WyvernHealth.Com

Somerset Practice Based Commissioning Consortia Commissioning Plan 2008/09 – 2010/11

WyvernHealth.Com

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EXECUTIVE SUMMARY

Introduction

This plan is for the period 2008/09 to 2010/11 and sets the commissioning intentions for the GP practices that it represents in Somerset.

Background

Somerset is a mainly rural county with an ageing population and a small but growing black and ethnic minority. We have included a needs assessment within Appendix 1.

Practice based commissioning is expected to construct care pathways which reflect the needs of the individual patients and provide scope to shift from treatment to disease prevention and health promotion.

WH.C was formally established as a consortium of the GPs in Somerset and has obtained new commissioning ideas from members to build plans for locally agreed schemes under the PCT framework. This plan for the period 2008/09 to 2010/11 builds on the 2007/08 Practice Based Commissioning Plan. The Primary Care Trust has agreed that freed up resources accruing against Practice Based Commissioning from 2007/08 can be utilised to support the continuation of existing schemes agreed in 2007/08.

The PCT has advised WH.C to plan on the basis of £1 million of freed up resources being available in 2008/09. This is in addition to the full year cost of the schemes approved for 2007/08 which is estimated to be £2.5 million.

The schemes proposed have been scored and those chosen for progression by the Board have been included as part of this plan. Our approach to the development of this plan is outlined in Appendix 2.

Key Features of the Commissioning Plan

The priorities of WH.C are to:

- Implement current practice based commissioning plans for 2007/08 and implement plans for 2008/09
- Develop practice based commissioning
- Develop plans for expanding the range of services in primary care
- Strengthen GP practice engagement

Six areas of priority for practice based commissioning proposals have been identified as below:

- Emergency Admissions
- Primary Care Mental health Services
- Diabetes
- Interface Services
- Diagnostics
- Public Health and Wellbeing

The schemes identified within these priorities cover all areas of the care delivery process.

EXECUTIVE SUMMARY (continued)

Commissioning Proposals

Details of the individual proposals are laid out within the Annex to this plan.

Impact of the Proposed Commissioning Plan

Public Health Need - Seven of the ten public health needs identified for Somerset are addressed in some way by the schemes proposed.

Patient experience – All schemes outlined within this plan are expected to improve patient experience.

Delivering Value for Money – Some of the schemes that have been proposed are expected to produce savings for the health community. Other schemes may deliver savings in the future which are not yet identifiable.

Delivering Care Closer to Home – Care should be provided in a setting more convenient for patients and the vast majority of the schemes in this plan look to address this objective.

Delivering "No Delays" – To support the local objective of achieving a health service which operates on a no waiting list system, many of these schemes are designed to make the patient care pathway more efficient.

Key Risks

A risk analysis has been developed and the significant risks identified for the plan. A more detailed risk analysis needs to be performed over each individual scheme as they are developed. The critical success factors for delivery of the plan are detailed in Appendix 3.

Next Steps

This commissioning plan is subject to endorsement by the Somerset PCT PEC and approval by the PCT's PBC Approvals Committee. Subject to approval, WH.C will be working with primary care and secondary care clinicians and managers to progress the plan. This will include appropriate patient engagement, developing service specifications and implementations plans.

Implementation Planning

Joint working between WH.C and the PCT will be required in order to successfully implement this plan. This will involve the establishment of joint WH.C project groups which should be clinician led to take the plan forward. It will require a phased approach and further discussion with the PCT.

EXECUTIVE SUMMARY (continued)

Communications

It is important to effectively engage with WH.C partner organisations including the PCT and the Foundation Trusts.

Relationships with patients, service users, staff and other stakeholders will need to be carefully managed. WH.C will continue to use the most effective methods of communication at our disposal – WH.C and PCT websites and intranet, WH.C locality meetings, LMC meetings and Practice Manager Locality meetings.

Planning 2009/10 and Beyond

WH.C plan to use the World Class Commissioning (WCC) model to develop commissioning plans in the future.

Appendix 4 lays out the relationship between the PCT and WH.C taking account of the 11 competencies identified for WCC.

WH.C will also make use of the DH guidance issued in December 2007 to allow us to work within a framework defined by the PCT to spend funding on a locally agreed menu.

An initial workshop is being planned for March 2008 being organised by the PCT and the Improvement Foundation to progress plans for 2009/10 onwards.

INTRODUCTION

This plan for WyvernHealth.Com sets the commissioning intentions for the GP practices that it represents in Somerset. The plan is for the period from 2008-09 to 2010-11 and will be reviewed and refreshed annually to reflect changes in local demographics and the needs of the population served by its member practices.

The plan is focused on ensuring the delivery of the objective for WyvernHealth.Com to:

- Shift care closer to home
- Prevent avoidable emergency admissions to hospital
- Provide greater patient choice
- Commission effective healthcare
- Improve the health and well-being of the population served by member practices.

The plan covers six main themes which are detailed on pages 12 to 19. The more detailed commissioning plan templates which detail the scope, benefits, justification for the proposal and costs can be found in the Annex to this plan.

BACKGROUND

Population Demographics

Somerset is a mainly rural county of 3,450 square kilometres (1,333 square miles) with a registered population of around 527,000. The county has a dispersed settlement structure and a low population density. Only Taunton, Yeovil and Bridgwater have populations of more than 30,000. Outside of these centres the population density is below 100 per square kilometre.

Statistics suggest that there is an expected 13.5% rise in the total population of Somerset over the next 17 years. The population aged 65 and above is set to grow by 51.6% over the same period. This is likely to place additional pressure on health and social care services. There is no expectation that there will be a consequent reduction in the working age population over the same period, in fact there is a predicted marginal increase (3.7%).

The county has a small but growing black and ethnic minority population and a significant number of migrant workers, the impact of which is still being established.

The population of Somerset is relatively healthy in terms of life expectancy and is prosperous, although there are pockets of deprivation within some of the larger towns and in isolated rural areas. Further details on the health needs for the Somerset population are provided at Appendix 1.

Practice Based Commissioning

Since 1 April 2005 practices have had the right to hold an indicative budget for Practice Based Commissioning (PBC). It is anticipated that PBC will enable primary care teams to construct care pathways that reflect the needs of individual patients and provide scope to shift from treatment to disease prevention and health promotion.

PBC in Somerset has previously concentrated on reducing avoidable emergency admissions to reduce expenditure on emergency secondary care and allow new investment in locally agreed community developments.

BACKGROUND (continued)

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In August 2007 WyvernHealth.Com (WH.C) was formally established as a consortium of 71 of the 75 GP practices across Somerset PCT area. A Board of eight representatives including GPs and a practice manager were appointed to work with GP practices and the PCT to develop the existing PBC schemes and build ideas for new areas in the future.

As part of this process, WH.C has obtained new commissioning ideas from GPs in Somerset to build commissioning plans for locally agreed schemes under the PBC framework. The detailed process of how this plan was developed is outlined in Appendix 2.

For each scheme an outline proposal was completed detailing the concept, why it was needed and how it should be progressed. These were then considered by the Board in terms of being achievable and importance in meeting local and national priorities. Schemes chosen for progressing are included within this plan. Some schemes related to diagnostics and therapies and may be progressed as further information around services already provided is obtained and service gaps are identified.

As part of the assessment process some of the projects were discounted, however they will need to be raised separately with the PCT relating to inequality of services and access to services across Somerset.

The 2007/08 plan included six schemes, which at January 2008 were in various stages of development. Further schemes were outlined in the 2007/08 plan with the intention of commissioning them in 2008/09, some of these have been included in this plan.

The details of the proposals can be found in the Annex to this plan.

2007/08

A detailed PBC plan was approved in March 2007 for Somerset for 2007/08 – 2008/09. This was prior to the formation of WH.C as a consortium in Somerset.

The plan was solely based around the aim of reducing avoidable emergency admissions. Although this is still a key part of the plan for 2008/09 the areas in which PBC is to participate in have expanded to include public health and well-being, diagnostics, elective care pathways and end of life care.

KEY FEATURES OF THE COMMISSIONING PLAN

WH.C will use its resources and influence to support the PCT in its objectives to:

- improve health and well-being
- reduce inequalities and social exclusion
- secure fair, fast access to a comprehensive range of services
- improve the quality and safety of services
- increase choice and convenience for the public.

The priorities of WH.C are to:

- implement current practice based commissioning plans, as outlined in PBC Plan for 2007/08 and to take forward practice based commissioning for 2008/09
- develop practice based commissioning, including the framework, infrastructure and capacity and capability of WH.C and primary care. This will include working with independent contractors including pharmacists, optometrists and general dental practitioners where appropriate.
- develop plans for expanding the range of services available in primary care as an alternative to secondary care – for urgent care, chronic diseases, and planned care.
- Maintain GP practice engagement.

In developing this commissioning plan WH.C has therefore taken into consideration:

- achieving the necessary reductions in emergency admissions and bed days;
- the need to address the practical question of priorities and challenges for primary care and the wider health community in improving the lives of people with long term conditions
- improving urgent care services in line with patient expectations
- opportunities to deliver more services locally
- addressing the public health and wellness agenda
- improving palliative care

Six areas of priority have been identified for practice based commissioning proposals as identified below:

- Emergency Admissions
- Primary Care Mental Health Services
- Diabetes
- Interface Services
- Diagnostics
- Public Health and Wellbeing

The commissioning proposals have been 'mapped' onto the core delivery value chain to demonstrate the wide range of proposals that were put forward.

KEY FEATURES OF THE COMMISSIONING PLAN (continued)

The initial commissioning proposals from GP practices covered a wide range of services.

Monitor / Preventing	Diagnosing / Screening	Preparing / Early Intervention	Intervening	Recovery / Rehabilitation	Monitoring / Managing
Young Persons Clinic	D-Dimer Analysis	Primary Eyecare Acute Referral Service	General Physician	Community Nurse Team	Terminally Ill People
Homeless People	Direct Access to Investigations	Anticoagulation Interface Service	Primary Care Mental Health x2		EMI patients in Specialist Residential Care
Dietetic Service	Mobile Ultrasound Service	Diabetes Education	Physio Service		Community Based Pain Service
Falls Prevention x2	Echocardiogram Service	Photodynamic Therapy	Audiology Service		Initiation and Titration of Insulin
Community Dietetics Service	Digital Retina Camera	Gynae Interface Service	Orthotics Service		Community Based Diabetes Nurse Specialist
	Rheumatology Service	Community Diabetes Services	Podiatry Service		COPD Incentive Scheme

KEY FEATURES OF THE COMMISSIONING PLAN (continued)

Monitor / Preventing	Diagnosing / Screening	Preparing / Early Intervention	Intervening	Recovery / Rehabilitation	Monitoring / Managing
		Community Dermatology Interface Service	A&E Access to 'Primary Link'		
		ENT Interface Service	Direct Access Physiotherapy Triage Service		
		Chiropractic Service			
		Cardiology Services			

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COMMISSIONING PROPOSALS

Emergency Admissions

Emergency admissions are forecast to rise by 1.5% per annum due to the ageing population alone. The conditions that place the most strain on the NHS are those related to heart disease and respiratory illness. These conditions account for around half of all GP consultations and 75% of time spent in a hospital bed. Over the next 20 years the ageing population will cause the numbers of people with these conditions to rise rapidly.

Somerset patients in the past have accessed urgent care services either by telephoning their GP, the Out of Hours Service, or telephoning 999 or by attending a local A&E department. In the past there has been no consistency in the assessment or the outcome of care provided.

Between 2003/04 and 2005/06 the total A&E attendances for Somerset residents increased by 12%.

During the first half of 2007/08 the total number of non elective attendances in Somerset was 24,048. This was up from 23,106 emergency admissions during first six months 2006/07. This is an increase of 4%.

Evidence collated as part of the Reforming Emergency Care Strategy (2002) suggested that 40% of A&E attendances could be dealt with by primary care.

The objectives in targeting avoidable emergency admissions are to:

- Reduce inappropriate emergency admissions to acute hospitals
- Generate opportunities to reinvest in care closer to home
- Provide an appropriate, timely and consistent response

COMMISSIONING PROPOSALS

Emergency Admissions (continued)

The schemes proposed to achieve these objectives in 2008/09 are:

- Falls Service - this would be aimed at patients over 65 and could include assessment followed by strength and balance training, a reduction in psychotropic drugs and modification of home hazards
- COPD enhanced service - the COPD service in Somerset has been established, however an enhanced service could be used to optimise the use of this new service
- EMI patients in specialist residential care - through staff training, GP consultation and use of OOH services, emergency admission of patients in EMI homes could be reduced and care provided in the home where possible
- Services for Terminally Ill Patients - since the majority of patients who die in hospital wish to die at home this service would look to provide palliative care to prevent unnecessary admissions
- DVT Treatment Service - This could be an interface service available for stabilisation of DVT patients who do not need to be in hospital. This could include access to diagnosis tools in primary care
- Expanding the GP Service in Acute Care (from 07/08 plan)
- Commission services to fill gaps identified by Somerset Primary Link Service (from 07/08 plan).

Further details of these schemes are in the Annex to this plan. At this stage the first four schemes are the most developed to progress as commissioning proposals.

COMMISSIONING PROPOSALS

Primary Care Mental Health Services

Mental health is the psychological and emotional well-being that makes it possible to enjoy life and live it to the full. Having good mental health enables us to make the most of opportunities, make good decisions, survive pain, disappointment and sadness and make a valuable contribution to society.

Unfortunately, mental health problems are very common, affecting people at any time of life and in different ways. They account for over a third of all illness in Britain and 40% of all disability. Unemployment, homelessness and broken relationships are just some of the potential consequences of mental ill-health for the individual. The total cost of mental ill-health to society is as high as £77bn each year in lost earnings, productivity and reduced quality of life.

Driven by the requirements of the National Service Framework for Mental Health, the last eight years have seen an unprecedented transformation in the way mental health services are delivered. However, while standards two and three of the National Service Framework focus on improvements in primary care, the greatest progress has been made in the development of acute in-patient and community based specialist mental health services.

Pressure on primary care mental health services has continued to increase, exacerbated by National Institute for Health and Clinical Excellence (NICE) clinical guidelines for the management and treatment of specific mental health problems (including anxiety and depression) and revised Quality and Outcomes Framework criteria, such as screening for depression.

In the White Paper, 'Our health, Our care, Our say', the important role of primary care is again highlighted, particularly in terms of improving access to evidence based psychological interventions (such as cognitive behavioural therapy and computerised cognitive behavioural therapy for people with common mental health problems) and adopting a 'stepped care' approach to service delivery where patients are offered an intervention following an objective assessment of their needs and 'stepped up' to an intervention of higher intensity if no improvement is forthcoming.

COMMISSIONING PROPOSALS

Primary Care Mental Health Services (continued)

The intention is that WH.C work with the PCT to reconfigure NHS provided services within Tier 2 of the stepped care model with a view to developing a countywide approach that provides:

- An improved quality of experience for patients: the most appropriate treatment, delivered in the least intensive manner, as close to home as possible
- A more evidence based approach to service delivery, available to a greater number of people
- An effective care pathway that promotes greater integration up, down and across the stepped care tiers and lessens waiting times for treatment
- Improved value for money.

Monies released through reconfiguring and/or decommissioning existing service elements will be redeployed to fund a new service provided by one or multiple providers working to an agreed set of patient centred standards.

The objectives of the proposal to improve mental care health in Somerset are:

- To shift care closer to the patient's home
- To provide a service to satisfy a gap in healthcare provision
- To integrate efficiently with other mental health services

The schemes proposed to achieve these objectives are:

- Sufficient practice based counselling to meet population needs
- Timely access to cognitive behavioural therapy
- Consistent access to CPN/Link workers
- Access to a range of non-pharmacological therapies.

However further details on the models and pathways of care with patients with common mental health problems will be developed with the PCT following the public consultation exercise which concludes in February.

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COMMISSIONING PROPOSALS

Diabetes

WH.C are working with the PCT to develop a model of care for adult patients with diabetes in Somerset, which delivers improvements to the health and the life expectancy of patients, reduces inequalities and maximises the use of NHS resources.

It is anticipated that the model will achieve the above aims by:

- shifting appropriate care closer to home
- supporting early intervention and prevention
- promoting self care
- preventing complications of the disease

The project will link with and incorporate learning from the Year of Care project, approved for implementation early in 2008. The Year of Care project focuses on supporting patients to manage their own care through the development of partnerships with community clinicians. Self management is recognised to be key to living with diabetes.

The project will also build on previous work, led by the former West Somerset Diabetes Local Implementation Team, on a tiered model of care offered in GP, community and secondary care hospital settings prior to the PCT restructuring.

Through the project outlined above we aim to:

- Introduce better management of patients to prevent complications
- enable practices to convert patients who require it to insulin, without the need to access secondary care
- avoid emergency admissions and reduce outpatient attendances

The main schemes proposed by member practices to achieve these objectives are:

- Community based services for diabetes sufferers
- Opportunities to improve patient education/self care/exercise.
- Community Dietetics Service – Preston Grove (also covered in the Public Health and Wellbeing section).

WH.C will work with the PCT to develop a comprehensive specification for the provision of a community based diabetic service in Somerset.

COMMISSIONING PROPOSALS

Interface Services

Interface Services are a way of providing a non-consultant led diagnosis and treatment centre for different clinical specialities in the community. The provision of these services is usually by GP with Special Interest (GPwSI), specialist nurses and Allied Health Professionals (AHP).

This can take the pressure away from secondary care and improve pathways for patients. This will help to improve patient experience, waiting times and patient satisfaction.

These can be provided in partnership with primary and secondary care and parts of the service can be provided by peripatetic medical professionals.

The objectives of the interface services in different clinical areas are to:

- Shift care closer to home
- Support delivery of 'No delays' targets
- Generate opportunities to re-invest in services closer to home by reducing the number of referrals to consultants and to improve the management of follow ups.

The interface services proposed to achieve these objectives are:

- Orthopaedic
- ENT
- Gynaecological - a one stop consultation including diagnostics and therapeutic procedures for patients
- Primary Eyecare Acute Referral Service (PEARS) - utilising the optometrists in the county to provide a primary care based eye care service
- Dermatology - a community based non-melanoma skin cancer service with provision of Photodynamic Therapy
- Audiology - a community based service for testing of hearing, and aid fitting and repair
- Headache

Further work needs to be undertaken jointly with the PCT on the orthopaedic interface service including the links with physiotherapy and chiropractic services. The gynaecological, dermatology, audiology and PEARS commissioning proposals should be progressed more promptly.

COMMISSIONING PROPOSALS

Diagnostics

Diagnostics are a significant part of the patient pathway in many cases. The waiting times for diagnosis can often lead to significantly increased length of pathway for patients in all areas of clinical health.

At 31 October 2007 within Somerset PCT 19 patients were waiting for more than 13 weeks for diagnostic tests. Although this is a good result when compared to averages for the country, if the target of “No delays” is to be met, further improvements to the diagnostic pathways need to be made to reduce this further.

In order to identify where demand is leading to increased waiting times before further or adjusted services are commissioned, a piece of work identifying the needs will need to be carried out. The main objectives of practice based commissioning of diagnostic services is to:

- Ensure equity of access across Somerset
- Support the delivery of the “No delays” target

The steps proposed to achieve these objectives are:

- Undertake a GP survey to identify service gaps and un-met needs
- Identify potential services to be commissioned, including direct access to investigations.

The results of the survey will be discussed with the PCT in early February 2008.

COMMISSIONING PROPOSALS

Public Health and Wellbeing

WH.C are working with GPs to improve the health of local communities. This will tap into the well of knowledge which GPs have about the needs of their area and help to provide tailor made commissioned services for the local people.

Schemes may be local to a practice area, to a general locality or across the whole PCT. The schemes included have an identified health need which they are addressing and GPs have developed them in response to a particular requirement of the local population.

As part of this we aim to:

- Implement schemes that can make a difference at practice level: improving patient experience and giving better access to services
- Address the public health agenda
- Pilot ideas which may be developed further across the PCT

The schemes proposed to achieve these objectives are:

- Young Persons Clinic, Glastonbury - a service already being provided in Glastonbury for the provision of specialist GP services for 13-18 year olds
- Homeless People, Glastonbury - access to a nurse led health care service in Glastonbury for those homeless who use the drop in centre
- Review of oral nutrition support and supplements, Frome - this would be a pilot scheme to provide a dietician to support GPs who prescribe to those who need nutritional support
- Community Dietetics Service, Preston Grove - a pilot scheme for GPs to refer obese patients to dieticians in an area which is currently not well served.

These schemes have been developed into detailed commissioning proposals which can be found in the Annex to this plan.

IMPACT OF THE PROPOSED COMMISSIONING PLAN

We have identified below how the schemes which are planned to be implemented through this plan meet the requirements of the local health community. The five areas below against which they have been assessed are identified as overarching objectives for the provision of public healthcare services.

Public Health Need: Identified within the annual public health report for Somerset are 10 health needs areas in which it is important for the county to make further progress. As part of the areas identified as priorities for WH.C to address through PBC, seven of these needs are addressed in some way as shown below.

Health Need	**PBC Priority**
Tackling health inequalities	Diabetes, Primary Care Mental Health, Emergency Admissions, Public Health
Reducing the number of people who smoke	Public Health
Tackling obesity	Public Health, Diabetes
Improving sexual health	Public Health
Improving mental health and wellbeing	Primary Care Mental Health
Reducing deaths from suicide	Primary Care Mental Health
Reducing falls in older people	Emergency Admissions

IMPACT OF THE PROPOSED COMMISSIONING PLAN

Although not all of the areas identified as priorities address a public health need as identified within the report on public health for Somerset, Diagnostics and Interface Services should result in improvements to patient experience and will improve access to health services.

Patient Experience: All schemes outlined within this plan are intended to improve patient experience, whether through improved pathways, reduced waiting times, more choice or development of service previously unavailable to patients in the area.

Most of the proposed schemes are designed to provide care closer to home which is believed to increase patient experience as detailed within the Department of Health paper "Shifting care closer to home".

Many of the schemes aim for high quality and safe care within settings which are more convenient for patients.

Delivering Value for Money: Some of the schemes which are to be implemented are designed to produce savings and there is considerable scope within many schemes to produce savings which outweigh their costs.

Other schemes may deliver savings in the future which are currently immeasurable or may be designed to provide an improvement in service or patient experience.

Predicted costs and savings are detailed in the Annex to this plan however further work is required.

Delivering Care Closer to Home: One of the key aims for the future of health service provision is to provide care closer to home in a setting more convenient for patients. The vast majority of the schemes which this plan is looking to implement will address this objective.

The main area where we are looking to bring care closer to home is through the use of interface services, which could be used to provide care within a primary care setting and prevent a large proportion of patients having to visit secondary care services.

Delivering "No Delays": Development of Interface services is designed to improve the status of waiting lists and could lead to a culture of "No delays" in the future as more triage resources are available to ensure only where absolutely necessary are patients progressed to secondary care.

Reducing unnecessary emergency admissions will also help to reduce waiting lists and enable secondary care to work towards "No delays" as resources would be freed from emergency care for other activities.

Conclusion

All of the areas identified within the plan have been shown to meet at least three of the objectives outlined above and three of the areas (Emergency Admissions, Primary Care Mental Health and Diabetes) are expected to deliver against all five of these objectives.

KEY RISKS

Implementation of this plan will require appropriate risk management processes developed to focus on key drivers such as patient outcome, safety and experience.

A risk analysis of the plan has been developed and has identified ways of managing each risk.

A detailed risk analysis of each scheme will need to be undertaken early on for each of the proposals. These have been included where identified already within the Annex to this plan.

KEY RISKS (continued)

Risk	Mitigating Action
Integration with other care assessment routes and services leading to duplication and confusion.	There will be careful planning of new pathways to ensure duplication is not experienced, which will involve liaison with secondary care and the services provided already.
Schemes are not of a sufficient scale for the costs to be recovered.	Pilot schemes will be run in many cases to ensure that savings are experienced before large costs are incurred. Detailed analysis of costs and savings will be developed before schemes are implemented. Performance information will be monitored as part of the ongoing management of the schemes.
The schemes do not improve patient experience.	All schemes will be assessed for improvement to patient experience prior to implementation. Performance management
Stakeholders are not sufficiently engaged to ensure the successful implementation of the schemes, including patients, GPs, social services and the PCT.	Stakeholder consultation is a key part of the PBC process and has been considered throughout the development of this plan and the schemes within it. There will also be a communications strategy developed.
Inability to recruit appropriately trained staff for the variety of posts required.	PCT recruitment procedures will be followed.
Secondary care is not engaged and has a conflict between reduction in income and achievement of targets.	Secondary care will be involved from the planning stage of the projects to ensure they are engaged and aware of the
Costs and savings prove to be unrealistic.	All financial information used in the predicted costs and savings will be based on the best evidence available and a robust monitoring framework will be implemented around each PBC scheme.
Data on the performance of the schemes is not accurate or valid.	A robust performance monitoring scheme will be implemented around each scheme and this will include assessment of the validity and accuracy of data.
Alternative services provided by primary care are unable to respond quickly enough to demand and having insufficient capacity.	Forecast take up will be robustly estimated to ensure capacity is available, and use of services will be monitored by Somerset Primary Care Link.
Inadequate clinical governance and accountability.	A clinical governance framework will be set up for each PBC scheme prior to implementation and these will be monitored as part of the performance management process.
There is insufficient take up of the schemes and patients do not choose to use the new services.	Use of the schemes will be monitored and where they do not meet their expected demand, procedures will be in place to enable the project to be reduced.
Difficulty in identifying savings from these schemes as other influences effect the results – e.g. general rise in emergency admissions, teenage pregnancy etc.	Performance management framework to allow for changes in base data to be removed from the results.
Instability for GPs and secondary care while the PBC plans are implemented	Effective project management process in place to ensure smooth implementation
Difficulty in finding potential providers	The procurement process of the PCT will be followed where required.
Insufficient time/resource allowed to embed the new ways of working	All schemes will be monitored over a sufficient period to assess whether the effect is as expected.
GPs do not take up the support provided and the standard of care does not rise	Engagement of GPs will be undertaken from the start to ensure they are aware of the support available.

IMPLEMENTATION PLANNING

The implementation of the commissioning plan will be dependent on joint working between the PCT and WH.C.

In order to successfully implement the Commissioning Plan, it is proposed to establish a number of joint WH.C and PCT project groups to take forward the individual elements of the Plan. These will need to be clinician led.

A similar approach was adopted in 2007/08, but the intention is to have dedicated WH.C and PCT resource available as commissioning/project managers to support the delivery of the commissioning plan *(to be confirmed).*

The implementation of the commissioning plan will require a phased approach and further discussion with the PCT.

	Needs significant work	**Needs quality assurance and challenge**	**Ready to submit to the PBC Approvals Committee**
Emergency Admissions	Community DVT Service	Falls Prevention (Tier 4) Terminally Ill (Tier 1) EMI patients in specialist residential care (Tier 1 initially)	COPD Enhanced Service (Tier 4)
Primary Care Mental Health Services	Will work with the PCT.		
Interface Services	Orthopaedics Headache Clinic	Gynae Interface Service ENT – Micro Suction Service Audiology service	PEARS Expanded Dermatology Interface Service including PDT
Diabetes	Generally will work with the PCT – but there may be opportunities to implement pilot schemes.		
Diagnostics	Awaiting results from the GP survey		
Public Health and Wellbeing		Young Persons Clinic (Tier 1) Dietetic Services – SIP Feeds (Tier 2) Community Dietetics Service (Tier 2)	Homeless People (Tier 1)

IMPLEMENTATION PLANNING (continued)

Key milestones (to be completed)

Area	Actions	Lead	Start Date	End Date	Output
Project management	Identify Board and clinical leader	PB	January	End of January	Clarity on role and responsibilities for commissioning proposal
	Confirm scope/benefits of the project – feasible and sustainable	PB	November	April	
	Link with PCT	PB	November	April	
	Identify management resources for the project	PB	November	December	
	Identify other key resources available	PB	November	January	
	Identify budget for project management	PB	November	November	
	Clarify ways of working – responsibilities/authority – meetings – time commitment – accountability reporting	PB	January	January	
	Monitor work plan	PB	November	April	
	Learning and development	PB	November	April	
	Produce final report at end of project including lessons learnt	PB	April	April	Presentation to Board – April 2008
Stakeholder management and communications	Undertake stakeholder analysis	PB	January	March	Communication Plan

IMPLEMENTATION PLANNING (continued)

There were some key stages that have not been completed for the 2008/09 plan due to resource constraints, they will be addressed in future commissioning plans.

Area	Actions	Lead	Start Date	End Date	Output
	Identify stakeholders and develop stakeholder engagement plan	PB	January	Ongoing	Communication Plan
Risk assessment	Initial risk assessment and on-going	PB	January	January	Risk Register
Needs assessment	Research best practice, previous work in Somerset	Public Health			
	Data analysis	Public Health			
	Review services and gap analysis	Public Health			
	Review national and local policies	PB	December	December	Needs Assessment
	Patient views	Patient involvement			
	Prepare needs assessment	Public Health			
Develop vision/strategy	Prepare for stakeholder workshop	PB	November	November	Locality Meetings planned
	Hold stakeholder workshop	PB	November	November	Locality Meeting held
	Draft strategies, options, priorities				
	Human resources strategy				
	Finance strategy	PB	November	April	
	Strategy endorsed by stakeholders	PB	April	April	
Develop commissioning proposal	Develop/validate options	WH.C Board			
	Draft outline commissioning proposal	PB	November	November	In this Commissioning Proposal

IMPLEMENTATION PLANNING (continued)

Area	Actions	Lead	Start Date	End Date	Output
	Outline commissioning proposal supported by stakeholders	PB	November	December	
	Strategy and outline commissioning proposals to PEC for endorsement	PB	January	January	Presentation to PEC 17 January 2008
	Develop service redesign plans	PB			
	Final commissioning proposal to PEC / Approvals Committee	PB	January	September	
Service specification	Organise development of service specification	TBC *			
	Identify and agree standards and benefits and outcomes	TBC			
	Clinical audit arrangements	TBC			
	Standards for Better Health Impact assessment	TBC			
	Equality impact assessment	TBC			
	Information requirements	TBC			
	Measurements and control	TBC			
	Specification approved	TBC			

* This will depend upon the specific commissioning proposal and the proposed procurement approach.

COMMUNICATIONS

The complexity of WH.C's goals and aspirations combined with the challenging environment in which it operates highlights the need for professional and consistent communications. The success of the commissioning plan will be determined largely by stakeholder engagement and by the process of delivery. It is important to effectively engage with our partner organisations including the PCT and the Foundations Trusts.

The impact of announcements about service redesign and the ramifications for patients, service users, staff and for the PCT's wider partnerships in the community should not be under-estimated. This will need to be carefully managed.

WH.C acknowledges the need to improve consultation processes with all stakeholders to seek their engagement.

WH.C will continue to ensure that our messages are concise, accessible and transparent.

WH.C will continue to use the most effective methods of communication at our disposal – the WH.C and PCT websites and intranet; WH.C locality meetings, LMC meetings and Practice Manager locality meetings.

WH.C's newsletter, as well as other WH.C and PCT systems, will be utilised to transmit messages to GPs and community partners in a timely and effective manner.

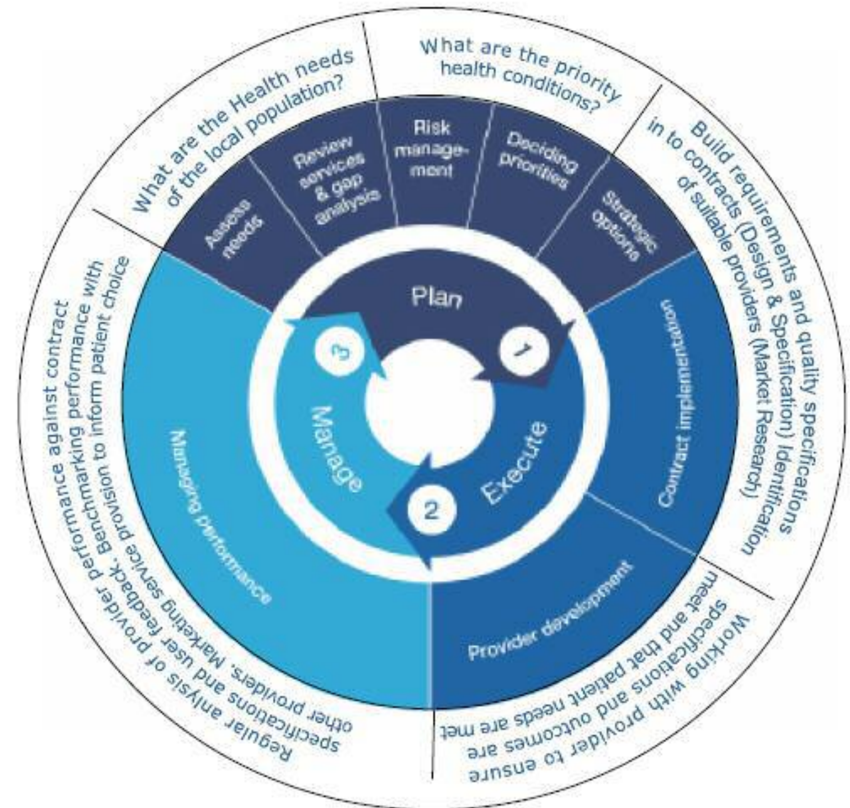
PLANNING 2009/10 AND BEYOND

Using the World Class Commissioning (WCC) model, WH.C will need to work closely with the PCT Directorates and other stakeholders to inform the planning for 2009/10 and onwards.

Part of this process will be building on the relationship between the WH.C and the PCT which has developed and summarised in Appendix 4 and takes account of the 11 competencies identified for WCC.

WCC is recognised by the Department of Health (DH) as the approach to achieve the objective of ‘add life to years and years to life’ and it is recognised that PBC is at the core of this process. Where PBC will be expected to focus on:

- Assessing local needs
- Helping decide priorities
- Helping change outcomes
- Designing care
- Developing future services
- Giving feedback on provider performance



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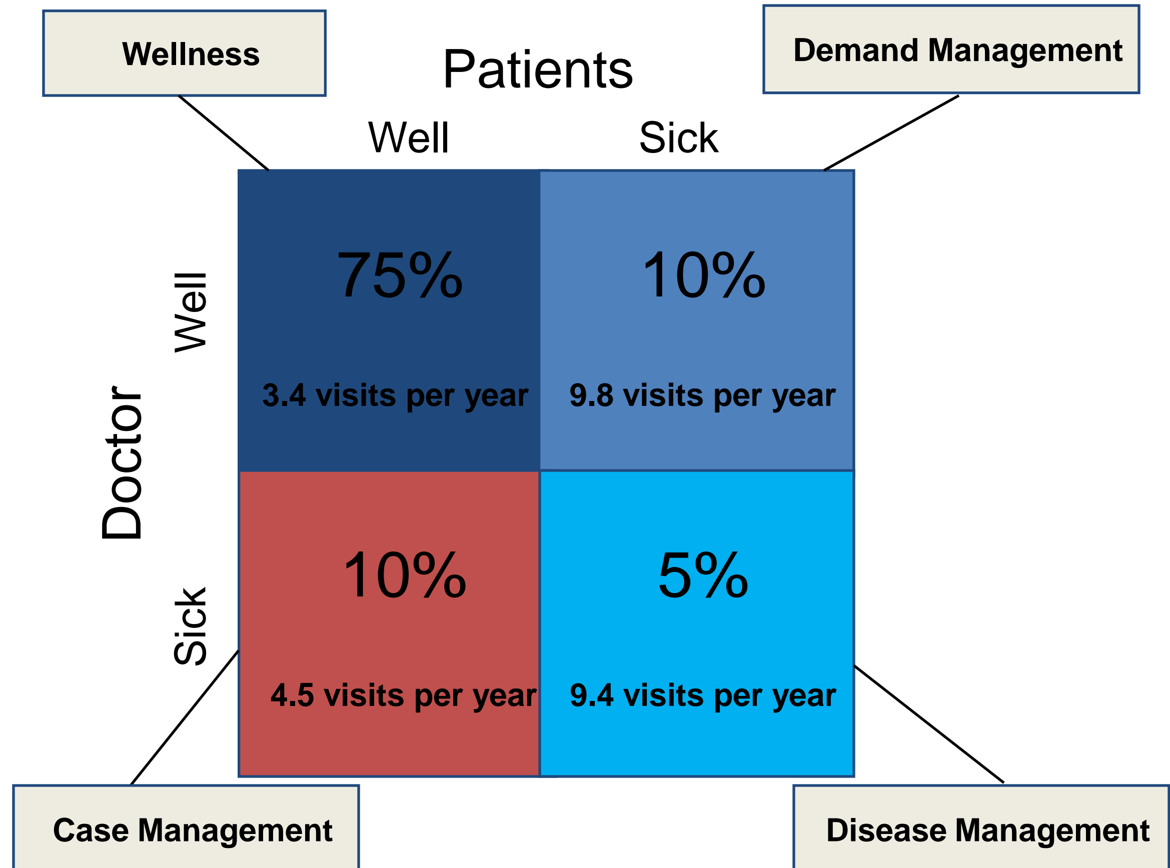
PLANNING 2009/10 AND BEYOND (continued)

There will be a need for greater engagement with patients and the public using practice based 'Patient Participation Groups' and Local Involvement Networks (LINks). To date a wide range of approaches have been adopted by the PCT to ensure that there is proper patient engagement, but there is recognition that there is more to do in this area. WH.C and its member practices are in a very strong position to engage with practice and locality populations. More work will need to be done in this area.

The Wellness Grid demonstrates the importance of the health and well-being agenda. Although the percentages below are indicative it is clear that any shift in population from the "well/well" proportion of the grid, (this is patients who are considered well by both the health system and the patient themselves), to any other section of the grid will have a cost implication for WH.C. This will need further consideration as future commissioning plans are developed.



PLANNING 2009/10 AND BEYOND (continued)

DH guidance issued in December 2007 – 'Using NHS Funding Flexibly', potentially allows WH.C within a framework defined by the PCT to spend funding on a locally agreed menu which could include:

- Supporting healthy lifestyles
- Provision of Citizens Advice, other advocacy, parenting, benefits, debt and return to work advisor sessions at practices
- Developing social and practical support for isolated older people
- Developing multi-disciplinary mental health resources in community settings
- Purchasing of programmes to promote positive parenting and improve the social and emotional development of children
- Support to parents
- Supporting greater independence for people with long-term conditions
- Purchase of respite care
- Crisis avoidance and intervention
- Supporting people who are approaching the end of their lives.

For 2009/10 to 2010/11 there is an opportunity to improve commissioning arrangements by giving proper consideration to the issues that require attention in Somerset which will deliver the objectives of practice based commissioning.

This could include:

- Further emergency admission schemes – the commissioning plan for 2007/08 highlighted some potential future schemes including possibly commissioning additional CATUs; examining the possibility of reviewing care pathways and building on the integrated COPD service to impact on admissions for lower respiratory tract infection (without COPD) and community acquired pneumonia; management of heart failure
- End of life care – Somerset is part of the Delivering Choice Programme for 2008/09 to 2010/11 and WH.C should be involved in this including considering commissioning services which allow more patients to die at home if that is their desire.
- Wellness and public health agendas including alcohol misuse; physical exercise and promoting healthy eating
- Development of a rheumatology interface service – this will consider the opportunities to develop community based rheumatology services for patients in Somerset.

Further work on this will be undertaken in an initial workshop planned for March 2008 being organised jointly with the PCT and the Improvement Foundation.

APPENDICES

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APPENDIX 1

Needs Assessment

Somerset is relatively affluent compared to other parts of the country. However there are pockets of deprivation within both urban and rural areas. The links between deprivation and poor health are inescapable and inequalities in health are one area that needs addressing on an ongoing basis.

From a health and wellbeing perspective the headline facts about Somerset's population are:

- 22% of people take part in at least three physical activity sessions per week, compared to the national average of 21%
- The level of hazardous and harmful drinking is 15% for women and 28% for men
- Children aged 2 to 19 years, 24.9% of boys and 29.9% of girls are overweight and a further 6.8% respectively are obese.

The population of Somerset is ageing along with the rest of the country; however Somerset has an older population than average.

The number of black and ethnic minorities has been increasing in recent years, although it is still low compared with other parts of the country. Transient populations are traditionally hard to reach and may pose particular problems in terms of providing equitable, accessible public health services.

Overall the health status of the population is good with life expectancy at birth in 2003-2005 being higher than the average for England: 78.2 (men) and 82.3 (women). However there are differences in life expectancy between those who live in the most deprived fifth areas and those who live in the lease deprived fifth of areas. Men in the least deprived area were living almost five years longer and women three and a quarter years longer.

Premature deaths from heart disease, stroke and cancer are generally low compared to the national average and are falling.

APPENDIX 1 (continued)

Needs Assessment

The ten areas where it has been identified that there is a need to make further progress are:

- Tackling health inequalities
- Reducing the numbers of people who smoke
- Tackling obesity
- Improving sexual health
- Improving mental health and wellbeing
- Reducing deaths from suicide
- Reducing harm from alcohol and encouraging sensible drinking
- Working with partners to reduce deaths from traffic accidents
- Improving children's dental health
- Reducing falls in older people.

These needs specific to Somerset were developed from the Choosing Health priorities as identified by Department of Health report in 2004.

- Reducing the number of people who smoke
- Reducing obesity and improving diet and nutrition
- Increasing exercise
- Encouraging and supporting sensible drinking
- Improving sexual health
- Improving mental health.

The overall strategic objectives for Somerset PCT are:

- Improving cleanliness and reducing healthcare-associated infections
- Improving access through achieving 18-week referral to treatment and better access to GP and primary care services
- Keeping people well, improving overall health and reducing health inequalities
- Ensuring we improve the patient experience, staff satisfaction and engagement
- Not being found wanting in our preparations to respond to emergencies such as an outbreak of pandemic flu.

APPENDIX 1 (continued)

Needs Assessment

Locally South West SHA has identified that the NHS needs to make progress against the following targets:

- 18 week waiting time from referral to treatment
  - Moving towards eight weeks
- Unscheduled care
  - Moving towards maximum two how wait in accident and emergency
  - Eliminating ambulance delays
- Public Health
  - Additional investment of 0.15% in 2008/09
- Responsiveness to Primary Care

APPENDIX 2

Approach to Plan Development

The development of this plan has been split into two phases.

Phase 1

This stage commenced in November and continues until the end of January. By the end of phase 1 a draft commissioning plan will be available in draft form. This will include a list of the projects to form part of the PBC activity in 2008/09 and some detailed information behind the needs and assessment of the projects.

- November 2007 - Briefing on the Annual Public Health report 2006/07 to the Board of WH.C
- November 2007 – Development of a process to evaluate PBC proposals
- November 2007 – Process shared with practices at Locality meetings
- 19 November 2007 – template issued for practices to complete
- 14 December 2007 – 50 outline proposals received from approximately 25 practices
- 19 December 2007 – WH.C Board assessed the proposals using an approach developed by the NHS Institute for Innovation and Improvement
- January 2008 – Work programme in place to develop proposals with PCT, GPs and external support from PricewaterhouseCoopers LLP
- 17 January 2008 – Presentation to PEC
- 23 January 2008 – WH.C Board to review draft Plan
- 31 January 2008 – Draft Commissioning Plan submitted to PCT.

APPENDIX 2 (continued)

Approach to Plan Development

Phase 2

This stage will build upon the plan already developed to include more detailed business proposals for each scheme. It will run during February and March 2008 with a final Somerset Practice Based Commissioning Consortia Commissioning Plan 2008/09 being presented to the PCT towards the end of March for approval.

- Detailed costing and savings plans for each scheme will be developed
- Comprehensive risk analysis performed for each scheme
- Complete implementation planning process to ensure that all schemes are ready to start preparation at the start of 2008/09 or as soon as they are approved by the PCT
- Communicate with all stakeholders and ensure that they are engaged and suitable management of stakeholders is in place

- WH.C Board review
- February 2008 – Presentation to PEC
- March 2008 – Submitted to PCT Approvals Committee
- March 2008 – Final approval of the plan.

APPENDIX 3

Critical Success Factors

To determine whether WH.C is making a difference the following have been identified as measures that will identify whether the organisation is being successful.

The Somerset population:

- Have improved quality of life, health and well-being and are enabled to be more independent.
- Are supported and enabled to self care and have active involvement in decisions about their care and support
- Have choice and control over their care and support so that services are built around the needs of individuals and carers
- Can design their care around health and social care services which are integrated, flexible, proactive and responsive to individual needs
- Are offered health and social care services which are high quality, efficient and sustainable.

WH.C are engaged in:

- The join-up at strategic level – e.g. Joint Strategic Partnerships, Joint Commissioning Boards, Joint Strategic Needs Assessments and Local Area Agreements
- Joint planning and shared goals based on outcomes. Multidisciplinary team working is common practice.

WH.C have in place systems and processes to ensure:

- Public and patient engagement at practice/locality level
- GP practice engagement
- Project management including risk management and performance management
- Robust management information.

APPENDIX 4

Somerset PCT and WyvernHealth.Com Commissioning Competencies

Commissioning Competencies	PCT	WH.C
Locally lead the NHS	Recognised as the local leader of the NHS	Support the PCT in identifying future priorities for the local NHS
Work with community partners	Lead on partnership agreements / arrangements	Engage with the PCT to ensure effective collaborative working
Engage with public and patients	Proactively seeking out views and experience of the public, patients, their carers and other stakeholders	Ideally placed to obtain patient and user views on services from primary care perspective
Collaborate with clinicians	Supports and ensures the involvement of clinicians in strategic planning and service design, commissioned services build on the current evidence base, maximise local care pathways and utilise resources effectively	Key methodology to drive innovative and transformational change
Manage knowledge and assess needs	Lead on the management of knowledge to inform needs assessment, service redesign and market development	Provide knowledge and evidence to support commissioning decisions
Prioritise investment	Set strategic priorities which are focussed on the achievement of key clinical and health and community outcomes	Provide clinical input to determining the priorities and monitors strategic health outcomes

APPENDIX 4 (continued)

Somerset PCT and WyvernHealth.Com Commissioning Competencies

Commissioning Competencies	PCT	WH.C
Stimulate the market	Develop the commissioning strategy and develop formal and informal relationships with existing and potential providers	WH.C to establish and develop formal and informal relationships with existing and potential providers
Promote improvement and innovation	Driver for continuously improving the NHS	Support development of specifications focused on quality and outcomes
Secure procurement skills	PCT lead	Support PCT to ensure that procurement plans are consistent with wider local commissioning priorities
Manage the local health system	PCT lead performance management of the local providers	Provides evidence to support PCT in constructive performance discussions with providers. Work with the PCT in defining the 'Vital Signs' which the health system will be performance managed against.
Make sound financial investments	PCT lead to ensure that their commissioning decisions are sustainable and provide a sound investment to secure improved health outcomes for both now and the future.	Provide guidance on PBC indicative budgets and provide financial information on the commissioning proposal.

ANNEX