Wiltshire Clinical Commissioning Group

Clinical Commissioning Group
Governing Body
Paper Summary Sheet
Date of Meeting: 28 May 2013

For: Decision ☐ **Discussion** ☒ **Noting**

Agenda Item and title:	**GOV/13/05/14 Quarter Four report on:** • **The NEW group operational plan outcomes 2012-13** **PbC and secondary care local enhanced services outcomes for 2012-13**
Author:	Section 1: Maddy Ferrari, Associate Director of Commissioning. Section 2: Elaine Smith, Practice Manager, New Court Surgery, Wootton Bassett With support from Dr Simon Burrell, NEW Executive Chair
Lead Director/GP from CCG:	Ted Wilson, New Group Director
Executive summary:	The report is divided into two sections Section 1: describes how the PBC LES and secondary care LES has been utilised and spent. Section 2: describes the key NEW group operational plan and outcomes for 2012-13.
Evidence in support of arguments:	Executive meetings: agenda and minutes Finance, Information and Quality Group meetings: agenda and minutes STARR activity and outcome data
Who has been involved/contributed:	Dr Simon Burrell, on behalf of the New Clinical Executive
Cross Reference to Strategic Objectives:	• Deliver improvements in the 10 principal health outcome indicators for Wiltshire • Contribute to community well-being by creating a sustainable healthcare system in terms of the models of care • Provide access to health services in line with best performance in England • Deliver all key NHS and LA health targets • Deliver financial balance and move to financial surplus to allow flexibility for innovation and development.
Engagement and Involvement:	There was been no public engagement in relation to the operational plan or local enhanced services, however the priority areas were generated by regular stakeholder assemblies.

Communications Issues:	Nil to date The issues are not confidential or exempt from FOI
Financial Implications:	None for 2012-13. Some schemes will be continued, as part of, QIPP into 2013-14
Review arrangements:	The operating plan has been reviewed via the NEW finance, information and quality executive (held monthly).
Risk Management:	Risks have been managed in year.
National Policy/ Legislation:	There are no legal implications
Equality & Diversity:	No adverse impact identified
Other External Assessment:	None
Next steps:	The Service Level Agreements for 2013-14 are currently under development, building on the outcomes of the 2012-13 Local Enhanced Services The operating plan priorities are being refreshed for 2013-14 building on the actions taken in 2012-13

Section 1

QUARTER FOUR REPORT ON THE NEW GROUP OPERATIONAL PLAN 2012/13

NEW group agreed a range of strategic priorities that became the basis of their work plan for 2012-13. Those priorities have included development of an executive team working closely with practices, enabling practices to take an increasing part in the commissioning of all care, improving commissioning links with secondary care providers, helping practices respond to increasing demands put on them to deliver increasing care outside hospital and developing numerous specific strands of clinical change.

Some of these developments are reviewed below:

1. Primary Care Development

- All practices in the NEW area have been involved in making changes to support better commissioning and specific strands of primary care development.
- Practice engagement via monthly North and East locality meetings.
- Two successful clinical fora were attended by a majority of NEW GPs. The first included detailed discussions about improved use of ambulatory care, a primary care based orthopaedic service, improved support from community based elderly care consultants, better support to care homes and improved end of life planning. The plans from these have been subsequently implemented in all practices.
- The second concentrated on developing dementia care and planning changes in community care as detailed below. ? 13-14?
- Specific clinical developments have been taking place in a range of areas including orthopaedic care, cardiac care, dermatology.
- Urgent care response has been improved by practices making better use of ambulatory care to provide diagnostic support, responding to urgent calls from ambulance services, using the STARR scheme alternatives to admission, improving care planning for care home residents and working with 'access to care' to try and reduce hospital stay lengths.
- NEW have established a system of 'grumpy and pleased' emails. This provides GP's with a simple route for reporting concerns or achievement in relation to health care providers. The majority of the emails received relate to:
    - The timeliness and quality of discharge summaries
    - Prescribing, and specifically secondary care providers failing to fulfil medication requests or prescribing inappropriately
    - Follow up on tests and procedures that GP's have requested
    - Concerns relating to AWP
- This feedback has enabled patient experience to be reported back to the commissioning process by front line clinicians. The opportunity for secondary care to also use the

system has been given to GWH to help remove snags in the communication processes both ways between primary and secondary care.

- We continue to work with the quality team, our contracting and commissioning managers and secondary care providers to manage and resolve the issues raised.

2. Community Care

- GP practices have been developing a broader range of areas of effect by doing more in a community related setting. Efforts are being made to improve coordination of working between GP surgeries and community staff.
- The Chair of the NEW Executive is also chair of the Community Transformation Programme Governing body.
- Building relationships with local care homes e.g providing care home residents with a leaflet outlining the services that the practices can provide.
- Community Geriatrician: NEW have established with RUH an arrangement to provide community based urgent and planned Geriatrician support as well as telephone and secure email advice and guidance on individual patients. A similar pattern is partly in place from GWH and plans to cover the whole area are in place.
- Development of Primary Care Link Workers has been slower than planned but is about to be implemented to enable better links between all those who support vulnerable people.
- A full review of community is under way across the whole of Wiltshire. The review is being considered by practices across 6 main strands of care namely:
    - Development of primary care based neighbourhood teams.
    - Improved links with social care and voluntary agencies
    - Improved use of bed based care in the community
    - Improved community diagnostics.
    - Development of access to care.
    - Review of specialist support to community care

3. Information

- The NEW executive has reached agreement on the format of ‘practice packs’ that will assist practices to monitor their performance in relation to other practices in NEW, Wiltshire as a whole and where available to benchmark against national referrals and activity levels.
- The development of monthly finance, information and quality executive meetings at which the executive receive and review reports from commissioning colleagues.

- The change from information provision from PCT to CSU has created some different boundary issues.
- All practices regularly review referrals and use of acute aspects of secondary care by their populations.

4. Organisational Development

Formal elections with LMC support were held during the year to move from a shadow GP board to a fully endorsed status. 7 GPs from local practices were elected; they work closely with the NEW executive team and are active executive members rather than non-executive. A number of other GPs are also involved in commissioning work as are a number of committed practice managers.

The Executive has allocated areas of particular concern a lead Exec GP as follows

Executive Member	Area of responsibility
Jonathan Rayner	GWH
Richard Hook	Mental Health
Anna Collings	Urgent Care
John Pettit	Independent sector/other contracts
Andrew Girdher	RUH
Nick Brown	Community/Diagnostics
Simon Burrell	Community/Elderly and EOL/ Chairman.

This group regularly attends a range of clinical engagement meeting with senior clinicians from a range of providers.

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- A practice manager is a member of the NEW executive to ensure that the needs and aspiration of practices are met.
- Two GPs from the group sit on the Wiltshire CCG board.
- Commissioning with GWH is now being carried out independently of Swindon CCG although links with Swindon CCG are anticipated where there is mutual benefit and have been formalised through a Memorandum of Understanding.
- Clinical links with GWH have been developed with discussions about dermatology, orthopaedics, ophthalmology and ambulatory care recently held.
- NEW is leading on commissioning of community health care with GWH on behalf of Wiltshire CCG..
- An Executive GP from north Wiltshire has supported WWYKD to develop its relationship with BaNES CC and to support performance management of RUH.
- Recruitment to the commissioning team has been going on through the year which has been marked by significant changes in the executive team. NEW aim to have a full team in place by 30th September

5. Mental Health Care

- A NEW Executive GP chairs both the mental health specialist placements panel and the Avon and Wiltshire Partnership performance meeting on behalf of all Wiltshire GP's.
- NEW have supported the development of the Primary Care Liaison Service and considerable improvement has been seen in mental health links with primary care.

6. Dementia Care

- NEW has been identified as the lead group for dementia and is working with the project lead to establish the 2013-14 Dementia assessment in Primary care SLA.
- NEW have worked with Alzheimer's Disease support groups in order to scope new ways of working.
- Primary care practices are now all signed up to providing memory assessments and dementia treatment.
- Work has gone on to improve links with voluntary organisations providing support for patients with dementia.

7. Urgent Care

- NEW clinical leads have developed links with senior clinicians in ED and ambulatory care at GWH in order to scope out new ways of working in relation to urgent and emergency care.
- A NEW executive GP has worked with BaNES and the Bath urgent care network to take forward initiatives for people in North and West Wiltshire.
- The practices have used LES monies to work with individuals who frequently attend and or have one or more long term conditions in an effort to reduce inappropriate use of secondary care.
- Practices have worked with the ambulance service to provide alternatives to immediate transfer to A&E.
- Table 1 below shows the ED attendance numbers for 2011/12 and 2012/13. Table 1a shows NEW activity in relation to the other group areas.
- An important feature of urgent care is the length of stay for those who require admission to hospital. Table 2

Table 1

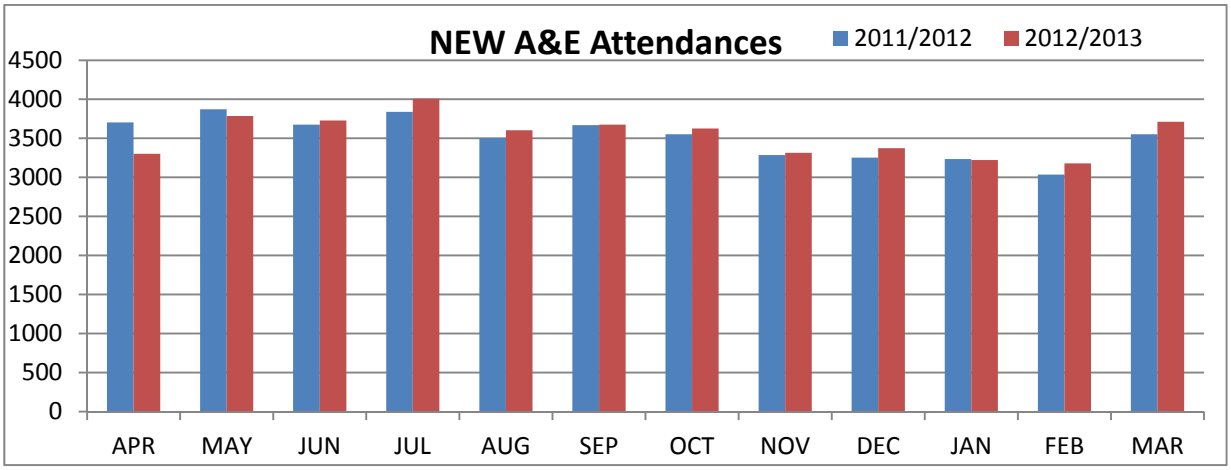


Table 1a

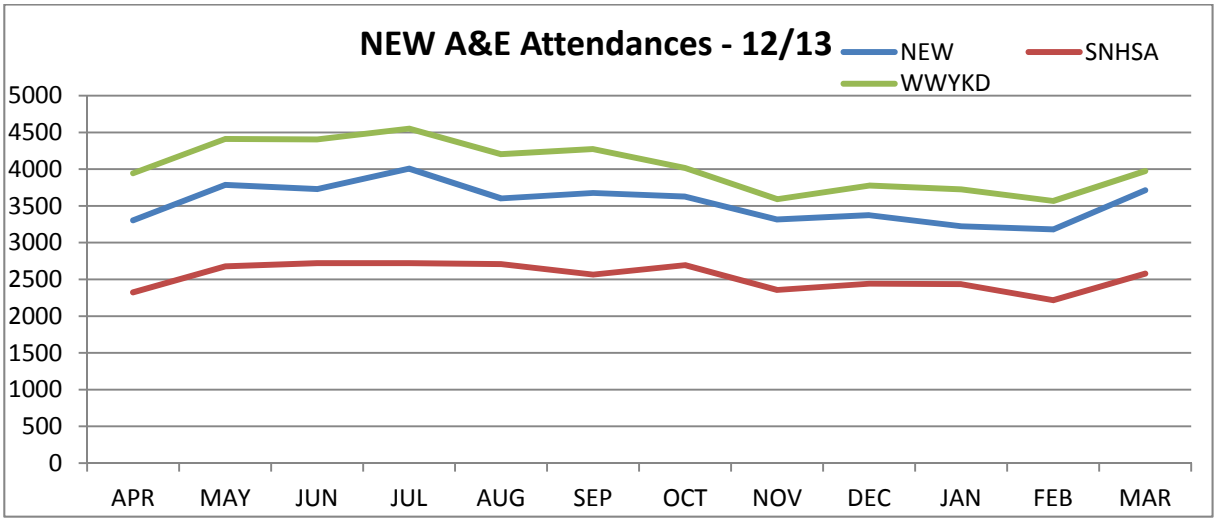
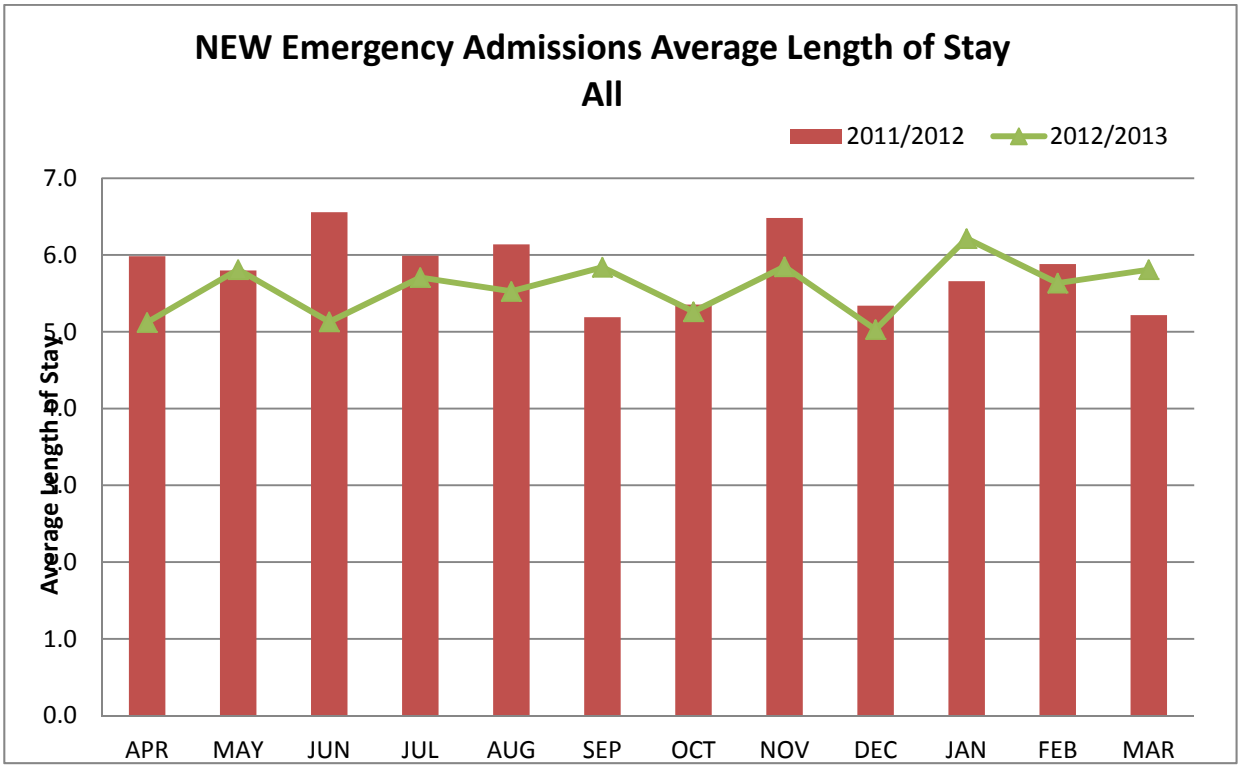


Table 2



8. Long Term Conditions

- NEW have worked with GWHFT to provide a Community Oxygen Assessment Service at 20 practices in North-East Wiltshire. An oxygen assessment service is already available in other areas of Wiltshire. The project is a six month pilot starting from 1st March 2013, with the potential to roll out if successful. All new oxygen assessment requests for chronic lung disease will be performed by the team. We will also be targeting patients on the Oxygen Register to assess for appropriate use and perform reviews and safety assessments.

- Cardiac Care: NEW have led on the development of a 24 hour ECG service in Primary care. This is a pan-Wiltshire initiative which will be implemented in 2013-14.

- The NEW commissioning team have led on the management and re-provision of neuro-rehabilitation services provided by RNHRD, Bath until 31st March 2013. They have worked with Specialist Commissioning group colleagues and the Wiltshire CCG quality team.

- NEW practices in general have good results for managing long term conditions as seen in QOF figures for care of Diabetes, Respiratory disease, Ischaemic heart disease, Epilepsy and other debilitating conditions. Tables 3 and 4 show the first out-patient attendances for Diabetes (3) and Cardiology (4). Tables 3a and 4a show NEW weighted activity in relation to the other two groups.

Table 3

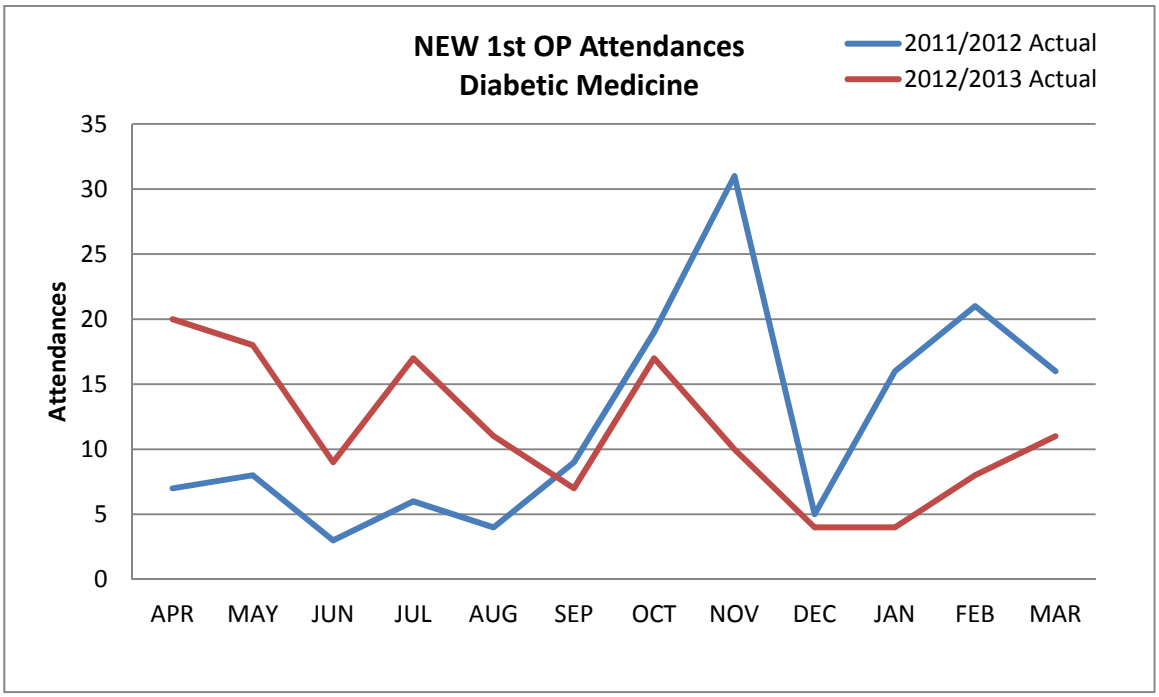


Table 3a

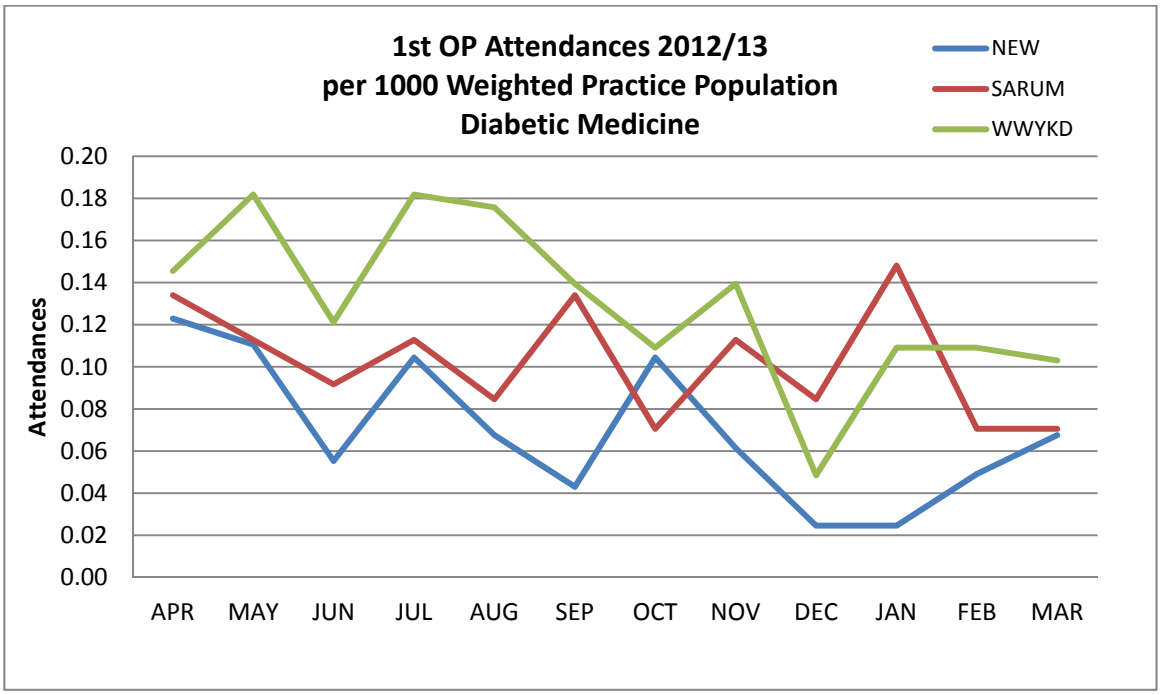


Table 4

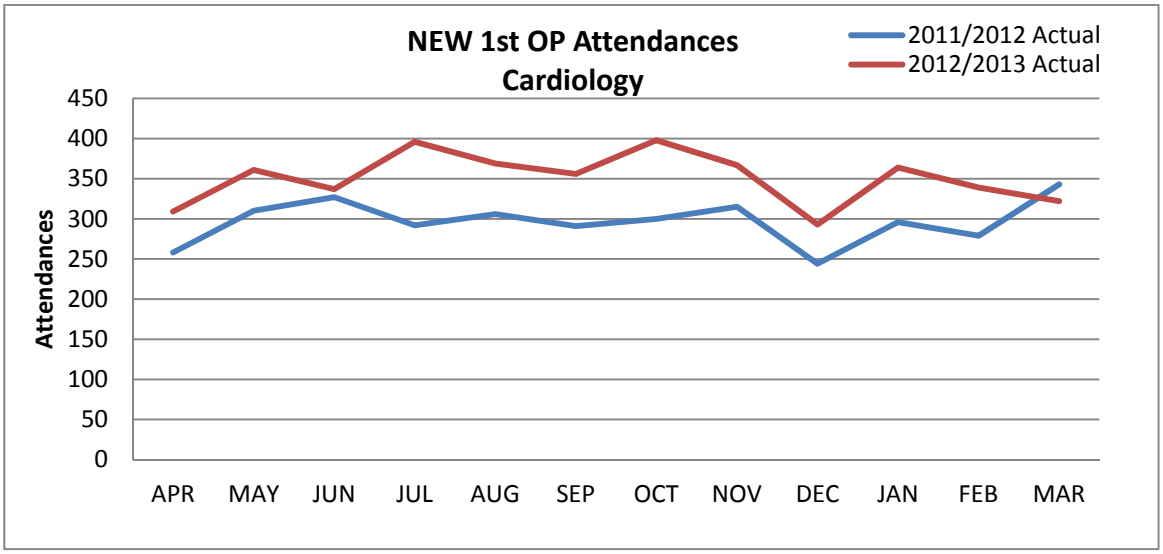
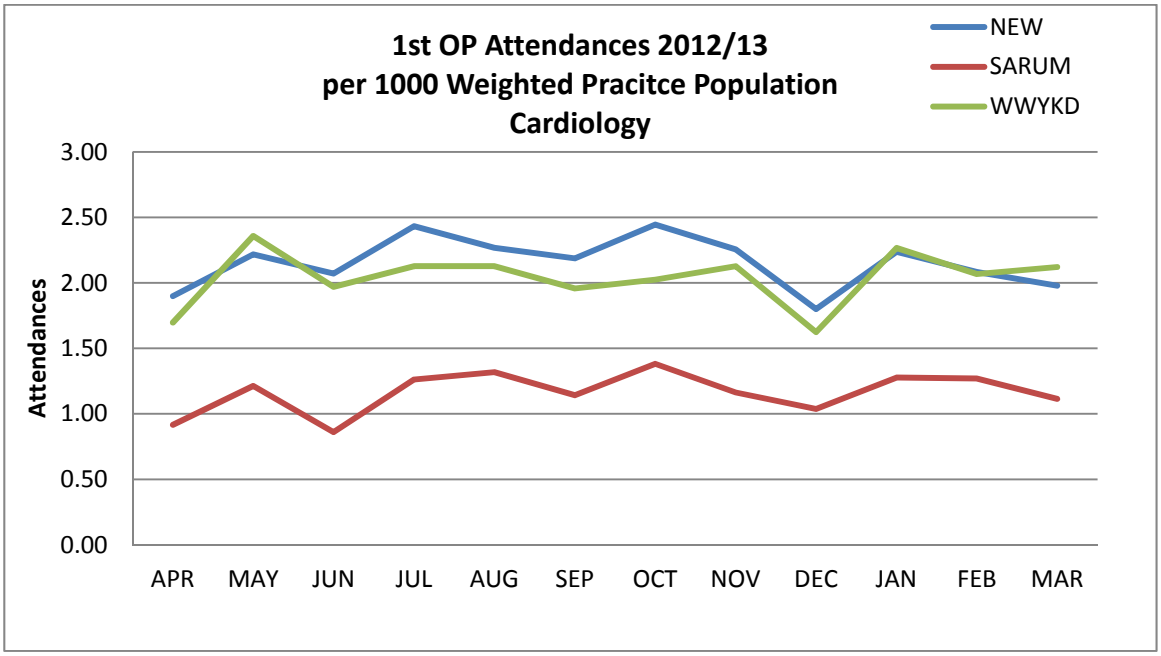


Table 4a



9. Musculo-Skeletal Care

In September 2013, and in support of reducing inappropriate referrals to secondary care orthopaedic services, NEW led a contract variation with an attached investment of £86,400. The contract variation for Wiltshire wide out-patients Physiotherapy services was based on:

- Achieving waiting times of 2 weeks for urgent and 4 weeks for non-urgent referrals.
- The service establishment being fully recruited and waiting times sustained once the initiative is complete.

- Baseline numbers and a tolerance level of 10% of current referral levels per week was negotiated, up to which we would expect the waiting times to continue to be achieved once the initiative is completed.

- Urgent & non urgent criteria was agreed prior to this waiting list initiative being established.

Unfortunately the scheme did not start until later than planned, however the resource allocated is now being utilised in the current year, 25% of the funding remains (as of end April 2013).

Reporting data (Table 5) shows an overall decrease in waiting times and although the two week target is being met, there has been a slight increase in urgent referral waiting times.

Table 5

Average Waits	Pre-Investment	Post-Investment
Routine	8.93	6.17
Urgent	1.67	1.69

Interestingly there a has been a change in percentage of urgent v's routine referrals (Table 6), potentially as a result of new criteria being established.

Table 6

Urgent / Routine Split	Pre-Investment	Post-Investment
Routine	60.37%	51.26%
Urgent	39.63%	48.74%

Table 7 shows overall waiting times for all referrals to community out-patient Physiotherapy

All Referrals	Pre-Investment	Post-Investment
Less than 2 Weeks	36.16%	42.24%
Less than 4 Weeks	50.50%	64.55%
Less than 6 Weeks	56.75%	73.29%
Less than 8 Weeks	63.04%	81.02%
Less than 10 Weeks	71.86%	88.24%
Less than 18 Weeks	97.56%	99.88%

Hip and Knee referrals

Secondary care referrals of hip and knee cases have included an assessment of their problems before referral to enable better response by secondary care. Plans are being finalised for an assessment process in primary care by an orthopaedic consultant to provide a rapid orthopaedic opinion for cases where an operation may or may not be appropriate. Tables 8 and 8 a show the knee activity levels for 2011-12 and 2012-13. Table 9 shows the same for hips

Table 8

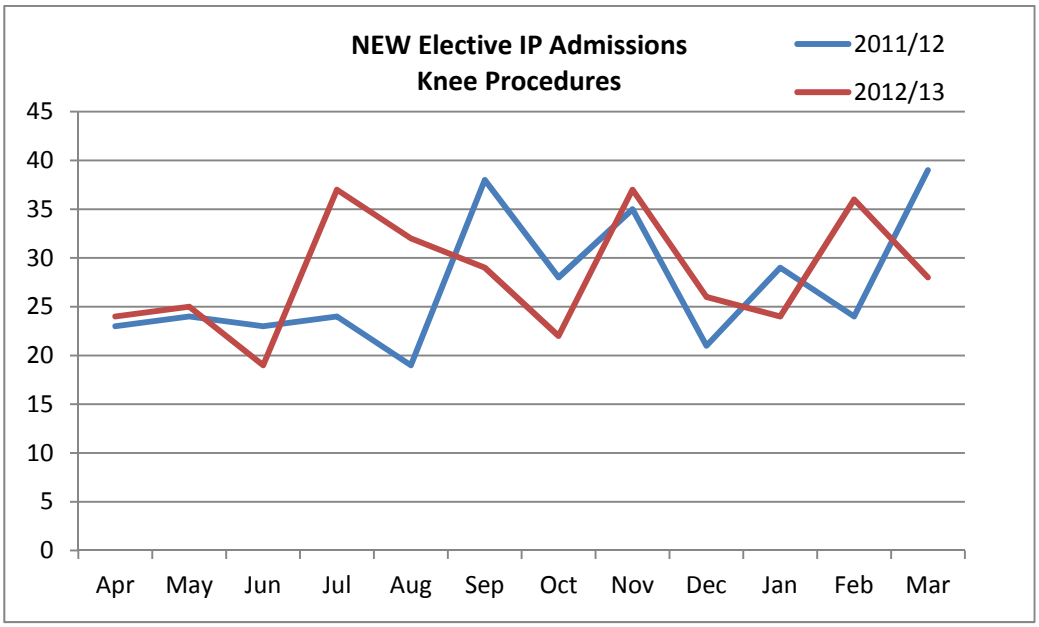


Table 8a

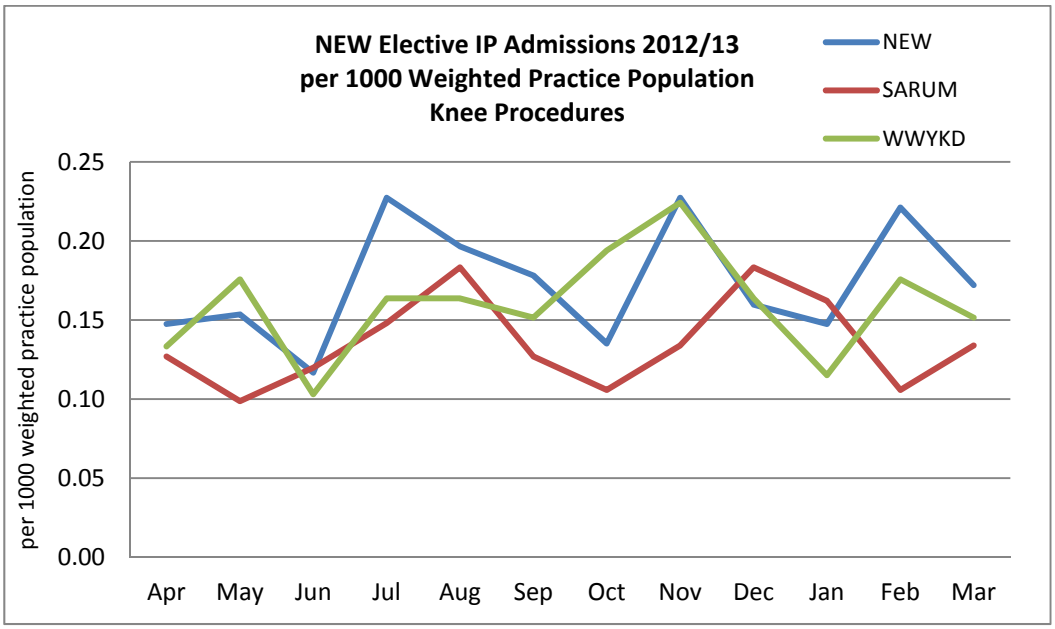


Table 9

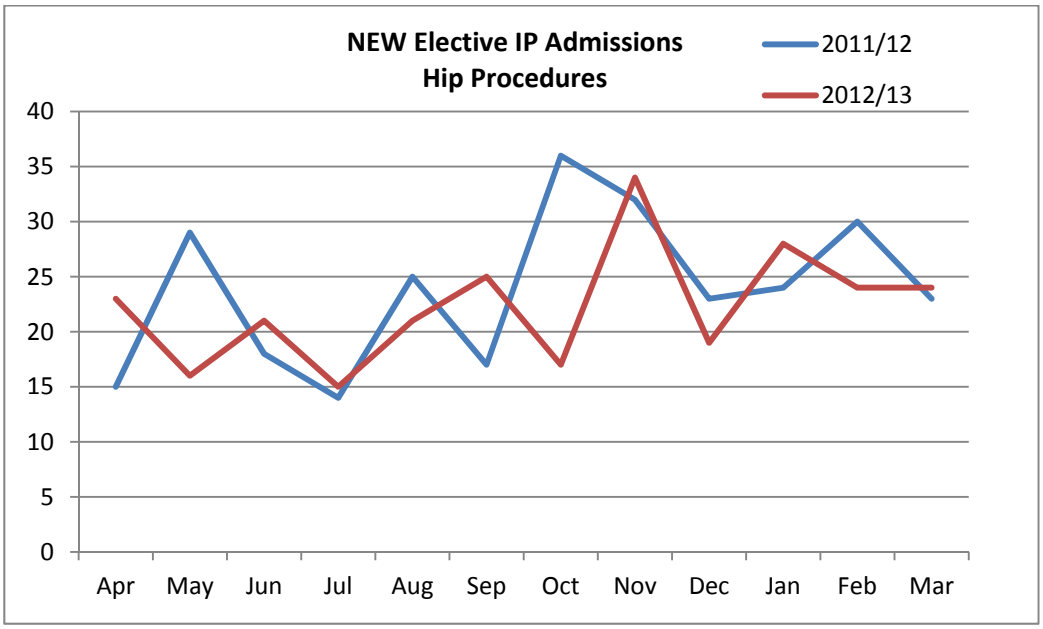
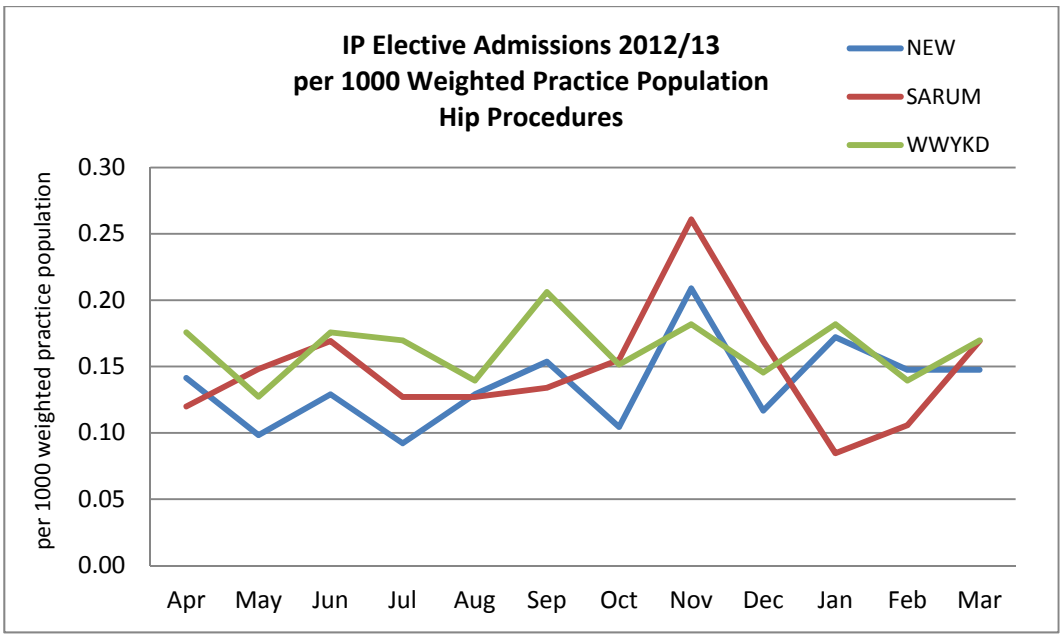


Table 9a



Operational Plan - Trust wide but led by NEW)

Work stream – Unplanned care and Long-term Conditions.

The further development of a re-ablement and post-discharge support service to prevent admissions to hospital and care homes, facilitate early discharge from hospital and support the independence of older people.

Desired outcome: reduce DToC's and length of stay and re-admissions.

The STARR scheme was implemented in August 2012 to provide reabling post discharge and admissions avoidance support. This step-up (from community/own home) and step-down (from acute or community hospital) care is now available in care homes across Wiltshire.

The figures below are the numbers of STARR patients from August 2012 to March 13. who were admitted to STARR before April and have completed their placement.

Step Down – a total of 112 people 61% of whom returned to their own home.

Step Up – a total of 230, 57% of whom returned to their own home.

A full report (based on documentation shared at the STARR evaluation session on 1st May) is available on request.

Outcomes

Patient centred: Of the 181 individuals that had been discharged from the beds as of 31st March 2013, 74% of step-down and 63% of step-up patients went home from the STARR bed.

Average length of acute hospital stay: there has been no material change in the length of stay for any of the acute providers.

Number of re-admissions to acute care: unfortunately data collected for re-admission does not allow us to see any in-year changes.

Permanent Care home Admissions: see table 10 below, which appears to show a slightly decreasing trend in the number of people entering care homes.

Delayed transfers of care: see table 11 below. The STARR beds do appear to have a positive impact on the numbers of DToC's, however levels have now plateaued at just below 40, so remain a high risk for the CCG.

Emergency admissions to acute care: The STARR beds do not appear to have impacted on the number of emergency admissions, however the number of step-up admissions to STARR beds are tiny in relation to the actual number of emergency admissions (also shown on table 11)

Table 10

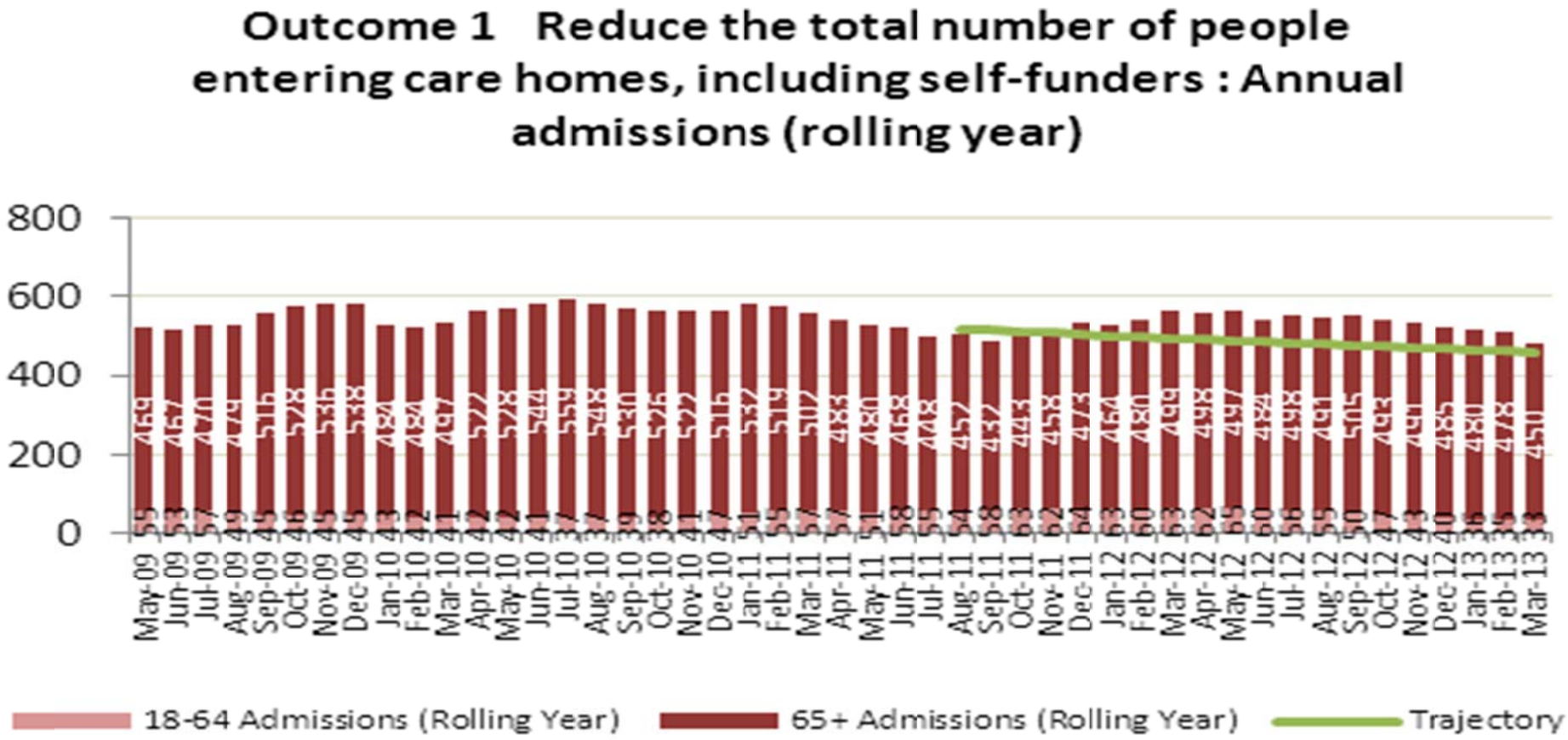
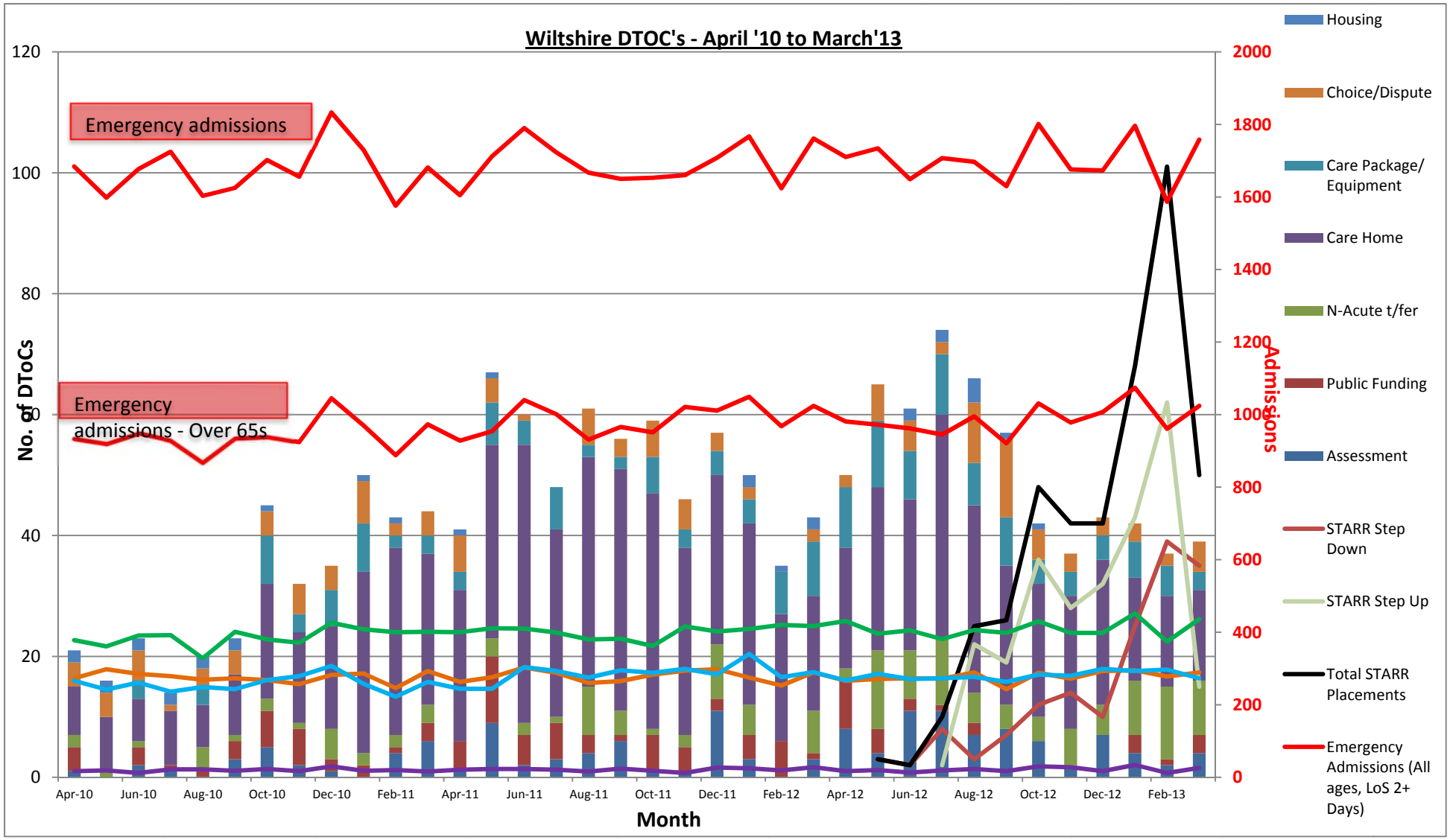

Outcome 1 Reduce the total number of people entering care homes, including self-funders : Annual admissions (rolling year)
800
600
400
200
0
May-09 Jun-09 Jul-09 Aug-09 Sep-09 Oct-09 Nov-09 Dec-09 Jan-10 Feb-10 Mar-10 Apr-10 May-10 Jun-10 Jul-10 Aug-10 Sep-10 Oct-10 Nov-10 Dec-10 Jan-11 Feb-11 Mar-11 Apr-11 May-11 Jun-11 Jul-11 Aug-11 Sep-11 Oct-11 Nov-11 Dec-11 Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13 Feb-13 Mar-13
18-64 Admissions (Rolling Year)
65+ Admissions (Rolling Year)
Trajectory

Table 11


Wiltshire DTOC's - April '10 to March'13
Emergency admissions
Emergency admissions - Over 65s
No. of DToCs
Admissions
Month
0
20
40
60
80
100
120
0
200
400
600
800
1000
1200
1400
1600
1800
2000
Apr-10
Jun-10
Aug-10
Oct-10
Dec-10
Feb-11
Apr-11
Jun-11
Aug-11
Oct-11
Dec-11
Feb-12
Apr-12
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
Housing
Choice/Dispute
Care Package/ Equipment
Care Home
N-Acute t/fer
Public Funding
Assessment
STARR Step Down
STARR Step Up
Total STARR Placements
Emergency Admissions (All ages, LoS 2+ Days)

Section 2

NEW PRACTICE LEVEL REVIEW – SUMMARY OF PBS AND SECONDARY CARE LES EXPENDITURE/INVESTMENT 2012/13

Secondary Care LES
PBC LES
QP 8, 11 and 14

1. Secondary Care LES

The principle behind the secondary care LES is that it is a payment to be earned in two halves, with the intention of increasing appropriate management of patients in the community, concurrently reducing referrals to secondary care. Part of the payment would reflect the extent to which this desired impact was achieved. The payments are intended to support practices and enable them to deliver the health care objectives out-lined above. Thus:

- Half (£2 per person on the practice registered list) paid at the start of the year based on the commitment of practices to complete an agreed list of actions.

- Second half (£2.01 per person on the practice registered list) paid at the end of the year. This payment on a sliding scale, i.e. if the anticipated change in secondary care activity to be achieved as a consequence of implementing the agreed list of actions, was not fully achieved.

Activities North Wilts practices committed to, and have completed, the following actions, with the intention of increasing appropriate management of patients in the community, concurrently reducing referrals to secondary care:

- On-going in-practice review of referrals and activity budget information, and RSS referral information
- Quality of patient information in referrals
- Practice to sign off locum referrals prior to sending
- Telephone access for paramedics and/or consultants to speak to a GP
- Improving GP support for patients and staff in nursing and residential homes. Requests for emergency home visits. Installation of SystemOne into two of the Nursing Homes.

Further detail on the above schemes is at Appendix 1.

2. PBC LES Expenditure

The on-going principle behind the PBC LES is that it is a payment originally funded from contributions from practice budgets to reflect and encourage the continuation and expansion of engagement by practices in the commissioning agenda. The production of an agreed workplan (the 12-13 Operational Plan) at the start of the year triggered payment of this LES element. This LES was worth £3.20 per person based on the practice registered list at 1st April 2012.

Payment is dependent on delivery and achievement of the intended or anticipated outcomes. Successful assessment of the outcomes was made by the Core Group in March 2013, triggering the appropriate payments.

Further detail of 2012/13 PBC LES schemes and funding utilisation is at Appendix 2.

3. QOF QP 8, 11 & 14

The report on engagement and evidence across all North Wilts submitted to the PCT QOF team in March 2013, provided detailed reports of the work undertaken at practice level on the following pathways.

It should be noted that QOF funding is essentially paid directly to practices, but is signed off at CCG Level and the Peer Review Actions that are attributed to the CCG for future actions are collated from this process. The funding related to QoF is not attached to the associated development work of North Wilts Locality. The list of pathways on which work was undertaken under the auspices of QOF are intrinsically linked into the overall Work Plan for North Wilts CCG and are included here for completeness. Full detail can be found in the QP8, 11 and 14 submissions made at year end to the PCT. A summary of that work is outlined in Appendix 3.

4. Summary of Expenditure for North Wilts and Kennet Localities – 12/13

A summary by locality of expenditure allocation is attached as Appendix 4.

Appendix 1 to

Section 2 - NEW Practice Level Review
Dated 10 May 2013

Secondary Care LES - Completed Practice Actions

1.	**On-going in-practice review of referrals and activity budget information, and RSS referral information** ➢ Use of RSS is a key part of North Wiltshire's strategy to support GPs in use of pathways, pre-referral advice, monitoring referral quality, compliance with INNF and PA at the beginning of the referral pathway ➢ Options can be developed for pre-referral intervention and support (e.g. guidelines, educative feedback, advice and guidance services)
2	**Quality of patient information in referrals** ➢ RSS to feedback to practices individually throughout the year, issues fed to locality group ➢ Practices to action accordingly, and report on actions to locality
3	**Practice to sign off locum and registrar referrals prior to sending** ➢ Embedded practice that practices review all referrals made by Locums and trainees to support the sending of appropriate referrals to secondary care ➢ Make sure all locums and GP Registrars are aware of Dermatology Clinics at appropriate practices
4	**Telephone access for paramedics and/or consultants to speak to a GP** ➢ Offer the service 8am to 6.30pm via a non-patient telephone line ➢ Ensure front desk staff are aware of requirements
5	**Improving GP support for patients and staff in nursing and residential homes** ➢ Involvement in locality project as required. Practice to support as required (locality project funded through PBC LES). Practices who cover Nursing Homes actively engage in communication with the Home staff to avoid unnecessary emergency admissions. Geriatrician rounds to continue where already implemented, and be developed in areas where this is not currently a service provision. ➢ Provision of information and support to the project as required
6	**Requests for emergency home visits** ➢ Ensure that requests are reviewed within 60 minutes by a GP, and respond where appropriate

Appendix 2 to
Section 2 - NEW Practice Level Review
Dated 10 May 2013

NEW PBC LES Completed Practice Actions

1.	**Engagement with Practice Based Commissioning** ➢ All practices supported and encouraged to engage with the Referral Support Service – 18 out of 19 practices signed up and using effectively. ➢ Attendance at Locality Meetings at an agreed level (GP attendance mandatory at 77% of meetings). 100% achievement by practices. ➢ Engagement with and use of Grumpy/Happy email reporting system. 17 out of 19 practices on board with system (85% achievement)
2.	**Community Review** ➢ Engagement with Care Homes o The focus for this year has been on establishing the relationships with homes, and for practices to be able to demonstrate the impact. In 12/13 the project also developed practice support for STARR beds. o All practices with Care Homes in their boundary, signed up to the concept of the project during 2012. Links between the practice and homes, community staff and pharmacist were reviewed and enhanced. o All practices have had the opportunity, when necessary and requested, to engage with providing clinical support for Step Up/Down STARR beds. ➢ Enhanced EOL Planning o The need for good/routine EOL planning has been integrated into normal working practice. o All care plans are entered onto Adastra, and updated regularly. However, Adastra is a clunky system and doesn't always facilitate the collation of good information. o Plans with every home for increased continuity and consistency of care from the practice. o Support and training to care homes to manage patient's care plans is being developed and enhanced.
3.	**Pathway Development** ➢ Orthopaedic – Hip and Knee Pathway o All practices committed to using the 'Harris' Hip and Knee Scoring methodology and incorporating this into normal working practice. All

	referrals made through the RSS are now accompanied by the appropriate hip and knee score. Referrals are not made if the score is not met. ➢ Practice Based Dementia Services o On-going work surrounding Dementia and the changing NICE guidelines was incorporated into the development of the Dementia LES. All practices signed up for Dementia training in preparation for the publication of the local and national Dementia LES's.
4.	**Public Health Initiatives** ➢ Practices engaged with the NHS Health Check LES, and worked towards enhancing that LES by offering additional NHS Health Check Services to capture/encourage a wider group of patients who might possibly be lost to their check because they are more difficult to engage.

Appendix 3 to
Section 2 - NEW Practice Level Review
Dated 10 May 2013

NEW QOF Outcomes - Completed Practice Actions

QP 8

Pathway 1: North Wilts - **Review of Orthopaedic Referral Pathway**. Using the RSS and appropriate threshold assessment of Hip and Knee Score, all practices have engaged with the protocol that was agreed locally to only send Hip and Knee referrals to secondary care if the Hip and Knee Score equalled or exceeded the agreed level.

East Kennet - **Dermatology**
continued use OF the Consultant Led Dermatology clinics held within two of the practices in the Kennet area. Originally setup mainly to improve the education and clinical skills of GPs, but also to improve the patient experience with care closer to home.

For the two years this has been running, it has shown a consistent drop in the number of referrals to Secondary Care with consequent savings. At present this is funded through previous savings from the Kennet area but we hope this will be taken up by the CCG in the coming year.

Pathway 2: North Wilts - **Implementation of Cardiology Pathway (24-Hr ECG)**. It must be noted that despite extensive work on the development of this LES its implementation is currently on hold. However, the preparatory work has been completed, the LES has been written and all practices are waiting to sign up to the LES and take delivery of the appropriate equipment required to support this service.

East Kennet - **Referral Support Service** -. Following a successful Pilot of the Referral Support Service in WWYKD, NEW decided to engage with this service which has been rolled out to all of the Practices over the year. Initially not all specialities were handled by the RSS but the number has been steadily increasing as has the uptake by the various practices.

The CCG have been able to monitor the referral activity rather than wait for the hospital data. It has also been able to check that the referrals have complied to the agreed care pathways on such referrals as Knee and Hip replacements as well as maximising the use of the ISTC Centres when requested by patients.

Pathway 3: North Wilts - **Home Oxygen Service Review**. Following the work commenced in 2011 on COPD pathways, this has been on-going and has led to enhanced working with the COPD Community Matrons in respect of a review of all HOOF patients, as it is well known that the Oxygen

Contract we are signed up for is complex and expensive. Full implementation of the patient review will continue into 2013/14.

East Kennet - **Joint Injections.** In conjunction with the Orthopaedic Department (GWH) referral activity was discussed with their Clinical Lead. A joint injection review identified considerable variation between Practices as to which injections could be done at different Surgeries and by different GPs. An audit was undertaken of all GPs and Practices in NEW. This showed significant variations in ability between GPs, and with training there was scope for referrals between Partners for Joint Injections reducing the need for referrals to Secondary Care.

An educational session was held with the Department of Orthopaedics; Practices have been encouraged to manage these procedures in-house wherever safe and practical.

QP 11

Pathway 1: North Wilts - **Dementia Assessment in Primary Care**. On-going work and pilot schemes, leading to the development of the Dementia LES to be implemented in 2013/14.

East Kennet - **STARR Scheme -** East Kennet has run the SHARP Scheme for many years and the principles behind this were rolled out to the rest of North Wilts and Wilts CCG. The STARR scheme has the advantage of allowing Step Down beds as well as Step Up. The service supports avoidance of crisis admissions to Secondary Care.

Pathway 2: North Wilts - **End of Life Planning/Care Home links.** On-going work leading to the formulation of a LES which has yet to be endorsed by the CCG, but will support an enhanced level of care to patients in Care Homes and Nursing Homes. As with East Kennet, plans are underway to forge closer working links with a Geriatrician from GWH to support this work.

East Kennet - **Nursing Home Rounds -** Practices work closely with Dr Debbie Finch (Consultant Geriatrician from GWH and Savernake) to help look after those patients in Nursing Homes. Dr Finch visits each of the Nursing homes in the Kennet area on rotation – approximately once every 6 weeks, in conjunction with the GP looking after the Nursing Home. The aim is to review the long term care of the patients, assess acute problems, if necessary to review the End of Life pathways and to ensure that the necessary paperwork is in place (includes use of Adastra). Educational development for the GPs and the Nursing Home staff (which in turn can prevent unnecessary Emergency admissions to Secondary care) is an added benefit of this service.

Pathway 3: North Wilts - **Caring for Carers** – development of higher level practice support and all practices working towards the Gold Standard award. This has envolved working through 3 levels of Carers Standards and all applications for the Gold Award have been submitted to Carers Support, this is currently awaiting assessment and hopefully the award will be made to all practices who have met the standards. The achievement of this award demonstrates a high level of support to Carers within practices.

East Kennet - Late transport run - Practices have developed a collection service for pathology specimens to be taken to the GWH in the late afternoon. This has the advantage of allowing patients to be seen and investigated by the GP on the same day and has reduced the need for both District Nurse visits and for admission to hospital to carry out these tests. Previously this has been funded directly from Kennet Consortium savings but we hope this can be continued by the CCG in the future.

QP 14

Focus 1: Patients with co-morbidities at high risk of admission (patients aged 65 yrs and older)

- Working closely with Care Homes. A key focus at CCG and practice level in the last 6 months has been avoidance of attendance at ED with a subsequent focus on trying to avoid admission to secondary care.

- Continued focus within practices on Chronic Disease Clinics such as COPD, Asthma, Diabetes. Development and possible implementation of Dementia LES in 2013/14.

- Easy access for paramedics to speak to a GP within the Practice to try to avoid admission.

Focus 2: Children with minor illness/injury (patients aged 15 years and under)

- The Surgeries have dedicated “Urgent” appointments each day with slots morning and afternoon to allow access to patients who are seeking same day/immediate advice (face to face and telephone) on ‘minor’ conditions – bee stings/ allergy rashes soft tissue injuries etc

- Practices have made patients more aware of more appropriate services than ED – advertising within Surgeries, newsletters, through Patient Participation Groups etc.

Focus 3: Patients who frequently re-attend ED that could be dealt with in primary care.

- We are advised by CCG of regular ED attenders (emailed spreadsheet). Patients are counted if they have had 5 or more ED attendances or emergency admissions during the last 12 months.
- The evidence has clearly shown figures are very small and all have been unavoidable due to long term chronic conditions or End of Life patients requiring Emergency treatment.

Appendix 4 to
Section 2 - NEW Practice Level Review
Dated 10 May 2013

Summary of NEW LES Expenditure

North Wilts

12/13 Resources			
Description			**Payment mechanism**
PBC LES 12/13 (£3.20)	£418,588		Paid to PBC Account
Secondary Care LES 11/12 2nd payment (£2.00)	£286,512 (NW)		Paid to PBC Account
Secondary Care LES 12/13 1st payment (£2.01)	£160,081 (NW)		Paid to PBC Account
12/13 Spend			
Secondary Care LES 11/12 2nd payment for achievement (£2)	£286,512 (NW)		Paid to practices for achievement of secondary care LES budget 11/12
Secondary Care LES 12/13 1stpayment(£2)	£160.081 (NW)		Paid to practices on delivery of plan for secondary care LES practice actions (see North Wilts Summary)
PBC LES spend on Delivery of North Wilts Operational plan 12/13			
Engagement with Practice Based Commissioning by Practices: Referral Support Service Attendance at Locality Mtgs Feedback by Grumpy Emails	£81,776		Paid proportionally to practices based on engagement/ achievement of objectives.
Core Group Costs for PBC Support of Management and Admin staff	£9,705		Payments for Management Time for support of Core Group and specific projects
Conference Costs	£1,766		GP conferences
Community Review : Engagement with Care Homes Enhanced EOL Planning	£102,208 £102,208		Paid to practices on achievement Paid to practices on achievement
Pathway Development Orthopaedics Practice based dementia services	£40,888 £40,888		Engagement with Hip and Knee Scoring methodology Engagement and training
Public health projects: NHS Health Checks	£30,000		Paid to practices for Health check follow ups, NEW education events
Total	***£397,968***		

East Kennet

12/13 Resources			
PBC LES 11/12	£24,940		Paid to PBC Account
PBC LES 11/12	£73,158		Paid to PBC Account
Secondary Care LES	£43,878		Second 50% - paid to PBC Account (first 50% directly to practices)
Prescribing Underspend 11/12	£6,448		
PBC LES 12/13 – 100%	£107,657		
Total	***£212,204***		*Includes prescribing underspend.*
12/13 Spend			
Second Blood Run	£11,439		
Broomwell Healthwatch – 24 Hr ECG interpretation	£ 1,487		
Sharp Scheme	£13,793		
Dermatology Clinics	£ 4,365		
Practice Allocations	£199,921		
Total	***£231,005***		*Includes carried forward income/prescribing savings from 11/12*