

## REPORT TO THE PBC GOVERNANCE TO BE HELD ON 8<sup>th</sup> July 2009

<b>Enclosure:</b>	PBC Locality Commissioning Plan 09/10				
<b>Subject:</b>	S/A				
<b>Lead Director:</b>	Geraint Griffiths				
<b>Lead Officer:</b>	Nicky Brooks				
<b>Recommendation:</b>	<b>For Approval</b>	<input checked="" type="checkbox"/>	<b>For Discussion</b>	<input type="checkbox"/>	<b>For Information</b>

### PURPOSE OF THE REPORT:

To present the locality's commissioning plan. This is in awaiting final ratification by Cannock Chase Commissioning Consortia.

### IMPLICATIONS:

<b>Legal and/or Risk</b>	N/A
<b>Standards for Better Health</b>	Services identified within the commissioning plan will be required to be compliant with these standards.
<b>Financial</b>	The commissioning plan will require finances to be available to support the developments / proposed changes. Therefore any financial constraints may be a factor which impacts upon full delivery of this commissioning plan.
<b>Training</b>	N/A
<b>PBC</b>	PBC Commissioning plan
<b>Patient Engagement &amp; Safety</b>	Specific areas of where this is being addressed is included within the plan

### RECOMMENDATIONS / ACTION REQUIRED:

To approve the locality's commissioning plan.



# **CANNOCK CHASE COMMISSIONING CONSORTIUM**

## **LOCALITY PLAN 2009/10**

## **Introduction**

PRACTICE BASED COMMISSIONING (PBC) IS ABOUT ENGAGING PRACTICERS 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 Cannock Chase Commissioning Consortia consists of 28 practices. Each year the practices elect a board which consists of up to 12 members. Once elected the board then elect a chair and a secretary.

This Commissioning Plan is agreed on behalf of all GP practices and is informed by national policy and PCT priorities. This sets out the areas of focus for the Consortium in 2009/10, and the direction of travel for future years.

## **Public Health Overview**

Cannock Chase Locality covers a population of approximately 128,200. Within this boundary lies Cannock Chase council with a population of approximately 92,900. Cannock Chase Council is ranked 134<sup>th</sup> most deprived out of 354 local authorities and is the most deprived local authority in Staffordshire (excluding Stoke on Trent). According to the index of multiple deprivation Cannock Chase has twelve areas, which fall, within the most deprived areas in England. These are: Cannock North, Etching Hill and The Heath, Hednesford North, Norton Canes, Cannock East, Cannock North, Cannock South, Cannock West, Hagley and Brereton & Ravenhill. Inequalities in Cannock, which have an impact of health, include:

- In Cannock North ward, 54% of children live in an income deprived family. In England the average figure is 21%.
- Only 15% of the adult working population has reached level 2 numeracy compared to 25% in England and only 39% for literacy compared to 44% for England.

There are some lifestyle choices, which will determine the type of services we will require for the Cannock Chase population. These include:

- Approximately a quarter of the adult population regularly smoke cigarettes
- Only 16% of adults eat the recommended 5 a Day fruit and vegetables
- For the West Midlands (there are no figures available for Cannock Chase) only 39% of people manage to take at least 30 minutes of physical activity 5 days a week
- 28% of the adult population is obese
- Domestic violence is increasing, 2003/04 rates were higher than the national average and were a two fold increase from the previous three years
- There are 700 habitual drug users with only approximately 30% accessing drug treatment services. Seventy percent of these are Hepatitis C positive.
- The under 18 conception rate is second highest in Staffordshire

## **2009/10 targets**

The NHS operating Framework 2009/10 (Department of Health) sets out the national priorities and targets. There are no new national targets, but some of the existing areas have been expanded. There are 3 areas:

1. National must dos
2. National targets with local flexibility
3. Local priorities (which may be informed by vital signs indicators).

*1. National Must Dos*

- Improving cleanliness and reducing hospital infections (N1). From April 2009, all elective admissions must be screened for MRSA. This should be expanded to cover emergency admissions no later than 2011.
- Improving access (N2) includes 18 weeks and GP access (including at evening & weekends).
- Improving health and wellbeing and reducing health inequalities (N3) including focus on reducing smoking rates, tackling obesity,, reducing alcohol harm, improving sexual health, treating drug addiction, vascular checks for people aged 40-74, prevention services for older people such as falls and fracture services, fot care, intermediate care, telecare and audiology services. Termination services should include contraception advice and counselling. People with a long term condition should receive high quality services and a personalised care plan. Support for carers. PCTs should work with local authorities to combine resources to support breaks for carers.

The 4 areas from 2008/09 are still included and PCTs are expected to improve these in areas:

- Cancer – patients should wait no more than 31 days for radiotherapy by December 2010 (N4).
- Stroke – implementation of the National Stroke Strategy (N5).
- Children’s services with a focus on tackling childhood obesity, promoting breastfeeding, improving the experience of services for children with a disability and their families including palliative care, review and evaluate the effectiveness of CAMHS services to ensure vulnerable children have swift and easy access to services, reducing teenage conception rates(N7).
- Improving patient experience, staff satisfaction and engagement (N8).
- Able to respond in a state of emergency (N9).

*2. National Targets with local flexibilities*

- Alcohol (N10)
- Dementia (N11)
- End of Life Care (N12)
- Mental Health (N13)
- Military personnel, their dependants and veterans (N14)
- People living in vulnerable circumstances (N16)
- Learning disabilities (N17)

*3. Local Priorities*

PCTs should develop local priorities based on the needs of their local population using evidence from vital signs, strategic needs assessment (JNA), LAAs (Local Area Agreements) and best practice to support local decisions.

**Cannock Chase Commissioning Consortia – priorities 2009/10**

Work Area	Targets
<b><u>Unique Care / case management</u></b> Pilot to continue with three practices in order to effectively assess the impact of this service before any further roll out.	N3

<p><b><u>COPD Met Office</u></b> Pilot with one practice during winter 0809 indicated early positive findings. To extend pilot to three practices for winter 09/10.</p>	N2 N3
<p><b><u>Primary Care Mental Health Service</u></b> The consortia successfully procured this service and this was awarded to Starfish a Social Enterprise. During this financial year the service will be implemented and a transformation plan developed in conjunction with the JCU in order to reduce activity accordingly within the Mental Health Foundation Trust.</p>	N13
<p><b><u>Adult Intermediate Care</u></b> The consortia implemented as 27-bedded intermediate care facility during 2008-09. A full evaluation of the success of this facility will be completed this year. A business case will also be prepared for the future of this long term facility with a view to this opening for 2010/11. This facility is anticipated to provide up to 40 beds and community facilities including accommodation for the intermediate care staff in health and Social.</p>	N2, N3,N16
<p><b><u>Paediatric Intermediate Care</u></b> The consortia in partnership with Stafford and Surrounds PBC have extended the Children's Community Nursing Service in order to focus upon hospital avoidance. Work this year will evaluate the impact of this additional investment. Additional work this year will focus upon the model of care at MSFT from A/E to PAU through to discharge and the implementation of a community constipation service.</p>	N2, N3, N7
<p><b><u>Primary Care Front A/E</u></b> To continue in partnership with Stafford and Surrounds PBC with the provision of a Primary Care Front End triage in the A/E department at MSFT. The model of care will be fully evaluated this year along with a plan for future delivery of the service.</p>	N2, N3, N10
<p><b><u>Screening in Primary Care</u></b> Supporting with the piloting the CVD LES software and advising on practical implementation. Offering to practices within the locality for roll out. Exploring the possibilities of warfarin monitoring and offering to practices within the locality for roll out.</p>	N2, N3
<p><b><u>Childhood Obesity Service</u></b> Introduce the Tier 3 service and work to develop a primary prevention programme.</p>	N7
<p><b><u>Review Health Trainers</u></b> A 3 year contract was implemented with a one year review to refine the model of provision.</p>	N7
<p><b><u>Stroke Service</u></b></p>	N5

The consortia successfully procured a community TIA/ Stroke service and will be supporting the implementation and evaluation of this service during its first year of operation.	
<b><u>Sexual Health</u></b> The local provision will be reviewed in light of a PCT wide sexual health strategy. Key areas locally with include primary care based services – namely community contraception provision, teenage pregnancy prevention.	N3
<b><u>Physical Activity</u></b> To expand the 'health-fit' scheme into General Practice.	N3
<b><u>Exercise on Referral Scheme</u></b> Introduce a commissioned exercise on referral scheme This will be part of patient treatment pathways. A physical activity room in partnership with the district council has been secured to support this and childhood obesity work	N3
<b><u>Primary Care Dermatology Service</u></b> An implementation plan is underway to training a local GP and Health Visitor in conjunction with MSFT. A business case will be developed during the course of the year with the intention of implementing a health economy wide dermatology service during 2010/11.	N2
<b><u>End of Life</u></b> To identify current gaps with end of life care in particular providing patients with a real choice to die at home if this is the preferred place of death. Service redesign and investment will then ensure that these gaps are 'plugged'.	N12
<b><u>The Implementation of Basic Foot Care Service</u></b> To implement a locally delivered toe nail cutting service to vulnerable patients unable to cut their own toe nails and provide basic foot hygiene.	N2, N3

**Prescribing**

The consortia has a reputation of achieving high prescribing standards. The consortia is committed to maintaining these high standards and will be agreeing a prescribing incentive scheme this financial year in order to address further areas of prescribing which require improvement.

- 1) A minimum of 75% of prescriptions for statins to be prescribed as the low cost statins, simvastatin & pravastatin.
- 2) The percentage of prescriptions for ACE inhibitors compared to the total ACE inhibitors and 'sartan' prescriptions to be no less than 77%
- 3) A minimum of 85% of prescriptions of ACE inhibitors to be prescribed as the low cost ACE inhibitors, enalapril, lisinopril or ramipril.

- 4) A minimum of 90% of prescriptions to be prescribed as the low cost proton pump inhibitors, lansoprazole or omeprazole capsules.
- 5) A minimum of 85% of prescriptions for SSRIs to be prescribed as the safe low cost SSRIs, fluoxetine and sertraline
- 6) In line with current PCT guidance, stopping further growth in blood glucose testing strips or achieving a maximum prescribing cost per diabetic patient in order to ensure appropriate use.
- 7) Ensure that all clopidogrel prescribing is appropriate and in accordance with NICE Guidance. Aspirin and dipyridamole would normally be expected to account for at least 87% of antiplatelet prescribing.
- 8) 80% of prescribing of biphosphosphonates should be for generic alendronate.
- 9) Achieving an 80% compliance with the wound care formulary and ensuring that quantities prescribed are appropriate.
- 10) Achieve a target of 78% prescribing for generic items.

### **Patient and Public Engagement**

As part of World Class Commissioning PBC has a duty to proactively build continuous and meaningful engagement with the public and patients to shape services and improve health. In response to this the consortia have undertaken a series of actions which are being currently implemented.

In Cannock Chase, the consortium is keen to work with patients and members of the public to establish an effective two-way process of engagement. The consortia successfully developed the Patient Participation LES which extended the remit from only addressing single GP practice issues to providing a locality support process for commissioners so that local needs can be identified. Having developed and implemented the Patient Participation Group LES (PPG LES) a district wide committee of existing patient participation groups is being set up to provide direct input into the commissioning process. Members of this district wide committee will receive information from the commissioning consortium about its work plan and priorities for the year ahead as well as being able to contribute to discussions. Committee members will also be able to feed information two and from the wider community to ensure that the consortium receives a representative view from patients and members of the public across the locality.

Patient engagement has also played a key role in procurement of services locally and in the implementation of these services – e.g community Stroke /TIA service and the Primary Care Mental Health Service.

External research was undertaken by Picker Institute Europe regarding patient's perceptions of Intermediate Care The research found:

- • very strong support for the existing services from service users
- • strong but qualified support for the idea from potential users
- • some concern that there is still a role for traditional hospital care
- • some concerns that intermediate care should not be seen as either second best
- nor cost (or target) driven

- • a lack of clarity among patients and health care professionals about the range of
- services available and how they fit together
- • some confusion from patients and professionals about the availability of, and
- uses for, intermediate care beds in the community
- • there is potential for increased joint working between different health and social
- care professionals. These findings were shared with the board and have informed thinking in terms of how intermediate care is developed further during this financial year.

The findings from this research have been shared with the PBC board and have shaped further plans for intermediate care in this years plans.

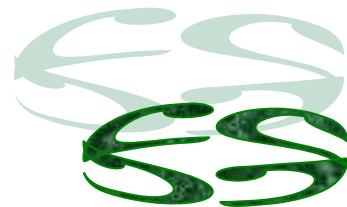
## Appendix 1

### **Chair:**

Dr Tim Berriman  
Tel: 01543 502391  
Email: timber@nhs.net

### **Secretary:**

Clive Cropper  
Tel: 07837 922471  
Email: clive.cropper@nhs.net  
**Commissioning Consortium**



**Cannock Chase**

**C/o Moss Street Surgery  
Moss Street,  
Chadsmoor, Cannock**

**Staffordshire**

**WS11 6DE**

**Cannock Chase Commissioning Consortium – Management Board Members  
2009/10 (to 30/09/09)**

Dr Tim Berriman	Chair and GP Representative, Cannock Town
Dr Andi Selvam	GP Representative, Hednesford & Chadsmoor
Dr Mohammed Huda	GP Representative, Rugeley
Dr Paul Ballinger	GP Representative, Cannock Town
Dr V K Singh	GP Representative, Hednesford & Chadsmoor
Dr Hirendra Choudhary	GP Representative, Heath Hayes, Norton Canes, Gt. Wyrley & Cheslyn Hay
Clive Cropper	Secretary, Practice Manager Representative
Patsi Hemmingsley	Practice Manager Representative
Jacqui Harrison	Practice Manager Representative
Tina Taylor	Practice Manager Representative
Kim Cyster	Practice Manager Representative

**Appendix 2**

Cannock Chase Commissioning Consortium

List of member GP practices

<b>Practice</b>	<b>Patient List Size*</b>
<b><i>Cannock (and surrounding areas)</i></b>	
Bideford Way Surgery, Cannock	<b>3,438</b>
The Red Lion House Surgery, Cannock	<b>4,097</b>
Hednesford Street Surgery, Cannock	<b>12,254</b>
GP Suite, Cannock Chase Hospital, Cannock	<b>8,712</b>
The Nile Practice, Old Penkridge Road Surgery, Cannock	<b>5,184</b>
Stafford Road Surgery, Cannock	<b>2,350</b>
Newhall Street Surgery, Cannock	<b>2,240</b>
Moss Street Surgery, Chadsmoor	<b>4,984</b>
Chadsmoor Medical Practice, Chadsmoor	<b>4,367</b>
Aung Min Gar Lar Surgery, Hednesford	<b>3,131</b>
Dr M Murugan, Hednesford	<b>2,720</b>
Dr J S Chandra, Hednesford	<b>2,256</b>
Dr V K Singh, Hednesford	<b>2,404</b>
Dr T R K Murty, Hednesford	<b>2,498</b>
The Surgery, Rawnsley Road, Rawnsley	<b>3,631</b>
Dr P K Jalota, Norton Canes	<b>2,975</b>
Norton Canes Health Centre, Norton Canes	<b>3,479</b>
Dr B K Singh, Heath Hayes and Norton Canes	<b>4,161</b>
Dr Y K Gupta and Partners, Heath Hayes & Chase Practice	<b>8,465</b>
<b><i>Great Wyrley and Cheslyn Hay</i></b>	
Dr E Wilson, Great Wyrley	<b>3,717</b>
Dr K A Desai, Great Wyrley	<b>2,220</b>
Dr A B Patel, Great Wyrley	<b>2,271</b>
The Medical Centre, Southfield Way, Great Wyrley	<b>3,071</b>

The High Street Surgery, Cheslyn Hay	5,437
The Nile Practice, Cheslyn Hay (branch surgery)	<b>Inc. in Cannock Practice figures</b>
<b><i>Rugeley and Armitage</i></b>	
Aelfgar Surgery, Rugeley	4,661
Horsefair Practice and Armitage	11,582
Sandy Lane, Rugeley	9,937
Brereton Surgery, Rugeley	3,905
<b>Total</b>	<hr/> <b>130,147</b>