

**REPORT TO THE PRACTICE BASED COMMISSIONING GOVERNANCE
 COMMITTEE
 TO BE HELD ON: 10th JUNE 2009**

Enclosure:					
Subject:	South East Staffs Consortium Annual Report 0809				
Lead Director:	Sue Price				
Lead Officer:	Frances Sutherland				
Recommendation:	For Approval	<input type="checkbox"/>	For Discussion	<input type="checkbox"/>	For Information <input checked="" type="checkbox"/>

PURPOSE OF THE REPORT:

To describe the achievements against the 0809 plan and the related work undertaken by the consortium

KEY POINTS:

The consortium have achieved the plans that were agreed and have achieved other projects. The report describes the structure of the consortium and their future commitment to PBC

IMPLICATIONS:

Legal and/or Risk	
Standards for Better Health	
Financial	
Training	
PBC/Other	Presented by PBC

RECOMMENDATIONS / ACTION REQUIRED:

Note the Annual report

South East Staffs. Consortium

Annual Report 2008-2009

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1. Foreword

The past twelve months have been a busy and challenging time for the consortium. The projects initially outlined in the business plan have developed and evolved. The implementation of the Professional Advice and Support service has gone from strength to strength, after overcoming many hurdles. The service now processes all referrals for the practices, offering choice of providers and appointments for South east Staffs patients. The renewed process is supporting the development of clinical pathways, providing greater information on referral trends, reasons for referrals and current practice.

Care outside of Hospital has focused on strategic development but the coming year will require much greater clinical involvement to ensure work streams are clearly defined and outcomes achieved.

The consortium has changed organisational structure during this year to share the workload and to provide a more cohesive executive. The role of Chair has now been replaced by the role of 'conduit'. This role provides the focus for communication with the consortium. The executive as a whole now provide the leadership and direction. Board meetings are now held quarterly whilst the executive meet fortnightly. This has focused efforts and ensured the clinical expertise is used to its full potential on specific projects driven by PBC.

The change in working relationships is working well and over the next year it is hoped that the role and involvement of practices will increase.

2. The Consortium

2.1 The practices

Twenty two practices are now part of the consortium. Each member practice has a representative on the board of the consortium.

Practice	Area	Representative
Ahmad	Burntwood	Dr M Ahmad
Aldergate	Tamworth	Dr M King
Anchor	Tamworth	Dr E Dabestani
Chasetown	Burntwood	Dr I B Bhatt
Cloisters	Lichfield	Dr G Kaul
Crown	Tamworth	Dr S Benkert
Fulfen	Burntwood	Dr J Ward
Heath view	Tamworth	Dr F Yunas
Hollies	Tamworth	Dr A Parkes
Khare(Stoneydelph)	Tamworth	Dr K Khare
Langton	Lichfield	Rosie Jones
Laurel	Tamworth	Dr M Zachau
Minster	Lichfield	Dr M Causer
Peel	Tamworth	Dr C Jones
Rajput (Stoneydelph)	Tamworth	Dr V Rajput
Riverside	Tamworth	Dr O Iijaola
Salters Meadow	Burntwood	Dr P Gregory
Spires	Lichfield	Dr G Husiman
Springhill	Burntwood	Dr PI Bhatt
Wilnecote	Tamworth	Dr RS Rajput
Yannamani (Stoneydelph)	Tamworth	Dr Yannamani
Fazeley	Tamworth	Dr Yarra

Between April and December board meetings were scheduled monthly. However, a decision was made a Christmas that board meeting would be held quarterly. The AGM for 2007/8 was held on May 8th 2009 and the AGM for 2008/9 was held in 26th March 2009

2.2 The executive structure

Between April 2008 and December 2008, Dr Adrian Parkes was chair of the consortium, taking over from Dr Peter James when he left the area in 2007/8. In addition there were 5 executive members:

- Dr Peter Gregory (Salters Meadow)
- Dr Vjie Rajput (Stoneydelph)
- Dr Chris Jones (Peel Medical Practice)
- Dr Gerbo Huisman (Spires)
- Rosie Jones (Langton)

When Dr Parkes resigned as chair in December it was decided that the consortium would no longer have an official chair person. Instead, Dr Gerbo Huisman agreed to become a 'conduit' between the PCT and the consortium, attending regular meetings with the Chief Executive. Dr Parkes became an executive member but continued to chair the twice monthly meeting of the executive and quarterly consortium board meetings. Each executive member took a lead role for specific projects.

Executive member	Key project areas
Dr Gregory	Nursing Homes
	PASS clinical lead
Dr Parkes	MSK
	ENT
	Mental health (including CBT LES)
Dr Vije Rajput	Prescribing
Gerbo Huisman	Drug and alcohol services
	Choosing Health (including development of lifestyle service)
	A&E audit
Rosie Jones	Ambulatory care sensitive conditions
	COPD, pulmonary rehabilitation
Dr Chris Jones	Discharge facilitator

2.3 Budget Management

The group continued to take a corporate approach to budgetary management believing that the financial issues are best tackled as a health economy rather than at individual practice level. There has been a deliberate decision to compile budget reports to a

consortium level to avoid fragmentation which might be caused by individual fortuitous under spends at a practice level.

2.4 Support from the PCT

The two PBC leads from South East Staffordshire support the consortium, one leading on unplanned care, the other on planned care. In addition the locality project team has increased to directly support consortium led projects. Support from the district public health leads has reduced through the year as their time has been spent elsewhere in the PCT. It is hope this will be addressed during 2009/10 with a change to the role and appointment of a new lead.

The locality team also provide support on contract monitoring, finance and PPI. The appointment of a new information analyst and additional CBSA post, will increase and improve the information available to the consortium.

2.5 The Business Plan 2008/9

Unscheduled care	
Care Outside of Hospital	Partnership approach with local authority to admission avoidance, early discharge and support for patients after discharge
Working with ambulance service to prevent hospital admissions	Development of an Enhanced service to provide an on call GP in hours
Identification of high-risk patients	Consideration of an enhanced service for practices to identify patients who are at high risk of admission to hospital
Implementation of Liverpool care pathway for the dying	Working with practices and care homes
Education and intervention with A & E frequent flyers	Audit of A & E Data with practices contacting patients who attend on a regular basis to support them
Care for vulnerable older people in nursing and care homes	Revision of the Enhanced service to focus on admission avoidance
Planned Care	
Clinical Advice and Support Service	Further development of triage for all secondary care referrals, including consultant to consultant
Further development of clinical pathways	To support the triage. Specialities will include ophthalmology, musculo skeletal and gynaecology.
Launch of ENT triage	Commences April 08 with one practice
Insulin instigation	Within primary care
Choosing Health	
Obesity –Child and adult	Implementation of a strategy for children and adults through Choosing health monies

Health Trainers	Development and implementation of a relevant model of service provision for both localities
Sexual health services	Review service provision across level 1-3
CBT	Review service provision and alterations to present service
Alcohol services	Survey of GPs to understand what services are required within primary care to feed into 0809 tender process
Implanon/IUCD/Mirena	Review of gynaecology/sexual health pathways and development of services for menorrhagia in primary care
Smoking	Implementation of an enhanced service and performance monitoring of the core service

Prescribing	
Stoma products	Aim to achieve national average rate and achieve a financial saving of £46,842 . Prescribing costs for stoma products are rising more than other medicines and the increases need to be slowed
Wound care	The consortium have lower than national average prescribing costs but it is felt that there are some savings to be made. The consortium will monitor prescribing against formulary within the provider arm and look at the possibility of bulk buying dressings.
Enteral/sip feeds	Whilst the consortium has lower than national average costs for prescribing for enteral/sip feeds prescribing costs are increasing at approximately 15% per year and this needs to be actively monitored
Analgesia incl NSAID.	There may be some cost savings within analgesic prescribing. There are issues regarding patient safety particularly regarding the prescribing of NSAIDS
Data validation	
Review data as deemed necessary to support the commissioning process	Audits as required
Review Continuing Care patient database	Review of patients to ensure they are registered with correct practice

Community Hospitals	
Review the use of hospitals	To ensure value for money and appropriateness of services provided.
Performance management of	Regular meetings and performance indicators set

contract	
Clinical alignment with QHB	To ensure pathway development governance issues with one provider

Practice budgets	
Review of individual practice budgets	Work with practices to consider referral rates and consider the public health practice profiles to tackle any key issues

3. Achievements against plan

3.1 Unscheduled care

Dr Parkes has continued to sit on the '**care outside hospital**' board and provide clinical input to the project. Most work to date has concentrated on higher level integration with social services. More local work streams will come on line during 2009/10.

The pilot project undertaken in 0708 had indicated that a GP working with the ambulance crew could actually help to prevent admissions. However, it was also acknowledged that development of this specific pathway particular to South East Staffs would be difficult to implement for an organisation that covers such a wide geographical area. However, it was recognised that further work with the **ambulance service** could be beneficial and will taken forward through Care Outside Hospital.

The consortium then focused on reviewing A&E data. All practices were given information on their patients who attended A&E more than twice over a 6 month period. They were asked to suggest whether anything could be done to support these patients and avoid further visits in the future. This **audit** indicated that 25% of records had incomplete or missing data. 10% could have been avoided if services were in place or if there was better education for patients. 16% of patients had cancer or a Long term condition. From this audit an education leaflet was devised and given out at practices to raise awareness of how to access services, it was also hoped it would help to alleviate pressures over winter.

The consortium also appointed a discharge facilitator to look at bottlenecks within Good Hope Hospital e.g. discharges from wards, flow through A&E. This project should have commenced in January 2009 but with winter pressures at the hospital the nurse was redirected to ensuring patients were discharged from A&E as soon as possible. The project ran from January 2009 and data indicated the following

- 45 out of 66 patients were signposted to other services
- Five were referred to social care
- Nine patients were referred to other community services
- Seven admissions to the ward were avoided.

The **Nursing Home Enhanced Service** was reissued to proactively support admission avoidance and an increase in quality of care of these vulnerable older people. From the audit data it appears that most admissions were unavoidable but issues regarding continuity of care out of hours and Care home policies for calling 999 had an impact on admissions. As part of this project a local GP has undertaken work in a specific home to consider **Advanced Care planning**, the medical model of care in homes and benchmarking of admission data for homes. The executive are reviewing the impact of the recommendations.

Practices within the consortium have undertaken audits of patients who have been admitted for **Ambulatory Care Sensitive Conditions**. This indicated that a high level of patients are admitted in the terminal stages of COPD and Heart failure; children are admitted repeatedly for febrile convulsions; it also reinforced the need for pulmonary rehab to be available locally. In addition the audit highlighted the poor data quality regarding this cohort of patients, which has lead to a programme of work for practices to check data next year.

All projects described above helped to contribute to identification of high risk patients and highlight services which could help to manage them in primary care.

3.2 Planned care

The original plan stated the intention to development a **clinical advice and support service**. However during the year this development became known as the 'professional advice and support service' (PASS). One of the initial aims was to refine the administrative process to channel all referrals through a central point. Business processes were refined, an administrative PASS team were appointed and Peter Gregory became the clinical lead (within his remit as executive team member). This initial aim has been achieved and all practice are now referring through the PASS. Feedback to date has been positive, but further work will take place with the practices over the next few months to further improve the service.

Other clinical projects ran parallel to this change in administrative process though **speciality based reviews** with the aim of defining clinical pathways then considering the potential benefits of clinical triage and commissioning of intermediate level services. A pilot was carried out during July and August where a clinician reviewed all referrals for **ENT** prior to referral on to secondary care. The pilot was a success; some referrals were not referred on until further treatment was provided in primary care, the urgency of some referrals were escalated and other referrals were forwarded for diagnostics. However, it was decided that rather than introducing clinical triage on a long term basis it would be more efficient to refine a small number of pathways and reinforce them with GPs to improve the appropriateness of referral through improved education. These pathways have been revised with local consultants and will be launched imminently, then referrals will be audited later in the year. It was also decided that there would not be any benefit in commissioning intermediate care services, given the good standard of service which is already provided locally in the community hospitals, with one stop clinics and short waiting times.

The lead GP also worked with local **gynaecology** consultants to define some clinical pathways. This work will be picked up later in 2009/10.

Ophthalmology referrals continue to be triaged by optometrists and the potential for commissioning services in the community to avoid outpatient appointments will be considered in the near future.

The consortium have been working very closely with physiotherapy, orthopaedic consultant and physicians to commission a new **MSK** service. Notice was given on the current service, a service specification with clinical pathways is being developed and pilots will begin shortly, it is hoped that a new MSK service will be fully developed and mainstreamed by Christmas.

The **insulin instigation LES** was developed and began in September and 7 practices are now signed up.

3.3 Choosing Health

The consortium have played an active role in developing the concept of the 'lifestyle service'. This service was commissioned from the provider arm and it is hoped that it will begin to deliver very soon. The service incorporates the '**health trainer**' role, **smoking cessation services**, brief interventions for people with alcohol addiction and mental health promotion.

The **implanon/IUCD/mirena** pathways have been looked at through the development of the PASS. An audit of the current level of service in practices and the training undertaken was undertaken. This will be used to enhance commissioning of primary care level services next year.

The development of **alcohol services** was put on hold at a consortium level whilst the central function reviewed commissioning of services across the whole PCT. The PCT lead has involved the consortium representative on progress and discussions are about to begin to establish the future of these services in the district.

The local **CBT LES** was revised to provide more appropriate funding based on practice size and also to encourage implementation of the stepped care model at a very local level. There are now 23 practices involved and this is deemed a success by practices providing much needed lower level mental health services. Over 500 patients have been seen within this scheme with over 2500 hours of counselling offered.

Work on the local strategy for **children's obesity** has begun and a new service will be commissioned in 2009/10. The **adult weight management services** will be incorporated into the lifestyle service.

3.4 Prescribing

The **First Dressing Initiative** was launched at the end of March 2009. This service enables district nurses to have a stock of dressings available to use with patients to on a trial basis thereby saving prescribing and also nurse time

The specialist stoma nurse has been reviewing patients who have problems with their **stoma products** and where costs are high. She has been available for all practices to refer to.

A formulary for **Sip/enteral feeds** is under development with the Dietetics lead in the provider arm

3.5 Data validation

As part of data validation the consortium practices have looked at emergency admissions. This indicated that the highest cost pathway for the district was Fractured Neck of Femur. The consortium have developed a pathway to ensure patients can have therapy support at home and therefore be discharged home early. This will ensure patients are more likely to remain independent. This pathway will be operationalised in August 2009.

4. Finances

In 2009/10 the consortium started the financial year with a cost improvement target of £2.8 Million with a final figures achieved of £2.5 Million overspend. The move to fair share allocation over the next two years has a positive impact on South East Staffs.

6 The Future

The consortium has considered plans for 2009/10 and these have been approved by the PCT. Much of the work is building on the work undertaken in 2008/09.

The vision for patients within this area is to provide cost effective health care, close to home supported by well-qualified staff. Two of the main areas for development in the coming year include the development of the Professional Advice and support Service (PASS) and Care outside of Hospital.

Our community hospitals are an asset to the local community and the consortium want to ensure that they are used effectively and ensure that they provide excellent value for money for the local community.

All these plans include undertaking more work in local practices, developing intermediate level services and working more closely with acute hospital providers, community providers, ambulance services and social care.

South East Staffs. Consortium will continue in 2009/10 to work with local communities to improve the local health services so that they are easily accessible, value for money and high quality.