

REPORT TO THE PBC GOVERNANCE TO BE HELD ON 12th August 2009

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

PURPOSE OF THE REPORT:

The ratified commissioning plan has been altered to contain the agreed prescribing incentive scheme. Therefore the final version is now being presented for information.

IMPLICATIONS:

Legal and/or Risk	N/A
Standards for Better Health	Services identified within the commissioning plan will be required to be compliant with these standards.
Financial	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.
Training	N/A
PBC	PBC Commissioning plan
Patient Engagement & Safety	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 BIENG PROVIDED WITH THE RERSOURCES 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 or 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 134th 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
<u>Unique Care / case management</u> Pilot to continue with three practices in order to effectively assess the impact of this service before any further roll out.	N3
<u>COPD Met Office</u> Pilot with one practice during winter 0809 indicated early positive findings. To extend pilot to three practices for winter 09/10.	N2 N3

<p><u>Primary Care Mental Health Service</u></p> <p>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><u>Adult Intermediate Care</u></p> <p>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><u>Paediatric Intermediate Care</u></p> <p>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><u>Primary Care Front A/E</u></p> <p>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><u>Screening in Primary Care</u></p> <p>Supporting with the piloting the CVD LES software and advising on practical implementation. Offering to practices within the locality for roll out.</p> <p>Exploring the possibilities of warfarin monitoring and offering to practices within the locality for roll out.</p>	N2, N3
<p><u>Childhood Obesity Service</u></p> <p>Introduce the Tier 3 service and work to develop a primary prevention programme.</p>	N7
<p><u>Review Health Trainers</u></p> <p>A 3 year contract was implemented with a one year review to refine the model of provision.</p>	N7
<p><u>Stroke Service</u></p> <p>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.</p>	N5
<p><u>Sexual Health</u></p> <p>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.</p>	N3

<u>Physical Activity</u> To expand the 'health-fit' scheme into General Practice.	N3
<u>Exercise on Referral Scheme</u> 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
<u>Primary Care Dermatology Service</u> 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
<u>End of Life</u> 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
<u>The Implementation of Basic Foot Care Service</u> 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

Local Enhanced Service for Prescribing & Medicines Management 2009/10

In March 2009 the number of ASTRO.PU's registered with Cannock Chase was 532,664 (Max award per Astro-pu=37.5471p)

The targets set out in this years incentive scheme include cost-improvement measures as well as quality improvement topics, not all targets will therefore deliver cost-savings. The proposed awards are therefore to recognise some degree of work needed for achievement, it should be noted however that all the targets are considered good practice, and the awards are not an inducement to prescribe particular drugs. Whilst this scheme is aimed at resourcing and supporting good practice it does not preclude the right of the PCT to exercise options relating to poor performance in relation to prescribing.

The consortium has aside £200,000 to fund the 2009/10 enhanced service.

There are three elements to the scheme:

(1) Antibiotic prescribing in this locality is causing concern in relation to the incidence of C-Diff cases locally. This is a priority target for the consortium to address during 2009/10. A £40K payment will be available for practices with Antibiotic prescribing below National average in Dec 09 qtr OR if at or above National average who have achieved a 5% point reduction against National average for Dec 08 qtr. **This target is a qualifying target- all practices must therefore achieve this target before any payments will be made under this scheme.**

(2) A £100K payment will be available for practices meeting a range of value for money indicators relating to prescribing expenditure against a range of drugs and classes of drug. Practices are expected to choose and work on up to 5 targets. Practices are required to choose targets they are NOT already achieving as priority and only count targets they are already achieving to make up the 5. All targets are equally weighted.

(3) A further £60K will be awarded for the achievement of the quality improvement targets. Practices are expected to choose and work on up to 3 targets and should give priority to target areas where they are not already achieving.

Targets

Group 1 – Antibiotic Prescribing				
	Target	Notes	%age of scheme	Target Selected
1	The volume/rate of antibiotic prescribing should be no greater than National average (Dec 08 = 0.311 items/STAR PU), or a 5% reduction measured against baseline. (as measured Oct-Dec 09)	Inappropriate antibiotic prescribing contributes to the increase in C-Diff and MRSA infections. GP prescribing of antibiotics in SStaffs is the highest in the WM, and overall 9% above the national average. Target to be measured using the Health Care Commission measures in the PPD toolkit	£40K	<input checked="" type="checkbox"/>

Group 2 – Value for money Indicators				
	Target	Notes	%age of scheme	Target Selected
1	Proportion of “Statin” prescriptions to be prescribed as low-cost “statins” to be no less than 80% of total “statin” prescriptions (or a 10%age point increase from baseline. (achievement as at Mar 10)	The use of low-cost statins is further endorsed by the recent NICE lipid modification guidelines. Potentially many new patients will be identified as a result of national moves to identify primary prevention patients and also from local work to identify patients already disease registers but not picked up by QoF. This should make the 80% target achievable and maintain focus on cost effective statin prescribing. This is a national target.	20%	<input type="checkbox"/>
2	The proportion of ACE inhibitors to be no less than 75% of all ACE + AIIIRA (sartan) prescribing. (or a 3%age point increase from baseline) (measured Mar 10)	Whilst cost-saving, this is also a quality measure, ACE inhibitors have superior evidence base in terms of improved outcomes over AIIIRA’s. There has been little movement against this target but with many new patients likely to be identified (see above) it is important that practices maintain an ACE first policy. This is now a national performance target	20%	<input type="checkbox"/>
3	Generic to branded modified release prescribing. PBC will be provided with a list of potential savings against three alternatives, Generic Iso mono 60mg vs Monomil, Fentanyl vs Matrifen and Mesalazine vs Mesren. Practices are required to achieve 50% of target savings.	In some cases alternative brands, which have been demonstrated to be bioequivalent to the brand leader are available at a significantly lower cost. TEVA has undertaken to guarantee to be the lowest cost brand. Practices should therefore consider changing patients to Monomil tablets, Mesren 400mg, MR Matrifen patches. These changes are also likely to be acceptable to patients as they will get consistency of product, which currently may not be the case. Practices will be notified of a potential savings figures	20%	<input type="checkbox"/>
4	For the expenditure on blood glucose test strips not to exceed £73 per cost based endocrine STAR-PU (Measured Jan – Mar 2010 inc) or a 5% reduction from baseline.		20%	<input type="checkbox"/>
5	For 92% of PPI items to be for low-cost generic drugs (lansoprazole & omeprazole caps) or 10% INCREASE FROM BASELINE (Measured Mar 10)	This is now a national performance target	20%	<input type="checkbox"/>

6	The proportion of low-cost “safe” SSRI’s to be no less than 80% of total. (this includes generic fluoxetine, citalopram and sertraline) (Measured Mar 10)		20%	
7	The proportion of bisphosphonates prescribed as generic Alendronate to be no less than 80% (Measured Mar 10)		20%	
Group 3 – Quality Improvement				
	Target	Notes	%age of scheme	Target Selected <input type="checkbox"/>
1	Audit prescribing transdermal analgesic patches used for chronic pain management (Submit Mar 10)	Transdermal analgesia costs are growing exponentially; there is significant variation between practices- transdermal analgesia should be generally reserved for patients with swallowing difficulties or intolerance issues with oral morphine. Audit to identify patient’s therapy prior to initiation of patch formulation and review appropriateness of use.	20%	
2	Prescriptions for evidence base doses of low cost statins, to be no less than 70% of total. (achievement as at Mar 10)	In terms of improving outcomes- there is strong evidence for doses of 40mg+ for simvastatin and 40mg for pravastatin. There is no outcome data for simvastatin 10mg	20%	
3	Nutritional Food Supplements Audit patients prescribed food supplements, focus on sip-feeds & prescribed foods. Identify patients, review indication and continued need. (audit & results to be submitted by Mar 10)	Prescribing of Nutritional supplements is increasing and evidence from some initial audits indicates monitoring and initial assessment of patient nutrition needs could be improved. Local Guidance has been developed and this provides suitable audit criteria	20%	
4	Audit of High Dose Respiratory Steroid Prescribing in patients with COPD. Aim to establish prescribing is in line with NICE guidance; i.e. for patients with predicted FEV1 =<50% and two or more exacerbations in 12 month period. (audit & results to be submitted by Mar 10)	Initial audit work conducted as part of last years scheme has indicated <ul style="list-style-type: none"> Few patients have predicted FEV1 recorded (not able to assess compliance with NICE guidance) Registers show patients as Asthma rather than COPD. This is a large piece of work and Practices would like to Re –audit this year.	20%	
5	To undertake and action an audit of clopidogrel prescribing against NICE guidance. (audit & results to have been submitted by Mar 10)	In ACS the combination of aspirin and clopidogrel should stop after 12 months and the patient maintained on aspirin. Patients considered intolerant of aspirin should meet the NICE defined criteria. If the patient has developed dyspepsia on aspirin, it should be co-prescribed with a low-cost PPI.	20%	
6	A minimum of 50% NSAID items to be prescribed as the safer alternatives of Ibuprofen and naproxen. (measured Mar 10)	Diclofenac has been associated with an increase in cardiovascular risk similar to coxibs. MHRA advice first choice NSAIDs should be Ibuprofen and Naproxen	20%	

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 year's plans.

Appendix 1

Chair:

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Commissioning Consortium

Surgery

WS11 6DE



Cannock Chase

C/o Moss Street

**Moss Street,
Chadsmoor, Cannock**

Staffordshire

**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

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

The High Street Surgery, Cheslyn Hay	5,437
The Nile Practice, Cheslyn Hay (branch surgery)	

**Inc. in Cannock
Practice figures**

Rugeley and Armitage

Aelfgar Surgery, Rugeley	4,661
Horsefair Practice and Armitage	11,582
Sandy Lane, Rugeley	9,937
Brereton Surgery, Rugeley	3,905

Total	130,147
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