NHS North East

# General practice commissioning consortia pathfinder programme application

## Contact details

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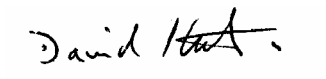
| **Signature of PCT Lead Director**  | |

## GP practices Group / Consortium details

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| **Number Practices within the group / consortium:** | 54 |
| **Patient population :** | 284, 618 |
| **Brief description of populations served:** | Sunderland is an ageing community and has some of the worst areas of deprivation in the UK and comes in at 33 on the list of all 354 local authorities in the UK. On average people in Sunderland die eight years earlier than people who live in the healthiest parts of England. 51% of children live in low income families. Nine areas have the highest health deprivation whilst Hendon and Southwick are the worst. |

| Local Authority | Practice Code | Practice Name | Practice List Size @ 01/01/11 | Number of GPs |
|---|---|---|---|---|
| Sunderland | A89001 | Dr Owen & Partners | 14458 | 8 |
| Sunderland | A89002 | Dr Bhate & Partner | 3252 | 2 |
| Sunderland | A89003 | Dr Vakharia & Hegde | 5757 | 2 |
| Sunderland | A89004 | Dr H Pepper & Partners | 12008 | 8 |
| Sunderland | A89005 | Dr Brigham | 5796 | 5 |
| Sunderland | A89006 | Dr Shetty & Partner | 6418 | 4 |
| Sunderland | A89007 | Dr Brown & Partner | 9920 | 5 |
| Sunderland | A89008 | Dr Reddy & Partners | 5334 | 3 |
| Sunderland | A89009 | Dr Lilley And Partners | 6833 | 5 |
| Sunderland | A89010 | Dr Stephenson & Partners | 12255 | 6 |
| Sunderland | A89011 | Dr Joshi & Partner | 3860 | 4 |
| Sunderland | A89012 | Dr Dixit & Partner | 4922 | 2 |
| Sunderland | A89013 | Dr J S Partington | 5552 | 1 |
| Sunderland | A89014 | Dr Mair | 1889 | 1 |
| Sunderland | A89015 | Dr Rutherford & Partners | 9265 | 6 |
| Sunderland | A89016 | Dr Ford & Partners | 7603 | 7 |
| Sunderland | A89017 | Dr Wright And Partners | 13035 | 10 |
| Sunderland | A89018 | Dr Parry & Partners | 5016 | 3 |
| Sunderland | A89019 | Dr Cloak & Partners | 9779 | 8 |
| Sunderland | A89020 | Dr Spagnoli & Partners | 8232 | 6 |
| Sunderland | A89021 | Dr Mishreki & Partners | 8934 | 8 |
| Sunderland | A89022 | Dr Mazarelo And Partners | 5320 | 4 |
| Sunderland | A89023 | Houghton Medical Group | 7594 | 4 |
| Sunderland | A89024 | Dr Mekkawy And Partners | 5652 | 5 |
| Sunderland | A89025 | Encompass Health Care | 4689 | 6 |

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|---|---|---|---|---|
| Sunderland | A89026 | Dr Ray | 3243 | 2 |
| Sunderland | A89027 | Dr Sharma And Partners | 6337 | 5 |
| Sunderland | A89028 | Dr Wallace & Partners | 6704 | 5 |
| Sunderland | A89029 | Dr Singh | 2115 | 2 |
| Sunderland | A89030 | Dr Hubbard | 6846 | 3 |
| Sunderland | A89031 | Dr Al-Khalidi & Partners | 5323 | 3 |
| Sunderland | A89032 | Dr K Stephenson And Partner | 5314 | 2 |
| Sunderland | A89034 | Drs Mackrell And Joseph | 3822 | 2 |
| Sunderland | A89035 | Dr Pattison & Partner | 5211 | 4 |
| Sunderland | A89036 | Drs Dhar And Kaul | 2307 | 0 |
| Sunderland | A89038 | Barmston Medical Centre | 4719 | 2 |
| Sunderland | A89040 | Dr Crummie | 2249 | 2 |
| Sunderland | A89041 | Dr Weaver | 4778 | 1 |
| Sunderland | A89042 | Church View Medical Centre | 6311 | 3 |
| Sunderland | A89603 | Dr O'bonna | 2240 | 1 |
| Sunderland | A89604 | Dr Weatherhead | 3494 | 3 |
| Sunderland | A89610 | Dr M C Hipwell | 3104 | 2 |
| Sunderland | A89611 | Dr Chhabra | 2279 | 2 |
| Sunderland | A89612 | Dr Nathan | 2172 | 1 |
| Sunderland | A89614 | Dr Widdrington & Partner | 3883 | 2 |
| Sunderland | A89616 | Dr Aiyegbayo | 1965 | 1 |
| Sunderland | A89617 | Dr Thomas | 2118 | 2 |
| Sunderland | A89618 | The Wearside Practice | 2019 | 2 |
| Sunderland | A89620 | Dr Thomas & Dr Joseph | 2805 | 2 |
| Sunderland | A89621 | Pennywell Medical Centre | 2990 | 3 |
| Sunderland | A89623 | Dr El Safy | 2597 | 1 |
| Sunderland | A89624 | Dr Bhatt | 2289 | 2 |
| Sunderland | A89625 | Maritime Practice | 1187 | 2 |
| Sunderland | Y02647 | Encompass GP Practice Two | 824 | 6 |

**Proposed date for consortium to start commissioning: 1.7.11**

## Description

**Please describe how the group/consortium will work and the scope of commissioning activities to be undertaken to benefit patients.** (This will include, for example, the organisational structure, the management arrangements and the working arrangements with the PCT during the transition)

**VISION**

Sunderland Commissioning Consortium is made up of 54 constituent practices led by a Board of 6 GPs elected by their peers. The Consortium has brought together 3 previous PBC groups. We are committed to providing excellent health outcomes for its patient population. We are passionate that these outcomes will be best achieved by developing closer and more effective working relations between primary and secondary care whilst integrating the health needs with the social and community needs of our patients.

It is envisaged that this vision aligns well with the results of the pause in the White Paper that suggest better integration of services is a driving factor to improving patient outcomes. The subsequent Pathfinder plan will ensure the development of the Consortium and it is envisaged our Pathfinder work will assist in our assurance to statutory status.

We will work in collaboration with the PCT, local providers, the Local Authority and patients to ensure that our vision is targeted via a whole system approach. We will work within the Sunderland Integrated Strategic and Operational Plan (ISOP) and also the Joint Strategic Needs Assessment. We are committed to delivering collaboratively on the local QIPP agenda and we have ensured our plans are aligned.

**PATIENT AND PUBLIC INVOLVEMENT**

We are committed to excellent patient care and it is essential that strong communication and relationships are maintained with our patient population.

We have appointed a Board lead who will actively develop a range of patient and public involvement mechanisms, working closely with a dedicated public involvement officer with experience in developing effective and productive communication methods.

The Board will be leading their first patient, public and stakeholder event in mid July, both to introduce ourselves to the Sunderland community and also to begin to ask the questions on how the public would like to be involved with the Board in contributing to future health decisions.

The Consortium members are cognisant of their unique position in communicating with patients on a daily basis and relish the opportunity of harnessing this experience in developing strong and effective ties within the community.

Our current discussion regarding possible methods of public involvement and engagement reflect our wish to ensure that public opinion is integral to our work and that the community we serve feels we are accessible and responsive to their views.

Many of our Practices have active patient groups and we are exploring the potential for these groups to supplement Board decision making processes with a geographical focus. We would anticipate these measures would be supported and extended with respect to representing communities of interest and in addressing issues of diversity and inclusivity.

**ORGANISATIONAL STRUCTURE**

A Consortium Constitution which regulates the relationship of the GP Practices with their elected leads is in development and builds on that developed by the North East Advisory Group (NEAG). An individual Practice level agreement setting out expectations of Practices as part of the Consortium has also been drafted and is about to be shared with all Practices.

The Board met with all the Practices on May 15th in an Organisation Development facilitated event to discuss our vision and organisational structure. The event was attended by multidisciplinary staff from all but three smaller practices – the most for over eight years to date. The clear consensus amongst Practices was to support the development of a sub structure of 5 geographically-based groups, co-terminus with Local Authority regeneration areas. This was identified by the Practices as aligning with our vision and provided the potential for more integrated working between primary and community health and social care. The event also identified the need for Practice Manager and Nurse representation on a Pathfinder Committee.

The five geographical groups will be accountable to the elected board and a designated Board member has been identified as the link with each group to facilitate dialogue and promote inclusiveness.

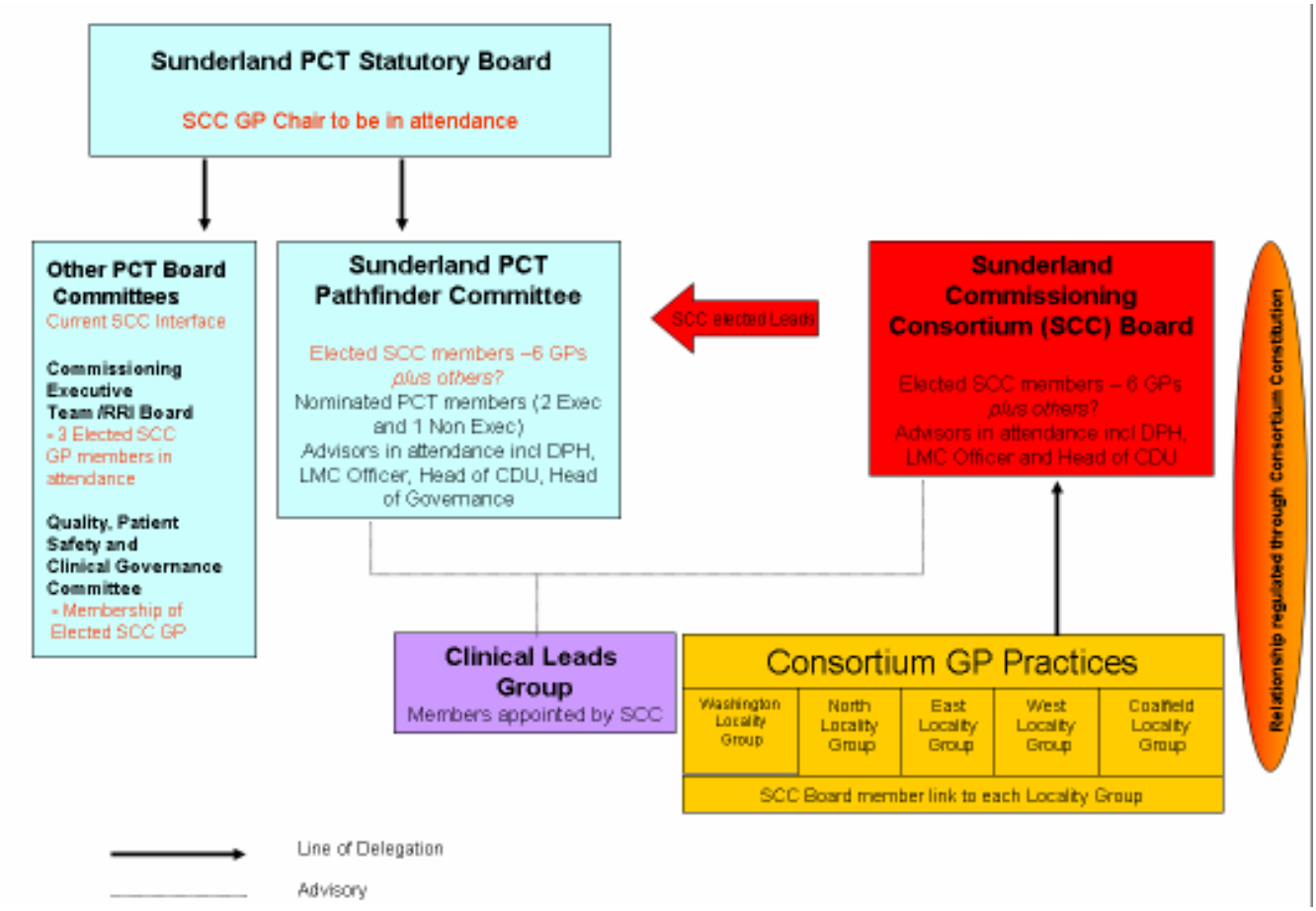
The Board has already held two protected development sessions to scope the Pathfinder application and discuss its evolution. An Organisation Development (OD) Plan is under preparation as a result and will be supported by regular board development sessions and leadership development opportunities for all Board members supported by the aligned PCT OD lead

Whilst the Director of Public Health (joint appointment with the LA), an LMC Officer and the PCT Head of Commissioning Development are in attendance at the current Board, any further extension is on hold until further information is known following the DoH response to the NHS Future conclusions. The Board however, understands and are supportive of the need to become a committee of the PCT in order to deliver the commissioning responsibilities that will be delegated by the PCT Board. The membership of the committee will include the elected GPs together with nominated PCT executive and non executive directors. Further members of advisors will be assessed in the light of the further information following the DoH response to the NHS Future conclusions. Terms of reference for the Pathfinder Committee are in a draft form building on the NEAG work to date.

The Board also supports the essential role of clinical leads with clear job roles/ objectives and clinical sub groups to support clinically led commissioning. Such roles may assist in contributing to clinical senates going forward.

We have representation on the Sunderland Early Implementer Health and Wellbeing Board which will act as a key driver for health and social care integration and ensuring the needs of local populations and vulnerable people are met. Our commissioning plans will be aligned to the City wide health and wellbeing strategy.

A skill matrix and city wide expressions of interest have been sought to support delivery of the Pathfinder application and Integrated Strategic and Operational Plan. In the interim we have supported the continuation of any historical clinical groups until they can be reviewed. All Pathfinder work streams have an aligned SCC Board lead.




The Consortium is supported by the aligned Sunderland Commissioning Development Unit within the PCT. Board members are also informing the development of the Commissioning Support Unit within SOTW and have liaised with the SHA and PCT both for the transition period and beyond.

The Chair and Vice Chair are members of the PCT Commissioning Executive team meeting on a weekly basis, along with membership of the RRI Programme Board overseeing the QIPP delivery plans.

Current GP membership of the Sunderland Contracting group (representatives from the 3

previous PBC groups) is being reviewed, recognising the new Consortium, the importance of the forthcoming contracting round, the Northeast wide review and the development path for the Consortium. Contract quality and activity reports are presented on a regular basis to the Commissioning Executive Team and the Chair has met with the Sunderland lead contracting manager to plan a way forward with any immediate pressures in the interim. To date the Chair and Vice Chair have contributed to the current years CQUIN and Penalty schedules for all major providers.

**WORKING WITH THE PCT DURING TRANSITION**

As part of the transition, we expect to be authorisation ready by July 2012 and authorised to take on statutory responsibility for commissioning no later than March 2013. To be authorised, the Consortium will need to go through due and proper process.

In terms of interim delegation of responsibility for the overall commissioning budget until we become a statutory body, the proposed timetable is set out in Figure 1 below. The total budget amount excludes the current PCT budget on areas such as primary care, specialised services and public health which will transfer to other bodies.

Figure 1 also includes a high level overview of the programme/service areas which will become the delegated responsibility of the Consortium to commission and the suggested timetable for that transfer of delegated responsibility. Day to day responsibility for service areas will be agreed with indicative amounts over time and this will increase in % terms as outlined in Figure 1. This needs to align with PCT's scheme of delegation and standing orders.

The Pathfinder sub committee of the PCT (with both executive, non executive and SCC membership) will be the committee that assures the PCT statutory board during transition.

**Figure 1** (note the budget figure is indicative, based on 10/11 and does not include any corporate budgets)

| Timeline: July 2011 | Aug 11 | Sept 11 | Oct 11 | Nov 11 | Dec 11 | Jan 12 | Feb 12 | March 12 | April 12 | July 12 | April 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Service: (none) | Prescribing | | Urgent Care | | Planned Care | | Community | | Mental Health | Authorisation Ready July | |
| Commissioning Budget transferring to GPCC: | | | | 25% (100M) | | 50% (£201M) | | | 100% (£402M) | | Authorised Consortia |

**Our initial focus and where we are currently ready to take a leadership role and responsibility will be:**

- **Improving the whole system Urgent Care response**
- **Improving the quality of care for people with COPD across the whole system as a key step to taking on more responsibility for patients with a range of LTCs**
- **Improving the quality and reducing the cost of prescribing**
- **Addressing clinical effectiveness in primary care**

This focus follows work with the Health Inequalities National Support team and the Director of Public Health to identify the factors contributing to the significant life expectancy gap in Sunderland and the worsening position for men in particular. Over 60% of the gap is as a result of Cardio-vascular disease, Cancer and respiratory diseases. Eight high impact interventions have been agreed and we will lead on four of these. All align to the QIPP agenda.

- Consistent use of beta blockers, aspirin, ACE inhibitor and statins following a circulatory event
- Systematic treatment for COPD
- Cancer awareness and early detection
- Identification and management of atrial fibrillation

The initial focus is on delivery of the 4 areas above as these are priority health requirements for the people of Sunderland and achievable within the pathfinder timeframe.

The Consortium is mindful of the target reduction of 1,388 emergency admissions in 11/12 for the Urgent Care system (equating to a saving of 2.84m) and the target reduction of 674 emergency admissions in 11/12 for the Long Term Conditions programme (equating to a saving of £2m). We will contribute to a reduction in the rising trend through the work streams outlined below. This equates to every Practice avoiding 1 inappropriate emergency admission a week.

The Consortium is also aware of the need to move towards the SHA average spend per head of population, currently 5% above average costs and will contribute to the system aim of being 3% above average for 2011/12 and 1.5% above by the end of 2012/13.

There is an imperative to improve the early diagnosis of Lung Cancer and we will contribute to the planned 10 % improvement compared to the 10/11 baseline, following NIHCE guidance. This will contribute to the NE Cancer Network target of saving 1,000 lives.

**1. IMPROVING THE WHOLE SYSTEM URGENT CARE RESPONSE.**

Urgent Care and Long Term Conditions are interdependent. People with long term conditions often present with urgent care needs at hospital. The urgent issues could have been prevented if they had access to better management and a wider range of services in the community.

We want to place a major focus on people with LTC, particularly those with COPD as well as focusing on ensuring all patients receive the right care at the right time and in the right place. This will require close working with key providers in the city, including the local Foundation Trust, South Tyneside Foundation Trust as the provider of community health services, the Out of Hours service and the primary care community.

Whilst there are a number of work streams to support the Urgent Care/LTC vision the golden thread is the need for an integrated community/primary care service, easily accessible and understandable to all.

Our vision identifies the need to move away from the current fragmentation of teams and the subsequent confusion for Clinicians and more importantly for Patients. The priority is the need for integrated pathways with secondary care and our community partners.

National policies and local pressures have led to the creation of a number of separate community teams and disintegration with primary care. However, we have started conversations with the current provider of Community Health Services, sharing our vision and clear intent for an integrated community and primary care service.

At this stage it is not envisaged that this will require any formal procurement. The intention is to work with the existing provider; building on the lessons learned from initiatives developed by the Provider, by Primary Care through PBC and via the PCT led Urgent Care and LTC networks. This work will represent a significant opportunity for clinical commissioning. Clinicians will be leading the change building on their understanding of patient need, experience of current services on the ground and a common belief that what unites Clinicians is a better deal for patients.

The current policy changes provide a major opportunity to drive forward this vision, which has a sense of urgency from all parties and is clearly recognised in the Sunderland Strategic and Operational Plan.

Sunderland Local Authority is currently and will continue to be engaged in this work and where appropriate align support services and commissioning intentions to enhance the urgent care response.

The work streams to be led by the Consortium are outlined below and are part of the Sunderland Integrated Strategic and Operational plan and Urgent Care Network plans:

- **Standard Assessment process**

  It is recognised that GPs locally are only responsible for some twenty percent of emergency admissions via A/E. However, in those cases it has been agreed that all GPs within Sunderland will follow the standard assessment process, building on the pilot developed by one of the Sunderland PBC Clusters. The outcomes from this work stream will mean that more patients who would have been referred to A/E by a GP are referred to alternative community health services. Those that do need to be seen in hospital will only arrive after having had a standard assessment including an early warning score to assist seamless care. This standard assessment process will also ensure clarity of whether the patient is being referred for advice only or admission. We expect to see some early success in this area as a result of Board leadership and the engagement of Practices.

- **Community based service for Cellulitis**

  This will enable the provision of IV antibiotics in the community. Currently patients have to be admitted to hospital for treatment principally due to lack of availability of I-V antibiotics in the community. It is envisage that we will work with current providers to allow development of a care pathway to prevent avoidable admissions.

- **Community based service for the assessment and diagnosis of suspected DVT**

  This will both improve the quality and cost effectiveness of treatment received. The pathway for suspected DVT currently involves patients attending the hospital to exclude a diagnosis of DVT. This often involves multiple attendances in order to have blood tests, administer drugs and ultrasound to exclude the diagnosis.

- **More integrated response to patients with COPD** – see section on LTC later

  We expect to see early success in this area as a result of SCC leadership and potential to engage practices.

The role of secondary care is also significant in achieving the overall vision and the Consortium through the Chair and supported by the Urgent Care Network, will lead the **remodelling of A/E** services in collaboration with City Hospitals Sunderland.

We equally recognise the role Primary Care needs to play in improving the overall outcomes for patients and the focus on people with LTC. The two key products from this work, which will be led by the Vice Chair will be:

- **Rolling out the Standard Admission Assessment to all GP Practices** including the Out of Hours Service adopting the same standard. This roll out will also provide an audit mechanism for potential future work on improving access to primary care.

- **Identification and treatment of people with AF at risk of a stroke**. The first stage of this development will be to launch the Grasp – AF toolkit across all Practices. This will enable the identification of patients at risk of a stroke who would be better managed on warfarin therapy. This will take place via partnership working with City Hospitals Sunderland (current provider of a warfarin service) responding to the increased numbers and as a result the treatment needs of those new patients will be met. The second stage will be to explore alternative ways of providing the service to improve the patient experience i.e. a community based initiation and monitoring service. This could also lead to a community based treatment for patients with DVT in addition to the assessment. We expect to see early success in this area as a result of Board leadership and the potential to engage Practices.

In summary we intend to take over the leadership of the Sunderland Urgent Care Network in the next few months with the Consortium Chair becoming the Chair of the Network

Sub measures which will help monitor our contribution to the whole system target of reducing emergency admissions will be agreed as part of the Pathfinder Delivery Plan. They will include for example: increased referrals and activity into community teams, percentage of admissions avoided due to DVT service, increased activity in warfarin clinics and a baseline to measure the impact of the Grasp AF tool on the prevention of strokes.

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## 2. IMPROVING THE QUALITY OF CARE FOR PEOPLE WITH COPD ACROSS THE WHOLE SYSTEM

We intend to be focussed on a number of key priorities as a key step to taking on more responsibility for patients with a range of LTCs. The concept of whole system working is paramount to our vision especially in relation to LTCs. The COPD work will:
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- **Monitor and improve the quality of care provided to COPD patents in a primary care setting, reducing variation between practices. This will be over and above the requirements of QoF**

- **Improve the training and education of primary care staff**

- **Reduce avoidable emergency activity in relation to COPD through for example post-exacerbation reviews of all COPD admissions and the use of the combined predicative model to identify patients at risk of admission**

- **Improve identification of patients with undiagnosed COPD and support patients in self management**

We expect to see early success in these areas as a result of Board leadership and the potential to engage Practices

Developmental work will include the Consortium working with the PCT to ensure other services to support COPD patients are commissioned, including pulmonary rehabilitation, non invasive ventilation/oxygen and early discharge schemes

The LTC Board Lead, as a member of the LTC Programme Board will work with the PCT to deliver these changes, setting a steer and gradually taking the lead for delivering the change as appropriate. The approach will look to build on the current health/local authority project utilising assisted technology for the management of long term conditions.

Sub measures which will help monitor our contribution to the reduction in emergency admissions will be developed as part of the Pathfinder Delivery Plan. These will include for example the percentage of patients with severity recorded; uptake of influenza vaccination in patients with COPD; referrals to community teams; percentage of patients having post exacerbation reviews, number of practice staff attending training sessions; and length of stay for copd patients. Targets can be extrapolated for these measures as a result of the COPD improvement made by one of the previous PBC Clusters in 10/11.

## 3. IMPROVING THE QUALITY AND REDUCING THE COST OF PRESCRIBING

We recognise considerable potential exits for local prescribing to maximise both cost effectiveness in prescribing and in optimising the use of appropriate medicines to enhance health outcomes for patients.

The Consortium Board has appointed a Clinical Lead with delegated authority for this area of work supported by the PCT Medicines Management team. The Pathfinder will address four

key prescribing areas with early priorities and successes being repeat dispensing, and the prescribing of four drugs post MI.

- **Repeat dispensing:**

The uptake of repeat dispensing is variable across Sunderland. We plan to increase the repeat dispensing rates across Sunderland (currently 9% average) with all Practices to be doing at least 10% of all items via repeat dispensing by the end of 2011/12 and 20% by the end of 2012/13. All Practices will need to demonstrate continued uptake.

We will do this through the development of a consistent approach to materials and communication and by working with community Pharmacists to ensure that there is a streamlined patient journey. The Prescribing lead has recently participated in a RPIW on this issue and is committed to taking the agenda forward.

Evidence suggests that in addition to improving patient care, the repeat dispensing process reduces waste medicines. Patients are, when stable, ideally suited to the repeat dispensing process. Whilst it is not possible to quantify this impact in advance it clearly aligns with the QIPP agenda.

This initiative will be monitored by the number of prescribed items dispensed via repeat dispensing as a proportion of all items dispensed on an individual Practice basis.

- **Four Drugs Post-MI: aspirin, beta-blocker, statin and ACEI**

Sunderland has higher than average morbidity and mortality from cardiovascular disease. Working with our public health partners it was highlighted that only 57% of post-MI patients currently receive all four drugs indicated which impacts on quality of life and life expectancy. 18% have apparent contraindications and the remaining 25% are on 3 drugs or less.

We believe the rate of contraindications is overly high and aim to increase numbers treated appropriately at Practice level. The improved quality of care resulting from this measure will not be immediate but is predicted to have an effect as early as 2-3 years hence.

The work can be achieved by Practice staff in conjunction with Pharmacy Support teams and will be overseen by the Prescribing Lead helping Practices understand their baseline and level of improvement. We aim to have a minimum of 80% of patients on all four drugs. And the new QOF indicator will act as the outcome measure for monitoring purposes.

We expect to see early success in both these initiatives because of Board leadership and the potential to engage Practices.

- **Moving spend per head of population**

The average spend per head of population within the Sunderland area is higher than Gateshead, South Tyneside and the Strategic Health Authority average. It has been estimated that there is the potential to free up around £2 million over the next 4 years (QIPP target) by moving towards more cost effective drug choices within Sunderland. These savings may be reinvested within the drug budgets for patients who need to have medication prescribed without compromising the drug budget or having to draw on other areas of

expenditure for support.

Supported by the PCT Prescribing Advisor we will develop a cross Sunderland action plan that can be delivered through the geographical groups to ensure implementation and peer review of prescribing.

Measures are available at an individual Practice level relating to spend per head of population and spend on specific drugs and or drug groups which may be useful in the case of outliers.

- **Care Homes Review**

CHUMS (Care Homes Use of Medicines Study 2009) reported on the high incidence (~70%) of prescribing errors in care homes (prescribing, dispensing, administering and monitoring).

Prescribing errors are also a common reason for hospital admissions in this vulnerable group. Work has already been done by a previous PBC group with the aim of reducing waste and encouraging safe and efficient medicines management. Consequently significant savings were generated.

At present there is no existing system for the remaining care home population in Sunderland. We want to consider this issue an area for development over the next few years, recognizing there will be a need to maximise the productivity of the Pharmacy Support team and ensure good communication with Practices. The work is likely to be linked to a Practice incentive scheme. Key measures to monitor progress would be the number of reviews undertaken and the number of interventions recommended which are fully acted on. Once we have a better picture of the numbers across Sunderland, targets will be set as part of the Pathfinder Delivery Plan.

This work will be enhanced by working with Sunderland Local Authority as the main commissioners of care home provision**.**

**4. TAKING A LEAD ROLE IN ADDRESSING CLINICAL EFFECTIVENESS IN PRIMARY CARE**

Clinical Effectiveness is defined as clinical intervention which can result in improving heath and securing the greatest possible health gain from the available resources.

A clinical effectiveness programme can be divided into three sections:- Inform, Change and Monitor

Inform: - Identifying information on clinical effectiveness and evidence based practice and sharing the information with local Practices

Change:- Changing practice to comply with well founded information
e.g. to reduce the variation between Practices and achieving higher standards

Monitor:- Assessing improvement against the set standards

Clinical effectiveness is a key component for whole system working and seamless patient pathways. It also has a partnership role with education and can help support professional

development.

The focus for the Pathfinder year will be:

- Four drugs post MI (as noted under the prescribing section)
- COPD treatment (as noted under the COPD section)
- Early identification of lung cancer.

Lung cancer is one of the commonest causes of cancer death and accounts for high death rate among males. One year survival rate is below 30% and late presentation is common, hence low resection rates. There are identifiable barriers to early diagnosis including access to primary care, GP awareness and belief about lung cancer, referral for Chest X Ray, safety netting, continuity of care, mechanisms to follow abnormal results and dealing with unresolved symptoms.

Early priorities are:

- Raising awareness of lung cancer among patients over 50 yrs attending COPD, CVD and Smoking Cessation clinics
- Education event with all Practices about early diagnosis of lung cancer
- Following NICE guidance to refer a new cough lasting over 3/52 weeks

As a result of the above interventions, we anticipate an improvement of diagnosing early disease, contributing to the 10 % system target.

Supporting measures to measure the our contribution to the achievement of the high level indicator will be developed in the Pathfinder Delivery Plan but are likely to include:

- 80% of those attending COPD, CVD and Smoking Cessation clinics are given national "Be Clear On Cancer" Campaign/ local Health Promotion leaflets to be measured through Practice read codes
- 100% Practice attendance of education events
- Increased number of Chest X Rays carried out by 5% in 2011/12
- Increased number of appropriate two week referrals for suspected lung cancer by 10% in 2011/12
- Reduced number of emergency presentations for lung cancer by 10% in 2011/12
- Increased number of T1 or T2 Lung cancer staging by 5% in 2011/12

We expect to see early success in these initiatives because of Board leadership and the potential to engage Practices.

**ENGAGEMENT OF PRACTICES**

The engagement of practices in all our objectives will be the responsibility of the Consortium Board Leads, working with their 5 geographical delivery groups and encouraging peer support in the groups. They will be supported by the synergy created from directing the new Quality and Productivity Indictors wherever possible to the goals we want to achieve as a Pathfinder. For example the new emergency admissions indicator 11 could be used to support the use of the standard assessment tool and integrated community teams. We will also use the local commissioning incentive scheme; the local prescribing incentive scheme; and educational opportunities through the protected learning time bi monthly programmes.

## Local GP leadership and support

**Please describe evidence of existing local GP leadership and support (or how this will be achieved if this is not in place)**

The LMC facilitated the approach to the development of the Consortium. The process started in September 2010 with a large open meeting for GPs and Practice Managers. Meetings also took place with all the previous PBC Groups along with consultation with local and national GP colleagues. This activity also involved close working with the PCT. All Practices were kept fully informed throughout. The LMC then organized a survey in December/January 2010 to all GP Practices on the future of GP Commissioning. The survey included a range of questions including the level of interest in forming one single Commissioning Consortium for Sunderland and the process for securing the Board. The response indicated clear support for the direction of travel recommended by the LMC which included the desire for one Consortium and an election process for GPs.

Following the survey, the LMC sought nominations from GPs to the Board. There were 12 candidates for 6 vacancies and the election saw a 63% response rate. The first meeting of the Board took place late March 2011.

As a result the Board is made up of the following elected GPs:

- Dr Ian Pattison (Chair)
- Dr Iain Gilmour (Vice Chair)
- Dr William Arnett
- Dr Jacqui Gillespie
- Dr Henry Choi
- Dr Gerry McBride

The first event with all Practices in mid May had 180 attendees (the most popular protected learning event to date). Excellent feedback was received on our initial work and a lot of interest in continuing communication with Practices. This was followed up with a full afternoon event on the 15th June with all Practices. The event sought further engagement in the Pathfinder proposals and in developing a joint vision for the Consortium through exploring the potential for commissioning. It was also an opportunity to bring the Practices together for the first time in their geographical groups.

195 people attended and heard from each of the Board members about the Pathfinder proposals and developments within Prescribing. The feedback was again excellent with Practices keen to engage with the Consortium to deliver our vision and early priorities. The Practices were equally keen to influence the commissioning of a range of services including community nursing and mental health.

Each of the Board members has leadership experience along a spectrum. Three of the members have led previous PBC groups and worked with the current PCT Executive team, one of whom was a PEC member and part of the WCC assurance process. The remaining three members have occupied roles as Clinical Leads, leading service change in particular pathways including LTC; Cancer, Diabetes, CVD and Prescribing. One member is also a GP

tutor supporting the education and training of fellow GPs. Two others are members of NE Networks e.g. Cancer and CVD. Each is also keen to explore their own personal development needs in relation to corporate and leadership roles.

The Board is also supported by two others in attendance, including the LMC Secretary and the Director of Public Health for Sunderland. Both contribute a lot of leadership experience, with the LMC Secretary having previously been a PCG Chair and a Chair of a PBC Group. The DPH is a member of the PCT Commissioning Executive team and the Local Authority Sunderland leadership team.

The Chair participates in the NEAG and is a member of the NE Transition Board influencing the direction of travel and accessing support for the Consortium. The Chair also meets with the other two GPCC Chairs in the SOTW area and the LMC and PCT Chief Executive, Medical Director and Director of Commissioning Development on a monthly basis to support the transition.

We are keen to access support via the PCT and are working closely with its aligned development team, OD lead and strategic leads for strategic priorities, accessing specialist support from PCT teams where required e.g. the medicines management team and prescribing support. This will further develop over the transition to April 2013 and the dissolution of the PCT as we are keen to retain the knowledge, skills and experience of particular PCT teams.

## Local authority engagement

Please describe evidence of existing local authority engagement（or how this will be achieved if this is not in place)

A fundamental part of the development of our Consortium is the establishment of the 5 geographical delivery groups.

Whilst a number of options for such groups were presented by the Board to its constituent Practices, our preference was to link with the Local Authority Area Regeneration Frameworks. This was supported by the Director of Health, Housing and Adult Services. Whilst this number and make up provide a manageable delivery mechanism for the Board, one of the key reasons it was suggested is the potential it provides for closer working with the Local Authority in neighborhoods and for more integrated responses to patients from front line primary and community teams – the key vision for the Consortium.

The geographical groups are just forming, however, the intention is to discuss further with the Local Authority, extending the membership to their staff and community staff. Equally to consider Practice representatives engaging with the Area Regeneration committees, informing the local area generation plans. This approach recognizes achieving a number of key health outcomes will require the joint efforts of both the Local Authority and Health bodies.

In addition the Chair of the Board has met both the Leader of the Council and the Director of Health, Housing and Adult Care on an informal basis and is due to meet with both parties and the Chief Executive on the 20th June. A further meeting is being planned with the Director of Children's Services.

Meetings have also taken place with the Deputy Director of Health, Housing and Adult Services, along with the Head of Personalization and the Head of Care and Support to explore opportunities for joint working and synergy in the delivery of the Pathfinder objectives. Our vision was positively received, building on the positive experience of the Unique Care Project – a joint project between Social Services, Community Services and one of the PBC Clusters.

Information is being shared about Board Leads for geographic groups and Social Services leads for assessment and support teams are profiling the pattern across the geographic groupings. This will include children's services who are also organizing around the Area Regeneration frameworks.

The Director of Public Health has been a key influence on the Pathfinder particularly the need to focus on health outcomes and as a joint Local Authority/PCT appointment has also brought the Local Authority perspective to our Board.

The Chair is also a member of the Chief Officer Group established to oversee the development of the Sunderland Early Implementer Health and Wellbeing Board. Wider GP involvement in this group is expected.

The Chair and Vice Chair of the Health Scrutiny Committee have also been briefed about the development of the Consortium and the Commissioning Development Unit and the Director of Public Health interface with the Committee on a regular basis.

A six month stock take meeting between the PCT, the Consortium and the Local Authority to discuss progress with the Integrated Strategic and Operational Plan including RRIs is also being planned, following on from the recent joint meetings.

## Delivery of the local quality, innovation, productivity and prevention (QIPP) agenda

**Please provide evidence that the group / consortium has taken greater responsibility and involvement in the QIPP agenda**

The Chair and Vice Chair are members of the Commissioning Executive Team meeting which oversees key commissioning decisions and business including keeping an overview of the Integrated Strategic and Operational Plan deliverables/ QIPP agenda. Once a month the meeting takes on the role of the Programme Board for the specifics of the QIPP programme, monitoring progress on targets and lessons learned.

Whilst the Strategic Plan needed to be submitted by mid March just as our Board members were being elected, four events were held with Clinical Leads including all those up for election. The Leads supported the direction of travel within the Strategic Plan including the Sunderland QIPP proposed savings and investments. Half of our current Board members participated and all Board members have since had an update on the QIPP agenda for Sunderland as part of our Board Development day.

The Board also recognises the need to work with the PCT on the transition to April 2013. To date our priority has been to form the Sunderland wide Consortium, keeping Practice engagement in this, recognising the historical fragmentation of primary care in Sunderland.

More recent Board focus has been on the key work streams within the Pathfinder and how they contribute to the QIPP agenda (described below). However we are aware that our future clinical leads will need to engage with all the current priorities in the Strategic Plan as part of the transition arrangements.

We are aware of the contribution made to this agenda by the previous three PBC groups and have built on the lessons learned particularly the refocused PBC Plans from the last two quarters of 2010/11. These Plans targeted the rise in emergency admissions. For example one of the three groups made significant headway in standardising the copd pathway in primary care leading to a 12% reduction in emergency admissions over the year.

Another PBC group piloted the Unique Care programme and saw a slower rise in emergency admissions that the rest of the Practices across Sunderland. The third PBC group required all Practices to actively review their emergency admissions. The findings which included best practice are currently being considered by the Sunderland Urgent Care Network and the LTC/Urgent Care Commissioning group and have informed this expression of interest.

Board members are also members of the SOTW strategic LTC and Urgent Care programme Boards and the Sunderland wide Prescribing Board

**Please describe proposals to contribute to the QIPP agenda in your locality**

Our four work streams all align to the local QIPP agenda as can be seen in our contribution to the high level KPIs noted earlier.

In relation to reducing the trend in emergency admissions (Urgent Care and LTC QIPP programmes), it is recognized that our initial priority work streams in this area will not be responsible for achieving the whole of the target. It would be unwise to try to allocate a proportion of the target as the agenda in these areas is complex. The priority is that our activity has been agreed as a crucial part of the Network activity due to our engagement of primary care. In addition over the next year we will take on clinical leadership of the Urgent Care Network.

We also recognise the Local Authority contribution to this particular aspect of the QIPP agenda in the form of reablement services and intermediate care provision which are a large part of the Sunderland health and social care provision.

In relation to prescribing, currently Sunderland is experiencing 5% cost growth against uplift of 2% (£1.5m gap) over and above the QIPP target of 500k for this year. A number of PCT led plans are in place to address the growth, including the four initiatives we will be leading. However the Consortium will also be a key mechanism to wider Practice engagement in all the prescribing initiatives. As a result we will be contributing to the overarching aim to move the spend per head of population nearer to the SHA average and this includes the £500m QIPP programme.

In relation to the Lung Cancer high level indicator, this work is not part of the QIPP programme on Planned Care for 11/12, as the QIPP initiatives in 11/12 focus on outpatient reviews. However, Board members have informed the outpatient work as part of the Contracting Group with the PCT and further work is due to take place on the Planned Care QIPP programme for 12/13.

We are also working with the PCT on a proposal to change the monthly SOTW RRI Programme Board meeting into a Sunderland specific meeting as part of the Consortium Board meeting on a regular basis. This will support our commissioning development and the transfer of responsibility for the QIPP programme.

Further information is outlined below as evidence of how our priority work streams will inform the current QIPP progammes:

- Evidence suggests that in addition to improving patient care, the repeat dispensing process reduces waste medicines as a result of the proactive intervention of community pharmacy. The potential to decrease the number of days supply of medication, also means unnecessary medicines wastage should be reduced

- A cross Sunderland prescribing action plan supported through the 5 geographical groups will ensure implementation and peer review of prescribing activity. The savings generated will support the Medicines Management QIPP programme for Sunderland. The work in Care Homes to reduce prescribing errors building on a pilot last year, will generate significant savings and reduce the number of hospital admissions in this vulnerable group

- The treatment of AF with warfarin reduces the risk of stroke by 50—70% which is projected will equate to 64 stokes per year in Sunderland. The estimated cost per stroke due to AF is £11,900 in the first year after stroke occurrence (of which 4k is the cost of the emergency admission). The total cost of maintaining one patient on warfarin for one year including monitoring is £383. The current pathway for suspected DVT patients involves patients attending the hospital to exclude a diagnosis of DVT. Patients often have 0-1 day length of stays to be diagnosed which costs from £413, within primary and community teams this cost could be greatly reduced

- Use of the standard assessment/admission process and form by all Sunderland GPs will enable faster turn around of patients by A/E. This will also mean avoiding admission when advice only is required and saving time when early warning scores are already available

- The whole system work to reconfigure A/E supported by the review of MIUs and integration of the community teams will ensure GPs are more likely to use the community services. This will also enable more appropriate use of A/E leading to a reduction in emergency admissions and length of stay. Effective and appropriate urgent care is also key to providing a whole system approach to patients with long term conditions

- People in Sunderland are 51% more likely to be admitted to hospital with COPD than the national average. Sunderland also has the 6$^{th}$ highest rate of COPD prevalence in the UK and length of stay is higher than the UK average (7-8 days longer). COPD is also the 2$^{nd}$ most common cause for emergency admissions. The LTC/COPD work will enable a more preventative approach, maximizing self management and joined up care. It will also enable the identification of high risk patients and implementing appropriate and personalized care plans, all of which will lead to less hospital admissions, readmissions and reduced length of stay

- Earlier diagnosis of lung cancer will result in reducing the burden of disease and increase life expectancy. Productivity will be increased by maximizing the opportunities of current COPD, CVD and Smoking Cessation clinics where 80% of those with lung cancer will attend

**Please complete and return to Richard Barker, director of commissioning development at North East Strategic Health Authority**
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