’Connell. Use of 24hr tapes and cardiac memos provided from one base within the consortium area using expertise available in current service. Invest to save.

### **3. Diabetes (ABH2)**

The consortium favours a model similar to that developed by Central. This service is being piloted and provides setting up of community clinics. The West Plan to be enhanced by an advice service developed by a GPsl.

### **4. ENT**

Enhanced service in the community, GPsl service.

### **5. Alcohol Service (Public Health and ABH2)**

West going to take the lead city wide as agreed at the confederation.

The Consortium has identified other clinical areas for development that will be included in future year plans.

## **10. 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)*

### **GP Referral Management Action Plans - Appendix 2**

The referral action plan for 2008/09 was agreed and implemented by west practices in October 2008. Its outcomes will be shown in the final quarter of 2008/09. Numerous audits have taken place by consortium practices on their own referral patterns over the last couple of years which has resulted in the development of the referral management action plan.

All practices are now engaged in Audits on ‘Other Referrals’. The results of which are to be analysed in depth. The consortium intends to closely look at the ‘Other’ activity generated by non practice means. The outcome of the audits will direct the consortium to liaise with the areas of most concern. This could result in further negotiation with the contracting department of the PCT or the redesign of care pathways to alleviate demand through better patient management.

With the introduction of the new Referral Information System, the consortium is intending to use this more accurate data to assist in assessing the future trajectory.

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

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

#### **Unscheduled Care**

Work has commenced in 2008/09 to identify frequent attenders to A&E. The work started by the initiative needs to be built on to challenge these patients use of emergency services and ensure they know the best way to access more appropriate services. The big publicity campaign raising awareness of where and when patients can access services has been started by NHS Sheffield. This should help to alleviate the high demand on A&E services by redirecting patients to more appropriate points of access.

Non Elective care is the single most pressing problem to the consortium in terms of managing the budget since much of this work is initiated by patient request and is therefore not manageable directly. Most practices seek to manage demand on a daily basis in ways which are diverse; however the use of telephone triage to handle urgent calls is an increasingly common manoeuvre. A telephone triage system was introduced by one practice 2 years ago but the effect of this on Non Elective workload has not been measured. The consortium will, in conjunction with the PCT, make an analysis of the non elective activity attributable to the practice to ascertain whether the use of a telephone triage system to manage in-hours demand has had any impact on non elective care activity. Clearly the outcome of this work will be important in deciding whether there are actions which can be taken by Practices to reduce non elective "out of hours" activity.

The consortium is also taking the lead on the city wide Alcohol Service redesign. This should reduce attendances to A&E, admissions to secondary care and reduce waiting times. At the same time as improving access for patients, improving the patient experience and saving lives.

#### **Non Practice Initiated Episodes of Care**

The continual upward trend in referrals into secondary care is of great concern to the consortium. Wherever possible the referrals generated within primary care are scrutinised by each practice in a variety of ways, however referrals from other agencies are not subject to scrutiny or validation. The relative rise in "other" referrals of this type is proportionately greater than the rise in GP referrals. For this reason the Consortium has decided to ask practices to audit the referrals coded as "other" for their clinical appropriateness and origin. All practices will audit the Gynaecology referrals

made by others and two clinical categories of their own choosing. This work will help inform an understanding of why these “other” referrals are increasing at a higher rate and provide data to present to the Acute Trust and reduce the referral rate.

#### **12. Prescribing Action Plan for 2008/09 (WCC competencies.....)**

*The consortium needs to develop a robust prescribing action plan, with clear milestones and performance measures to demonstrate effectiveness*  
*Prescribing element of the plan*

The Consortium remains committed to achieving balance on its prescribing budget and will continue to work closely with the MMT to improve prescribing where areas of concern are identified.

The Consortium practices are all currently engaged with the medicines management team and it is intended that this should continue. The Executive receive regular reports from the MMT and representatives from the MMT attend the Executive meetings at appropriate times.

In 2008-09 the consortium accepted the recommendations of the MMT in respect of action which could be taken by prescribers to reduce spend overall. Ten of the twelve consortium practices were showing opportunities to reduce the cost of prescribing by taking actions to amend the medications prescribed in a number of clinical areas. The executive recommended these actions should be taken by practices and the council endorsed this position.

In 2009-10 it is proposed that work will continue in these practices to change the prescribing patterns as advised to recover the £169K approx which is available from this source. We expect that the MMT will continue to monitor this element of the prescribing budget and advise us if the trajectory of savings falls short of reaching the intended reductions before the year end.

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

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

##### **APPENDIX 3**

The West plan for 2009/10 includes the activation of the Public and Patient Engagement policy agreed in the latter part of 2008. This includes the marketing of the consortium and its aims and objectives. The first meeting of the Patient group will be during the first quarter of 2009/20. It has been agreed by the constituent practices that clinical areas for development will include the engagement of appropriate patients identified by the practices.

A Website is currently being developed which will have access for the public. This should be live by the beginning of April.

#### **14. 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*

These objectives are numbered according to the Question area in the plan.

- 4 Continue to strengthen the Consortium through robust Organisational development plans. Supporting Practices in delivery of all PBC initiatives, engaging with clinicians and managers, planning training and educational events, engage with confederation and all stakeholder groups
5. Engage with Public Health initiatives
- 6 Financial Management
  - Aim for financial balance of the PBC budget through monitoring and service redesign.
  - Monitor the quality of care being provided, utilising the evidence to develop improvements to the patient experience
  - Maintain internal budget
  - Check data provided for High Cost patient episodes
- 7 Evaluate ongoing service redesigns and impact on services
- 8 Deliver timetable for Business Case and Service Redesign in the five clinical areas identified.
- 9 Continue to monitor referral performance data and implement action plans as agreed
- 10 Non Practice Initiated Episodes of Care: Examine outcome of audit on 'Other Referral data' to understand increased rate of referrals in this area.
- 11 Continue to work with medicines management to achieve cost effective prescribing and aim for maximum incentive payment.
12. Launch website/Engage Public through participation schemes.

**15. Measuring Progress of the plan (WCC competencies.....)**

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

<b>What</b>	<b>When</b>
<b>Submission of Business Cases</b>	<b>Quarterly</b>
ECG – 24 hr enhanced Service	Quarter one
Gynaecology	Quarter two
Diabetes Advice	Quarter three
ENT	Quarter four

**Sheffield West PBC LLP  
GP REFERRALS TO SECONDARY CARE**

## **RECOMMENDATIONS TO PRACTICES**

- **Use ten top tips**

Circulated to all practices by NHS Sheffield

- **Review referrals at practice meetings**

At weekly meetings discuss that weeks referrals, this list could be prepared by the assistant manager/secretary. GPs will soon have an idea of average levels of activity and whether this has fluctuated. This will also help to identify non GP generated referrals. Comparison of practice and consortium referral figures on a monthly basis.

Discuss difficult cases clinically with other partners if complex, to consider other ways of managing things. Dialogue to be sensitive and productive ie – the referrer briefly setting the scene and describing the case. There could be other ways of looking at things and this could be a valuable clinical learning opportunity in itself as well as reducing referral times.

- **Review PBC data for activity and cost performance**

Make this a regular agenda item

- **Ensure all pathways are known to practice staff and easily accessible**

Produce a referral assistance memo for reference for each GP, including available services and alternatives to secondary care.

- **Utilise special knowledge in practice and refer to partners for assistance**

Look at range of specialist knowledge and interest among the doctors in the practice. Set up a more formal arrangement of sharing that knowledge over appropriateness of referrals. Consider In house services provided.

- **Countersign Locum, Registrar and F2 referrals**

Locum may not know patient as well as other partners or indeed the referral pathway adopted by the practice.

- **Consider obtaining specialist advice**

Advice available through Chose and Book for Renal cases.

- **Referral Audit**

Act upon results of practice based audit which looks at referrals and outcomes. This may influence future patterns of referral. Not all practices will have the same results but shared information and suggestions can be useful.

- **Other ideas/suggestions**

Practice Referral Tsar – eg rotate a clinical lead on referrals management

Sign up to additional Enhanced Services/incentive schemes to reduce referrals

Identify specialist interests within practices and therefore consortia which can be further developed to introduce primary care services.

Manage Hypothyroidism in practice

## **GP REFERRALS TO SECONDARY CARE – ACTIONS FOR PRACTICES**

Practices to agree with all GPs of the best way forward for them.  
All GPs to have a copy of consortium plan, ten top tips, referral pathways.

### **Practice meetings**

Develop culture of looking at PBC data – activity and expenditure  
Include Agenda item of reviewing number of practice Referrals  
Discuss difficult cases, use knowledge within practice.

### **Referral Pathways**

Use Directory of Referral Pathways for local services. Consider what works best for each practice. Suggestion of Desk Top access.  
Paper information in each consulting room, detailing how and where to send patients.  
Agree standardised practice referral pattern

### **Administration**

Maintain tally charts or whatever method best fits the practice to enable practice monitored numbers of referrals. eg secretary/administrator.

### **Locum,**

Ensure locum knows of practice procedure for referrals and care pathways.

### **Audits**

Useful tool for identifying areas where changes can be made

### **Responsibility**

Decide who in the practice will take lead with referrals, whether to alternate/rotate between clinicians or to have one dedicated lead.

## **IDENTIFIED PATHWAYS**

Pears  
Ankle and Foot  
Exercise ECG  
Scash – Vasectomies  
Orthopaedic ISTC – Barlborough  
MSKCAS  
Community Podiatry

**Sheffield West PBC - Patient Participation**

**1. Awareness**

Posters to be displayed in each practice explaining what the consortium is and what its aims and objectives are. Content to be agreed. Design to be coordinated at UHS.

**2. Involvement**

Patients to be invited to engage with a consultation group. This invitation will be displayed on the poster asking for interested patients to give their details to the practice manager who will pass this information to Liz.

**3. Meetings**

The intention is to meet quarterly. There are a couple of forums across our consortium. The Practice forum established at Fairlawns to be used as a base for the PBC Forum initially. This group is geographically central to our consortium.

**4. Surveys**

Business plans and service redesigns need consultation with stakeholder groups. Surveys will be developed centrally and then distributed to target group. The target groups will be a maximum of five patients from each practice, depending on the clinical area. The survey will be sent to the practice to pass onto the identified patient so that the response will be anonymous at PBC level. This will provide a cross section of patients from the consortium area which will ensure that the results are a true representation of the consortium population.

**5. Website**

There will be an area for comments and communication from patients built into the website. Patients will also be directed from practice websites to the PBC site.

**6. City wide consultation**

Where appropriate, the forum and PBC group will engage with the Links project and other community patient forums for mutual benefit.

**7. Working with NHS Sheffield**

With our service redesign projects we will share our intention with regard to patient engagement and will expect full support to ensure successful delivery.

08/09

Business Cases/Service redesign projects 08/09						
Service Description and ABH(2) linkage	Service Objective	Scoping commencement	Submission	Start date	Clinical	KPIs Expected outcomes
<b>PEARS - Optometry Service</b> ABH(2) linkage Local initiative 12 Planned Care 21 Optometry Service	More eye treatments and diagnostic tests in the opticians	01/04/2008		Pilot Sept 08	Dr A Mackie	Reduce referrals to secondary care Cost per referral saved Closer to home Improve patient experience
<b>Urology Pathway</b> ABH (2) linkage Local priority 8 reducing inequalities in life expectancy 14 Cancer 15 Unscheduled Care	Improve care of the patients with urinary symptoms Lower urinary Tract symptoms (LUTS) Haematuria - visible and non visible Close working with RHH urology dept	01/04/2008		TBC	Dr J Poyser	Reduce referrals to secondary care Care closer to patient Keep patients out of hospital Upskill GPs with training.
<b>Maximal Stress Test ECG Service</b> ABH (2) linkage Local priority 1 Heart disease Local initiative 12 planned care	Assist GPs diagnose angina and heart problems with community setting Cardiologists interpreting results	01/04/2008		1 <sup>st</sup> April 2009	Dr J O'Connell	Reduce referrals to secondary care Central Service for West practices Continuation of existing service Value for money
<b>Qute Data Validation Pilot</b>	Data query Tool, validating data between primary and secondary care. 18 month pilot in UHS	01/01/2009		1 <sup>st</sup> April 2009	Dr M Jakubovic	Improve confidence in data accuracy Enable challenge to error reporting Clinical advantages

Business Cases/Service redesign projects 09/10						
Service Description and ABH(2) linkage	Service Objective	Scoping commencement	Submission	Start date	Clinical	KPIs Expected outcomes
<b>Gynaecology</b> ABH (2) linkage Local priority 8 reducing inequalities in the expectancy Local initiatives 12 Planned Care 14 Cancer	Further existing treatment pathway of menorrhagia. Pipelle Biopsy ABH2, closer to patient value for money	01/04/2009	Quarter 2	Quarter 4	Dr F Hilditch	Reduce referrals to secondary care Cost per referral saved Out patient procedure cost reduce Upskill Gps/Practice Nurses Patient Satisfaction
<b>Pears</b> ABH(2) linkage Local initiative 12 Planned Care 21 Optometry Service	Citywide roll out	01/06/2009	Quarter 2	Quarter 1	Dr A Mackie	Reduce referrals to secondary care
<b>Cardiology</b> ABH (2) linkage Local priority 1 Heart disease Local initiative 12 planned care	Introduce 24hr ECG tape to community service with in house interpretation. Invest to save ABH2 priorities	01/04/2009	Quarter 1	Quarter 2	Dr J O'Connell	Reduce Referrals to secondary care Care closer to patient Central service for West Practices 24 Hour tapes at specialist centre
<b>Diabetes</b> ABH(2) linkages Local priority 5 diabetes Local initiatives 12 Planned Care	Specialist Nurse And advise service ABH2	01/04/2009	Quarter 3	Quarter 4	Dr J Stephenson	Reduce referrals to secondary care Upskill workforce In consortium advice service Mirror consultant service in other areas of the city
<b>ENT</b> ABH(2) linkages Local initiative 12 Planned Care	Develop GPSI Service for delivering in community setting	01/04/2009	Quarter 4	Quarter 2 10/11	Dr A Bradley	Care closer to home Reduce cost Reduce referral numbers Utilise GP skills
<b>CITY WIDE Alcohol Abuse</b> ABH(2) linkages Local priority 6 drugs and alcohol	Service Redesign	01/04/2009	Year long	TBC	Dr P Harvey	Improve access Reduce waiting times Save lives

09/10

Business Cases/Service redesign projects 09/10						
Service Description and ABH(2) linkage	Service Objective	Scoping commencement	Submission	Start date	Clinical	KPIs Expected outcomes
8 reducing inequalities in life expectancy Local initiatives 15 Unscheduled Care						
<b>Weight Management</b> ABH(2) linkages Local priorities 5 diabetes 7 Children and Young people (Clinical obesity) 8 reducing inequalities in life expectancy Local initiatives 12 planned care	01/04/2008	Problems with the business case as no one knows where to position it Not yet in format for submission on advice of NHS Sheffield – on hold until decision reached				
<b>Public Heath</b>	01/04/2009	Data from Yorkshire Public Health Observatory and report produced by NHS officer to be used by Practices in development of their practice plan				