

REPORT TO THE PBC COMMITTEE TO BE HELD ON: 9th June 2010

Enclosure:	10				
Subject:	Seisdon Peninsula PBC 2010/11 plan				
Lead Director:	Mark Powell				
Lead Officer:	Liz McCourt				
Recommendation:	For Approval	x	For Discussion		For Information

PURPOSE OF THE REPORT:

The plan sets out Seisdon's work plan for 2010-11 that is aligned to meet the QIPP agenda and deliver benefits to their local population. The work plan has been informed by a patient and public health priorities questionnaire.

KEY POINTS:

Seisdon Peninsula PBC work areas include case management, risk stratification, medicines management, and implementation of public health 5 year plan, primary care mental health and data validation.

CORPORATE OBJECTIVES:

CP12, CP9 and CP5

RESPONSIBLE COMMITTEE:

NAME:

APPROVED at cmte: YES/NO

Date of Cmte:

IMPLICATIONS:

Legal and/or Risk	None
WCC	1,2,3,4,5,7,8,9 and 11
Patient Safety	All commissioned services/changes will be compliant with CQC and best practice.
Patient Engagement	Seisdon health priorities questionnaire highlighted top 4 areas which are featured in the PBC 10/11 work plan. In addition Seisdon district patient group are involved in PBC work plan areas.
Financial	Payment of part 1 10/11 PBC LES
Sustainability	None
PBC	Locality work plan approved by consortia in March 2010.
Workforce / Training	Chronic disease management and case management for provider arm staff

RECOMMENDATIONS / ACTION REQUIRED:

The committee are asked to approve this PBC plan.

SEISDON PENINSULA LOCALITY COMMISSIONING GROUP

Practice Based Commissioning Plan 2010/11



1. Introduction

Practice based commissioning (PBC) is about engaging practices and other primary care professionals in the commissioning of services. Through PBC, front line clinicians are being provided with the resources and support to become more involved in commissioning decisions.

The Seisdon Peninsula Locality Commissioning Group (SPLCG) is made up of 8 General Practices. There are two acute hospitals, Royal Wolverhampton hospital and Dudley Group of Hospitals, where South Staffordshire PCT is not the host PCT. 7 of the 8 of practices come under South Staffordshire District Council. The Claverley practice is served by Shropshire Council. The 8 practices have a registered population of 46,495. SPLCG is lead by 2 key roles:

Clinical lead	Dr Dukes
PBC Chair	Sue Brookes

The group meets on a monthly basis with a nominated GP and practice manager represented from each of the 8 practices. These are:

- Bilbrook Medical Centre
- Dale Medical Practice, Wombourne
- Dr Hall and Partners, Claverley
- Gravel Hill Surgery, Wombourne
- Lakeside Surgery, Perton
- Moss Grove Kinver
- Russell House Surgery, Codsall
- Tamar Surgery, Perton

2. Demographics

Practice	Grand Total	0-9	10-19	20-39	40-49	50-64	65-84	85+
BILBROOK	7,578	821	942	1,722	1,184	1,476	1,205	228
CLAVERLEY	4,469	356	548	768	718	977	975	127
DALE MEDICAL CENTRE	6,402	577	763	1,279	1,044	1,212	1,347	180
GRAVEL HILL	7,113	667	811	1,412	1,099	1,522	1,420	182
LAKESIDE	6,252	589	778	1,613	974	1,515	679	104
MOSS GROVE SURGERY KINVER	4,808	422	535	837	735	1,052	1,103	124
RUSSELL HOUSE	6,822	549	645	1,367	993	1,478	1,576	214
TAMAR	3,051	321	420	793	550	638	269	60
Grand Total	46,495	4,302	5,442	9,791	7,297	9,870	8,574	1,219

South Staffordshire council area is made up of small settlements and parishes each with its own identity. To maintain their identity the council in partnership with its LSP partners has decided to adopt a locality working approach. The district council area has been divided into 5 locality areas which will enable Local Strategic Partnership (LSP) partners to address the needs of each individual locality. SPLCG covers localities 4 & 5.

3. QIPP - Improving quality and productivity through innovation

Health and social care are not immune to the national economic climate and face significant financial challenges. QIPP is a national initiative that aims to focus efforts on key priorities to deliver the financial savings by ensuring we get the best healthcare possible and achieve value for money for each pound spent.

QIPP initiatives by theme:

1. Prevent disease and ill health
2. Reduce demand on unscheduled secondary care through improved management of long term conditions
3. Reduce demand on unscheduled secondary care by providing alternatives to A&E
4. Reduce demand on unscheduled secondary care by providing alternative pathways for children in health care
5. Reduce demand on scheduled secondary care by managing patients in primary care where appropriate and ensuring best practice is followed.
6. Reduce demand on secondary care beds by ensuring patients do not stay in hospital unnecessarily (include allowing patients to die at home)
7. Reduce demand on secondary care mental health care
8. Ensuring existing resources are used most productively

Seisdon Peninsula PBC has aligned their 2010/11 work plan to the QIPP agenda. This will set out the commissioning objectives of the PBC group.

4. Seisdon Peninsula Locality Commissioning Group - priorities 2010/11

PBC work areas	
1. QIPP: Prevent disease and ill health	Timescales
<u>1.1 Public health 5 year plan</u>	
Work with the South Staffordshire Local Strategic partnership, district council and other partners to implement locally delivered schemes outlined in the Public Health 5 year plan. Measure of contribution: <ul style="list-style-type: none"> • Uptake in number of people for physical activity, childhood obesity and adult weight management. 	
2. QIPP: Reduce demand on unscheduled secondary care through improved management of long term conditions	
<u>2.1 Care closer to home team (CCTHT)</u>	
Last year the implementation of this service was delayed due to Provider Arm reorganisation. Whilst work is still ongoing, there are clear messages for a desire to have a local service based upon a Neighbourhood model. Acute contracts have significantly over performed in 2009/10. To address this, the PCT and StHA are promoting a proactive case management approach with a	

focus on hospital avoidance and reduction in excess bed days.

Because of the prevalence of long term conditions in the over 65's, the Care Closer to Home team will mostly work with this age group although they will work with any one over 18 who is deemed suitable for case management. The team aims to provide care closer to home to people in their own homes and residential/nursing homes. It is envisaged that the team will have several components to it and this work plan reflects the development of these components.

1. Scoping the development of the role of a GPwSI/medical consultant/physician in the care of the elderly to work as part of the Care Closer to Home team. This role will deal with all patients regardless of where they live ie include residential/nursing care homes.
2. Use risk stratification to identify patients that will benefit from proactive case management and development of a bespoke care plan.
3. Include proactive case management through developing additional chronic disease management skills/staff.
4. Single point of access for team to provide referrers one referral route. This will be triaged daily by a trained professional who is able to make a holistic assessment.
5. Supported discharge - ensuring patients discharge is planned early and all elements of their discharge plan is organised. (Refer to QIPP 4.1)
6. Develop appropriate workforce to include generic workers who can undertake previously traditional social care and health roles.
7. Use of Bilbrook House to provide both health and social activities. Further work will be carried out with the public to involve them in designing and contributing towards health promotion activities that support self care.

Measure of contribution:

- Number of community matrons recruited
- Reduction in revolving door admissions
- Number of people identified using risk stratification
- Number of care plans produced

Milestones:

- | | |
|---|------------------|
| • Paper taken to Executive committee for approval | May 10 |
| • Project group established | June 10 |
| • Provider arm approved vacancies | June 10 |
| • Project implementation plan and base data collection process agreed | June 10 |
| Recruitment process (assuming successful first time) | July -
Oct 10 |
| • Pathways and promotion of service to practices and other stakeholders | Oct 10 |
| • Commencement of staff | Nov 10 |
| • Risk stratification for Kinver | Nov 10 |
| • Kinver assessments | Dec 10 |
| • Risk stratification for Claverley/Lakeside/Tamar | Dec 10 |
| • Claverley/Lakeside/Tamar assessments | Jan 11 |
| • Risk stratification for Russell House | Jan 11 |
| • Russell House assessments | Feb 11 |
| • Risk stratification for Bilbrook | Feb 11 |
| • Bilbrook assessments | March 11 |

Timescales will be reviewed and revised as appropriate on a monthly basis.	
3. QIPP: Reduce demand on scheduled secondary care by managing patients in primary care where appropriate	
<u>3.1 Community dermatology service</u>	
Scope potential for community dermatology service as an alternative to secondary care.	
Measure of contribution: <ul style="list-style-type: none"> Evaluation of current pathways and practice usage of the service. Milestones: <ul style="list-style-type: none"> Scope out current patient flows to Dudley and Wolverhampton Explore with Black county PCTs potential community schemes/options Establish accreditation process for GPs Scope out best practice and feasibility of providing in Seisdon area 	June/July July June August
<u>3.2 Implementation of diabetes strategy</u>	
In partnership with Royal Wolverhampton hospital, Provider Arm and PBC to implement diabetes strategy that links community diabetes nurse specialist to secondary care.	
<u>3.2 Community Ophthalmology service</u>	
Continue working with Local Optometric Committee to develop ophthalmology service in the community to reduce the reliance on hospital activity and inappropriate referrals. Options being considered are referral refinement and glaucoma follow ups.	
Measure of contribution: <ul style="list-style-type: none"> Clinical lead working with Wolverhampton consultants, the LOC and local optometrists. Milestones: <ul style="list-style-type: none"> Identification through the LOC of local optometrists to work on project. Identified optometrists undertaking training to carry out a referral refinement scheme. 	
4. QIPP: Reduce demand on secondary care beds by ensuring patients do not stay in hospital unnecessarily	
<u>4.1 Supported hospital discharge</u>	
In partnership with the Provider Arm ensure the discharge liaison element of the Intermediate Care team works proactively with both Wolverhampton and Dudley hospitals.	
Measure of contribution: <ul style="list-style-type: none"> Excess bed days controlled/reduced. Milestones: <ul style="list-style-type: none"> Scope out current discharge liaison function at both hospitals and 	

<p>identify reasons for blockages and potential solutions.</p> <ul style="list-style-type: none"> • Proposal on way forward to Provider Arm/Execs. 	<p>July 10 Sept 10</p>
<p>5. QIPP: Reduce demand on secondary care mental health care</p> <p style="text-align: center;"><u>5.1 Mental Health</u></p>	
<p style="text-align: center;">Primary care mental health service</p> <p>Continue working with South Staffordshire & Shropshire Healthcare Foundation Trust to deliver a local mental health service within the Seisdon district. This model is based on a social inclusion model and builds on the primary care mental health provision already in place.</p> <p>This service will deliver the "stepped care approach" in line with NICE guidelines.</p> <p style="text-align: center;">Appropriate use of Mental Health Contracts</p> <p>Each practice will ensure appropriate use of mental health contracts. Note that SSSFT is a block contract and other Provider PCTs are cost and volume and traditionally used for cross border patients.</p> <p>Measure of contribution:</p> <ul style="list-style-type: none"> • Reduction in secondary care mental health outpatients and occupied bed days. <p>Milestones:</p> <ul style="list-style-type: none"> • Further expansion and development of primary care mental health service 	<p>April - Sept 10</p>
<p>6. QIPP: Ensuring existing resources are used most productively</p> <p><u>6.1 Data validation and audit</u></p>	
<ol style="list-style-type: none"> 1. Each practice will carry out a monthly validation exercise and audit (if appropriate) of non elective activity. 2. Each practice will carry out a monthly validation exercise on high cost patients. 3. Each practice will adhere to PCT policies of limited therapeutic procedures and aesthetic procedures. 4. Practices will carry out audits on outlier areas as informed by the Knowledge Management Unit. <p><u>6.2 Medicines management</u></p> <p>Commitment to working on PCT medicines management targets in particular validation and reduction in use of specials.</p> <p>Measure of contribution:</p> <ul style="list-style-type: none"> • Production of practice audits and action plans in respect of medicines management. <p>Milestones:</p> <ul style="list-style-type: none"> • Practices to start validation when data is available. 	
<p>7. Other PBC work plan areas</p>	
<p><u>7.1 Transport issues</u></p>	

<p>South Staffordshire district council are undertaking a review of transport services and are aware of the problems remote rural areas face. PBC are committed and support joint working with the council to address this issue.</p> <p>Measure of contribution:</p> <ul style="list-style-type: none"> • Representative attending South Staffordshire District council rural transport group meetings • Practices contributing views on transport issues <p>Milestones:</p> <ul style="list-style-type: none"> • Attendance at district council meetings (dates set by council) • Clarification on health criteria for use of patient transport (work undertaken by Public Health in conjunction with PBC). 	<p>July 10</p>
<p><u>7.2 Patient & public consultation</u></p> <p>Undertake patient consultation exercise when considering new developments and identifying gaps in services.</p> <p>Measure of contribution:</p> <ul style="list-style-type: none"> • Meetings held for the Seisdon Peninsula district patient participation group with suitable agenda items focused around work plan. <p>Milestones:</p> <ul style="list-style-type: none"> • Feedback from district (PPG) into service developments and redesigns. 	
<p><u>7.3 Engagement with South Staffordshire Council Locality working</u></p> <p>South Staffordshire district council have adopted a locality working approach. The district is now sub divided into 5 localities. The Seisdon peninsula falls into localities 4 & 5. PBC will ensure a representative links into locality 4 & 5 parish council workshops and will endeavour to work with them on any forthcoming partnership work.</p> <p>Measure of contribution:</p> <ul style="list-style-type: none"> • PBC attendance at Locality 4 & 5 district council events. • Ensure partnership working is included in work areas and developments where appropriate <p>Milestones:</p> <ul style="list-style-type: none"> • Attendance at locality 4 & 5 work shops 	<p>June- Aug 10</p>
<p><u>7.4 2010 and beyond</u></p> <p>Continue working with practices, Provider arm, Social Services, PCT and other partners to scope and develop the proposal outlined in 2010 and beyond, especially around premises.</p> <p>Measure of contribution:</p> <ul style="list-style-type: none"> • Inclusion of Seisdon Peninsula estates requirements in the PCT CIAMS strategy. 	

All PBC LES plan areas are equally weighted