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

For: Discussion

Agenda item & Title:	**GOV/13/05/15 Sarum Quarterly Report, PbC and Secondary Care LES**
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Executive summary	The Sarum PBC and Secondary Care LES work programme was presented to the CCC in April 2012. It was agreed that quarterly update reports would be provided during the year. This is the third such report produced for the year end as the work did not start until quarter 2. The CCG Governing Body is asked to note the significant progress against the Sarum work plan. Sarum had developed local clinical pathways with GPs, local consultants and professionals working together to achieve agreed approaches to care. Individual practices have been closely involved in reviewing their own and other provider's services, highlighting and starting to address areas for change. These processes have also led to close clinical involvement and leadership in the commissioning process. Overall the programme of work has progressed well and the impact is starting to emerge. The Sarum Executive reviews activity against budgets and continues to work with practices, supporting them in internal changes where appropriate. The CCG Governing Body is asked to consider the progress shown and the achievements to plan and to agree the final payment of the 2012.13 Secondary Care Local Enhanced Services.

Evidence in support of arguments:	This report has been developed from practice reporting within Sarum localities and activity and finance information reports from the CCG and PCT.
Who has been involved/contributed:	GP leads via Locality Groups. NHS Wiltshire Information and finance teams
Cross Reference to Strategic Objectives:	Supports implementation of QIPP. QiPP for QoF also informs some of this work
Engagement & Involvement	The work has involved close working within and between practices and with key providers. No requirement for formal public or patient engagement has been identified to date
Communications Issues:	Not exempt from FOI. Issues re data capture may be of media interest
Financial Implications:	This report includes activity impact summaries and information for the work undertaken to date. The financial impact of the work undertaken has not been fully analysed due to lack of data and the difficulty of attributing effect with wider system influences. An analysis of the allocation of funds for these Local Enhanced Services is shown in Section 4 of the Report
Review arrangements:	Monthly reviews in Sarum Executive and the 3 Sarum Locality Groups Programmed review within practices Quarterly reporting to CCC.
Risk Management:	See risk assessment in each scheme.
National Policy / Legislation:	Detailed matching to national policy has not been outlined here but the work takes account of national requirements and good practice.
Equality & Diversity:	A full equality impact assessment is not appropriate for this work.
Other External Assessment	N/A but there has been significant peer and stakeholder involvement
Next Steps:	Sarum has taken the learning from this work to inform its proposal for its 2013.14 work plan which it intends will target the critical areas of urgent care, effective use secondary care, prescribing and harnessing the benefit of local innovation and improvement. Sarum will work to ensure that all practices are aware of the progress that has been made and can benefit from the learning and recognise the successes as well as the challenges that have arisen. We will be developing further definition on the measurable outcomes of our work for 2013-2014 where this is appropriate. Specific Next Step targets for

	these 2012-2013 projects are outlined within the detail of each of the project reports

Sarum Local Work Programme Quarter Four Report

2012- 2013

1. REPORT PURPOSE AND BACKGROUND

This report provides a summary of the Sarum Local Work programme at the end of March 2013, Quarter 4.

Sarum's activity this year focussed on working towards the delivery of best practice in local health care and optimising the use of resources this can be grouped into three main themes each of which has several supporting projects:

1. Developing clinical involvement and leadership in the commissioning process and providing the tools to support this
2. Developing clinical pathways to improve patient care and the effective and efficient use of services
3. Reviewing activity with a view to ensuring best practice and the appropriate use of services

The projects were designed to support the objectives and also have clear links to the delivery of the Wiltshire QIPP.

In addition to the projects described below, which are as detailed on the original PBC and Secondary Care LES, Sarum is undertaking a further range of work streams linked to local and wider health care issues. These include:-

Mental Health work including the development of dementia services.

Appropriate management of benign skin lesions

The development of skills in caring for military personnel and their families.

STARR beds

Public Health Projects

Community Services

The outcome and learning from all these areas are being shared across Practices at locality meetings and Locality leads meetings.

2. SUMMARY OF THE YEAR 2012- 2013

The work this year has been based on sound clinical understanding of the drivers for best practice and the appropriate use of services. The emphasis has been on achieving improvements in pathways and the use of resources through the development of skills and understanding and developing joint working with other Practices and key providers.

Sarum will work to ensure that all constituent Practices are aware of progress and can benefit from the learning and recognise the successes as well as the challenges that have arisen. We will also be developing some further definition on the measurable outcomes of our work where this is appropriate.

The general consensus from the GPs is that:

- This PBC work has improved practice knowledge of what they are doing and the work to improve the quality of care they provide in house was worthwhile.

- These processes are now largely in place in all practices and working well. The approach should be continued but this year's detailed reporting is probably not necessary in the future.

- Quality improvement in primary care will lead to less use of secondary care and when secondary care is used this will add more value to patient care – this should be the driver for future work and not necessarily aiming solely at activity reduction.

- Working together, sharing data, supporting and respecting each other, sharing good ideas and the practice willingness to change all lead to better quality of patient care. Clinical staff also now appreciate more their colleague's skills and specialities, and appreciate their support "in house" where this is available.

- There is still some variation between practices due to various and different factors, but all are willing to continue to work towards the ideal.

- It is recognised now that only significant changes across the health and social care spectrum will lead to the patient centred joined up care, in the right place at the right time, that is urgently needed.

3. SUMMARY OF PROJECTS AND PROGRESS TO DATE

The projects are outlined below.

Further detail of milestones and progress is included in the detailed description of the projects shown in the Detail of the Projects, Appendix 1 to this report

3.1. Developing clinical involvement and leadership in the commissioning process and the tools to support this activity

Project ID	Project	Supports QIPP?	Progress against Plan
1a	Setting up a focussed GP group to enable localisation of pathways to be included on the electronic referral decision support software system, dissemination of these pathways and supporting the Clinical Cabinet Team by providing clinical leadership to working groups in a range of services.	Yes including: Hip and Knee. Appropriate use of services	A total of 20 Sarum GPs, medicines management and 25 Salisbury FT consultants have worked together to localise clinical care pathways. This has not only clarified but also developed the care pathways and developed positive closer working relationships across primary and secondary care. Following overall review there are now in 24 pathways for use in Sarum see 1b.
1b	The development and implementation of an electronic referral support system for use by GPs	Yes Including Hip and knee and appropriate use of services	The initial development of this project was delayed by a necessary change in the software system provider and implementation has been delayed by need for server and software installations at some sites. Testing is now underway and full roll out is scheduled. All Sarum GPs trained and aware of Map of Medicine which featured at the Sarum wide GP meeting on 30.04.2013
1c	Provision for targeted clinical leadership work in localities to share best practice in clinical, prescribing and commissioning skills.	Yes underpinning scheme	Successful meeting with many GPs and consultants in Nov 2012, leading to joint pathway development as detailed in 1a above.

Project ID	Project	Supports QIPP?	Progress against Plan
1d	The development and monitoring of "activity budgets" at Practice level	GP Referral activity (OP discharged at first appointment)	Budget information was delayed until December 2012 but referral activity was shared with practices and has since been monitored against budgets. GP referral activity broadly is flat in spite of pressure in some key areas
1e	The Development and use of the Sarum Data Centre to provide feedback on service issues and Practice referral activity	Changing settings of care, GP Referral activity	All areas engaged and most using the SDC. One locality using an alternate system

3.2. Developing or optimising clinical pathways to improve patient care and the effective and efficient use of services

Project ID	Project	Supports QIPP?	Progress against Plan
2a	The use of the Oxford Hip and Knee scoring system to inform referral decisions for further care	Hip and Knee pathway	MOM Pathway in place, audit completed. Issues identified with plan to implement on Map of Medicine.
2b	Practice review of daily hospital inpatient activity to identify patients, ensure relevant patient information is available to the hospital and support timely discharge.		LOS held stable at SFT. Some limitations found on the approach. Key findings being considered in service design and commissioning activity
2c	Pre-operative assessment for day case surgery to be delivered in primary care	Yes, pre-operative assessment	On track, most Practices now supplying relevant data
2d	Faster response times for home visits to improve care and prevent avoidable admissions	Non-elective admissions	Initial audit completed. Practical barrier identified. Plan to address issues identified

Project ID	Project	Supports QIPP?	Progress against Plan
2e	Advanced Care Planning with patients thought to be nearing the end of their life to support patient choice		MDT meetings being delivered for all EOL patients at all Practices. Issues being identified and addressed

3.3. Reviewing activity with a view to ensuring best practice and the appropriate use of services

Project ID	Project	Supports QIPP?	Progress against Plan
3a	Monthly review of Practice referrals to secondary care to promote appropriate referral activity		M11 data shows a small increase in YTD Sarum GP referrals to SFT at 0.5% (83 referrals) However non GP referrals are up by 1.3%. 1st OP appointments overall are up by 4.07 % which is disappointing. This reinforces the need to consider all referrers and drivers for outpatient care.
3b	To review unusual consultant to consultant referrals with the aim of reviewing referral practice and monitoring provider practice		On-going within all Practices
3c	Practices comply with the Wiltshire Clinical Priorities Policy		Good progress against plan. Processes and approach under continuous review
3d	Practices to improve the quality of information provided to providers for both elective referrals and non-elective pathways		Audit 1 completed. Audit 2 completed and overall showed an improvement in quality of information provided on referral
3e	Best practice in prescribing and utilisation of "Scriptswitch"		Discussions with the Prescribing team continue.

Project ID	Project	Supports QIPP?	Progress against Plan
3f	Optimisation of outpatient follow up activity	Changing settings of care, reduce out-patient follow ups	Audit completed. Work to agree specialties for further work with SFT underway. M11 FU data shows a significant 5.4% reduction in FU OP appointments (4,501 appointments) against a full year overall plan of 4,599. Work to continue in this area.
3g	Work to reduce attendance in secondary care of those patients identified as Intensive users of A&E services	Secondary Care resources, A&E attendances	Audit 1 Completed. Audit 2 completed. Most intensive users of A and E are well known to the GPs and have care plans etc. in place.

4. SECONDARY CARE ACTIVITY INDICATORS

This report is largely based on month 11 data as some month 12 data was not available at the time of writing.

GP Referral Activity

Referral activity is collated on a per provider basis so this report shows referrals made by Sarum GPs to Salisbury FT. Salisbury is Sarum's main provider. GP referrals to Salisbury were up by 83 (0.5%) against last year's activity. Non GP referrals were up by 147 (1.3%)

Notable reductions were in trauma and orthopaedics and gynaecology but an increase in urology.

Outpatient Activity

This covers activity relating to Sarum patients at all providers

First outpatient attendances at month 11 were 1,299 higher than the same period last year (4.07%) at a cost of c £78k. However Sarum benchmarks at 23.5 first attendances per 100 weighted population as against NHS Wiltshire's 27.6

Follow up outpatient attendances were 4,501 lower than the same period last year (5.39%) with an estimated cost saving of c £133k.This represents a significant achievement at month 11 as the full year target for reduction was 4,599 Nevertheless Sarum benchmarked at 56 follow ups per 100

weighted population against NHS Wiltshire's 48.9 and it is recognised that further work is required in primary care and with our main provider

The net financial benefit as a reduction in costs in outpatient activity at month 11 is calculated at c£55k

Elective Activity

Inpatient Activity

Ordinary Elective activity for 12/13 is slightly down by 1.2% (48 admissions) compared to 11/12. Notable reductions are in General Surgery (35.1%, 182 admissions) and Paediatrics (53.8%, 21 admissions). Sarum benchmarks at 27.15 per 1,000 weighted population, above NHS Wiltshire's 25.31.

Day Case Elective Activity

Day Case activity is slightly higher than 2011/12 by 0.9% (103 admissions)

Specialties showing significant reductions from 11/12 - General Surgery (63.4%, 944 admissions) and Urology (48.1%, 555 admissions). However, there have been 1259(131.1%) more Gastroenterology admissions and 185 (139.1%) rheumatology admissions in 12/13. Sarum benchmarks overall at 80.82 per 1,000 weighted population, below NHS Wiltshire's 89.36.

Outpatient Procedures

Outpatient Procedures are up 34.4% (4754 procedures) compared to 11/12.Specialties showing major growth from 11/12 - Dermatology (138.1%, 1,379 procedures) General surgery (144.4 % 26 procedures) and Urology (170.4%, 944 procedures). Nevertheless Sarum benchmarks at 131.6 per 1,000 weighted population, below NHS Wiltshire's 141.87.

The overall impact of these changes is likely to be a cost increase against last year however estimates based on average cost are not appropriate and it should also be noted that a waiting list initiative at the main provider took place in the early part of 2013.

Non Elective Activity

Non Elective activity is slightly below 2011/12 levels by 1.0% (150 admissions). However Sarum benchmarks at 108 per 1,000 weighted population above the NHS Wiltshire 98.7. The variation is particularly notable in obstetrics.

A&E /MIU

There were 1136 (4.25%) more attendances from April 12 to Feb 13 than for this period in 2011 /12.

4. USE OF FUNDS

Sarum was allocated funding for PbC Local Enhanced Services (LES) at £3.20 per person based on raw population numbers (135,409) and £4.13 per person for the Secondary Care LES based on the

weighted population (140,508). This led to a budget of £433,308 for the PbC LES and £580,298 for the Secondary Care LES.

The funding was allocated specifically for workstreams and tasks and has been monitored at practice and locality level and reported to the Sarum Executive.

The full PbC LES monies have been distributed to Sarum and 50% of the Secondary Care LES funds have been distributed direct to practices. When the CCG is able to confirm its approval the remaining 50% of the Secondary Care LES funds will be available to Sarum for appropriate distribution.

The full breakdown of the allocation and use of the funds is shown in the table below. It should be noted that an allocation of £2.20 of the PbC LES was allocated for key infrastructure and development work. The full audited accounts for this allocation will be available by the end of June, as in previous years.

Use of Funds

Population (raw for PbC LES and weighted for Secondary Care LES)					135409	140508						
			BUDGET				**PAYMENTS**		**ACCRUALS**	**VARIANCE**	
	Project	**Details**	**PBC LES per head**	**Sec Care LES per head**	**PBC LES Total**	**Sec Care LES Total**	PBC LES	Sec Care LES 1st 50%	Sec Care LES 2nd 50%	PBC LES	Sec Care LES
1	sec care referrals	In-house checks		£0.35		**£49,178**		£24,589	£24,589	£0	£0
		Quarterly reports reviewed by locality		£0.10		**£14,051**		£7,025	£7,025	£0	£0
2	Clinical priorities policy	Monitor procedures		£0.05		**£7,025**		£3,513	£3,513	£0	£0
		Report contract variations		£0.10		**£14,051**		£7,025	£7,025	£0	£0
		Locality meeting discussion re new policy		£0.10		**£14,051**		£7,025	£7,025	£0	£0
3	Quality	Practice audit on 1/12 ref	**£0.10**		**£13,541**		£13,541			£0	£0
	on referrals	Practice action plan	**£0.05**		**£6,770**		£6,770			£0	£0
		Practice re-audit	**£0.10**		**£13,541**		£13,541			£0	£0
4	Hosp inpatient	Daily review with weekly plan		£0.35		**£49,178**		£24,589	£24,589	£0	£0
		Quarterly review at locality mtg		£0.10		**£14,051**		£7,025	£7,025	£0	£0
5	Early home visit request	Practice to keep records of time of request for 2 months								£0	£0
		Time of response and outcome, present at locality mtg	**£0.25**		**£33,852**		£33,852			£0	£0
6	Advance care planning	Monthly meeting with all profs involved (GSF)		£0.15		**£21,076**		£10,538	£10,538	£0	£0
7	Hip and Knee Referrals	audit 1 month ortho and MSK refs that are expected to be THR or TKR, for use of OHS or OKS amend practice policy and re-audit	**£0.10**		**£13,541**		£13,541			£0	£0
8	Prescribing	Audit with prescribing team . Continued use of script switch.	**£0.20**		**£27,082**		£27,082			£0	£0
9	Reduce OP FU appts	Audit FU OP letters, identify any possible in-house changes re FU in surgery		£0.30	**£0**	**£42,152**		£21,076	£21,076	£0	£0
10	Cons to cons	monthly report to locality		£0.10	**£0**	**£14,051**		£7,025	£7,025	£0	£0
11	Use Sarum Data Centre	all practices to move towards using this with ref decision tool	**£0.05**		**£6,770**		£6,770			£0	£0
12	Infrastructure and work	To Support LES workplan, see LES	**£2.20**		**£297,900**		£297,900			£0	£0
13	Pre op assessment	As detailed and in addition use SystmOne template to insert details into referral letters.		£0.10	**£0**	**£14,051**		£7,025	£7,025	£0	£0
14	Use referral decision tool	Practice champion, understand, teach others	**£0.05**		**£6,770**		£6,770			£0	£0
		Work with locality to localise a min of 3 set pathways	**£0.10**		**£13,541**		£13,541			£0	£0
15	Intensive service users	Audit of users (PCT data)		£0.10		**£14,051**		£7,025	£7,025	£0	£0
		Care plans / discussion and roll out to all agencies		£0.10		**£14,051**		£7,025	£7,025	£0	£0
		Re audit same patients		£0.10		**£14,051**		£7,025	£7,025	£0	£0
16	Sec care LES	Pump priming re 6 months staff costs to do Sec care LES work		£2.00		**£281,016**		£140,508	£140,508	£0	£0
17	Sec care LES	Mx costs for collation reports / payments etc.		£0.03		**£4,215**		£2,108	£2,108	£0	£0
		TOTALS	**£3.20**	**£4.13**	**£433,309**	**£580,298**	£433,309	£290,149	£290,149	£0	£0

APPENDIX 1

DETAIL OF THE PROJECTS

Project 1a and 1c	PRINCIPLE AND REASON	MEASURE OF SUCCESS
Establishment of a focussed GP group to enable localisation of pathways to be included on MoM, dissemination of these pathways and supporting the Clinical Cabinet Team by providing clinical leadership to the working groups in a range of services. **Enable best practice in clinical, prescribing and commissioning skills to be shared**	▪ Setting up of small GP group to enable localization of all pathways available on the electronic referral decision support system and roll out to each Practice. ▪ Dissemination of pathways already agreed but not yet published which are:- 1. COPD and prevention of acute admission 2. Back Pain and reduction in surgical procedures 3. Emergency Chest Pain 4. OA Hip and Knee Helping the Clinical Cabinet Team by providing clinical leadership to working groups in the following areas: 1. Ophthalmology 2. Cardiology 3. Falls and Fractures 4. Mental Health 5. Links with Public Health Team 6. Community Nursing Teams 7. Physiotherapy provision 8. Veterans Health 9. Obesity management Localities may also use pooled funds as they agree for work to promote improved quality leading to better commissioning or prescribing.	Pathways fully developed and “live” in surgeries, at SFT or other secondary care provider, and easily available on localised map of Medicine. Reduction in 1st OP appointments

Project 1b	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Use of electronic referral decision support tool (Map of Medicine MoM)	Electronic referral decision support software, with local pathway information, and available on every clinicians computer will be in place to provide best local management for each patient. These clinically evidenced pathways to be championed in each Practice and used by all clinicians.	Practices will be closely monitored during the pilot phase, and their reports and feedback used to make changes to allow full roll out of the MoM by end of October 2012. Thereafter MoM can provide reports re use of the MoM, for which specialities, by which Practices.	Practices to identify a Practice Champion for implementing use of the electronic referral decision support tool within their Practice. All Sarum GPs using MoM MoM reports giving useful information re patterns of referral

31.03.2013 Update on 1a, 1b and 1c

Initial plans to use Optimise did not come to fruition for many and varied reasons which have already been shared.

Subsequently meetings with Map of Medicine proved that they had listened and acted upon previous suggestions and made significant useful changes to their system. It was decided to use their software and agreements drawn up with PCT.

Working with MoM enabled 6 initial pathways and many referral forms to be uploaded into their system, and pilot started 11.09.2012

Following the pilot significant changes were required to the product which has just been completed. This has involved securing improvements with links into TPP and capturing patient data there in a usable fashion. The full MoM package was installed again in 2 of the pilot sites last week, with 2 more to follow shortly. Once those sites are secure, full roll out across Sarum will be implemented. There may be some delay in some surgeries as IT hardware needs upgrading first.
MOM visited all pilot Practices, gave full training and is giving good support to the Pilot users.

MoM visited the Sarum Half Day for all GPs on Sept 4th, so all GPs saw the system in action there and final rollout took place at the Sarum wide GP event on 30.04.2013

20 GPs and 25 Consultants completed 20 Pathways in December 2012 which have been handed to MoM. MoM has completed 12 of these which are ready to go with the rest to follow shortly.

Governance to agree Pathways has been drafted and will shortly be finalised so that Pathways can be authorised to be published.

Future Plans.

1. Complete and analyse pilot study.
2. MoM Practice Champions to be identified.
3. Complete roll out to all Practices
4. Analyse data re usage per Practice / per GP / per speciality as per MoM data captured**.**
5. Later….to modify referral forms to be "smarter" with prompts for fields that need consideration or completion

Key Risks to Achievement of Objective

1. Software does not do that which it is expected to do.
2. Practices do not engage with using the software.
3. Hardware not up to coping with the new software, and needing upgrading.

Risk Mitigation

1. Work closely with MoM and pilot sites to ensure maximum effectiveness of MoM
2. Encourage, enable, inform, cajole and peer pressure factor to get Practices using the software.
3. Investment project to upgrade Hardware and SARUM Practices prioritised.
4. Consider further training support in the use of the system

Project 1d Activity budgets

The activity budgets for 2012/13 are at Practice level, based on PBC budgets for 2011/12 updated for changes to list sizes. The total PCT activity budget continues to be allocated to Practices using weighted list sizes and the Nuffield Formula (DH recommended methodology) which indicates the expected share of secondary care resources to be used by each Practice.

Practices were given an overall weighted activity budget covering the specialties:

- A&E attendance
- First out patient attendances
- Follow up outpatient attendances
- Out patient procedure
- Day case
- Regular attenders
- In patient admission
- Non elective inpatients

31.03.2013 Update

Practice budgets were released to Practices after significant unavoidable delays at PCT level. It was unfortunate that this process took so long, but these are now calculated so that Practices are working towards full Fair Share financial budgets by 01.04.2013

Practices will be considering activity rather than financial spend as in previous years. Overall budget figures for Sarum will be used for achievement payments , not the budgets of the 3 Sarum groups (North, South, West) as there will be so little time to effect changes based on budget figures.

Month 11 data, the latest available when developing this report, has been put into useable format against these budgets. These show increases over 10% in three specialties but reductions in other areas have resulted in a steady state in GP referrals. Summary details below:-

>10% increase >10% decrease

Specialty	GP Referred 11/12 M11	GP Referred 12/13 M11	GP Referred %	Other Referred 11/12 M11	Other Referred 12/13 M11	Other Referred %
100 - General Surgery	1669	1733	3.8%	192	255	**32.8%**
101 - Urology	864	1084	**25.5%**	73	143	**95.9%**
110 - Trauma & Orthopaedics	1367	1194	**-12.7%**	2126	1960	-7.8%
120 - ENT	1210	1195	-1.2%	503	424	**-15.7%**
130 - Ophthalmology	2025	1901	-6.1%	1390	1443	3.8%
140 - Oral Surgery	1799	1836	2.1%	136	129	-5.1%
301 - Gastroenterology	309	362	**17.2%**	94	108	**14.9%**
320 - Cardiology	1217	1172	-3.7%	409	366	**-10.5%**
330 - Dermatology	1672	1703	1.9%	157	151	-3.8%
410 - Rheumatology	606	670	**10.6%**	110	94	**-14.5%**
420 - Paediatrics	690	632	-8.4%	1591	1947	**22.4%**
502 - Gynaecology	1187	964	**-18.8%**	249	295	**18.5%**
Other Specialties	3408	3660	7.4%	4224	4086	-3.3%
Grand Total	18023	18106	0.5%	11254	11401	1.3%

PLANS

Practices continue to critically analyse their activity in various areas that are measured, and compare their activity to other local Practices. Those Practices identified as being significantly over budget will be working closely with Sarum Practice Advisory Teams to ascertain reasons for this, and make appropriate changes at Practice level.

They will be encouraged to do this to ensure that all efforts are made to achieve budget targets.

Work is or will be undertaken in the specialties experiencing pressure (e.g. urology) to ensure effective care pathways are in place and used

Risk

Overspend

Mitigation of Risk

Ensure above information is discussed, acted upon and areas which can be changed by Primary Care activity are specifically targeted.

Project 1e	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Sarum Data Centre	All Practices to start using the SDC to enable accurate processing of all referrals, with associated data collection. This will be a staged process as the SDC is expanded to cope with the increase in work load, but all Practices are expected to be supplying data to the SDC fully by Dec 2012.	Practices to fully set up systems in house to enable this to happen. Use of an electronic decision support system also enables the Sarum data centre to capture data but this can also be captured by Practices agreeing to data share referral information (TPP Practices). The SDC will produce referral reports in a timely fashion which can be used to inform Practices and Sarum board re referral rates etc.	All Practices fully engaged in using the SDC by December 2012

31.03.2013 Update

At 30th December 2012 17 Sarum Practices were using the Sarum Data Center. There are no further Practices expressing an interest to join the SDC at the present time. Most of those who do not use the SDC are in the West group of Sarum. Under the leadership of Dr Patrick Craig McFeeley for many years now they have always managed their data satisfactorily in house, and by using the PBC web tool.
Referral rate reports are available monthly per specialty and per Practice.

Over 1000 referrals a month are now processed by the SDC staff; this gives useful data re areas at SFT or other secondary care facilities where there may be difficulties, as they have the volume of work to pick up on this information which individual Practices may not. Difficulties with the Breast clinic were spotted by the SDC staff and acted upon by BM to resolve the issues.

PLAN

Continue to facilitate Practices to use this facility. Sarum Executive is reviewing the facility and further opportunities to maximise its potential.

Key Risks to Achievement of Objective
Practices do not engage with using the centre
Staffing issues at SDC reduce manpower there.

Project 2a	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Reduction of Hip and Knee Referrals by use of Oxford Hip and Knee scores .	To use Oxford Hip Score and Oxford Knee Score for MSK referrals that the GP considers may be referred on for THR or TKR Wiltshire still benchmarks high on hip and knee replacements. **This area has the potential to deliver the largest savings for the group.**	Audit to measure usage of OHS and OKS in Muscular Skeletal Pathway and Orthopaedic referrals through Practice data as per web tool. Audit Sept 2011 and Sept 2012 data.	Reduction of THR and TKR (recognising demographic factors)

31.03.2013 Update
Month 11 shows a 12.7% year on year reduction in T&O referrals

Audit has been completed by all Practices
Most using Oxford Hip and Knee scores on Orthopaedic referrals
All should now also be using on Physio referrals
MOM pathway developed and in place
Biggest difficulty is length of wait for physio appointments

Next Steps
All Practices to continue to refer to physio first using MSK pathway
All Practices to continue to be aware of consultant offering to do second hip / knee in 6 months which may be earlier than is necessary.
Obtain and monitor activity data to identify outcomes

Key Risks to Achievement of Objective
Access to physiotherapy services
Premature surgery to 2nd Joint

Project 2b	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Review of hospital in-patient activity	*To review information on admissions/discharges provided from the main acute trusts in order to be able to review patients who are still in - patients and discuss discharge plans for the patient with hospital staff.* Practices to engage with the reduction of hospital bed days by considering Length of Stay data. Practices to assess the data provided daily and discuss relevant patients in minuted internal meetings with actions arising	Peer Review at Locality Quarterly	Success would be a reduction in Length of Stay.

31.03.2013 Update
Practices more engaged with contacting hospital re patients that have been admitted as an emergency, and find this MAY be useful for handing on relevant information. All too often the "right" person is not present to take that information for that patient. GPs find this very time consuming with little perceived benefit.
It has highlighted that the community matron often discharges the patient from her care on admission, and then has to have a further referral to take over their care again on discharge. It would be more useful if she could be more involved with discharge planning. This has been reported as an issue and is being taken forward, see below.
Community matrons do now attend the DToC meetings weekly at SFT.

SFT Length of Stay figures (based on forecast outturn for 2012.13)

		2010/11	2011/12	2012/13
Non Elective	All	5.8	5.4	5.5
	>2 days	11.9	10.9	11.0
Elective	All	2.7	2.7	2.8
	>2 days	5.8	5.9	6.0

It is important to highlight that these LOS figures are set against significant increases in Delayed Transfers of Care, these pressures have inevitably had an impact on LOS

PLAN
Excellent initial meeting with GWH re Community Services and it is hoped that the role of Community Matrons will change so that those who know that patient well in their home environment will become more involved in the discharge planning process. On-going commissioning and service design work to improve the efficiency and effectiveness of care across settings

Key Risks to Achievement of Objective
Discharge from hospital may be a multi disciplinary team effort, any lack of staffing / availability in the community of care packages will delay LoS, over which the GPs in the field have no control. Discharge too soon may also result in a readmission.

Project 2c	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Pre-Operative Assessment – next stage	Stage 1 of this process is to use the Minimum Data Set as last year. This stage involves including a minimum data set for all day case admissions to be sent with referral:	Provision of: NHS no BP BMI Heart Rate Pulse – Irregular/regular Most recent HbA1c (if diabetic) Carer status Home circumstances If for a surgical procedure: FBC, U&E, LFTs	All referrals requiring this information have it recorded at point of referral.

31.03.2013 Update
Revised template is now available that links to Auto consultations and Hot Keys.

PLAN
Practices will continue to be reminded at locality meetings monthly re using this template.

Key Risks to Achievement of Objective
Practice do not provide sufficient, relevant data on their letters
Practices are not aware that their referral will lead to day surgery, so the full data is not sent at point of referral.

Project 2d	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Emergency home visit requests	To commit as a Practice, that a GP will review any request for an emergency home visit as soon as is practicably possible to enable appropriate action to be taken. This could involve Practices identifying whether contact with the patient or their relatives or an emergency visit needs to be undertaken early in the morning to enable earlier attendance by patients at hospital so facilitating same day discharge. An earlier visit may also enable community services to be put in place to prevent admission.	That all patients who need emergency hospital admission get this very soon after requesting a home visit. That patients do not end up being admitted because of a delay in community management. Practices to keep 2 months records of time of request, time of response and outcome and present results to Locality Meeting, with suggestions as to how changes in their current Practice systems may achieve admission avoidance/ same day discharge.	Admission earlier in the day Better community management of patients so preventing admission if not necessary. Audit with suggestions for changes in Practice systems.

31.03.2013 Update
Audit findings and comments reported were :-
Most of the acute admissions – 80% to MAU are NOT generated by GPs
Most requests for visits occur at 10.30 – 11.00 in the morning when the carer or community nursing team do their visit to the patient, or at 4 – 6pm on a Friday afternoon when relatives decide that the patient does need to be seen prior to the weekend.
One larger surgery reported a change in their internal arrangements, freeing a GP to do visits almost immediately, this prevented 2 “999” calls from a nursing home from being admitted, and allowing them to die peacefully in their preferred place of death, and 2 other admissions also avoided.
Smaller Practices commented that with perhaps only 1 GP on duty, with booked lists, it is more difficult to visit any earlier.

PLAN
STARR beds to continue, this has developed significantly in the last 3 months, with 10 beds in regular use in Amesbury being supported by GPs from 1 surgery, and spot beds purchased as required in Salisbury.
Consideration to Urgent Care GP again
Nursing Home LES essential and being developed
Joint working of smaller Practices to provide support to enable earlier visiting where appropriate to be considered

Key Risks to Achievement of Objective
Practices do not do the audit
Practices do not make changes after the audit
Community services cannot provide sufficient immediate community care at home

Project 2e	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Advanced Care planning	That patients die in their location of choice having received the interventions they had wished.	To undertake Advance Care Planning with all patients thought to be nearing the end of their life, discussed at monthly (as appropriate) multidisciplinary palliative care meetings (Gold Standards Framework) and documented via the Adastra End of Life Register.	On going review of deaths with regard to whether ACP took place, and if the outcome was as patient wished.

31.03.2013 Update
All Practices currently have MDT meetings to discuss EoL care.
Castle Practice, Tidworth had recent problem with Hants ambulance being called to one of their patients and refusing to accept the Wilts DNAR form and so patient was unnecessarily transported to SFT and admitted.

Plan
Discussions are underway with GWS and Hants ambulance service as for this Practice on the Hants border, with 27% patients having a Hants address, this is a significant issue. Discussions continue and it is hoped a generic DNR form will be available in the future.
Other Practice near county borders should be alert to a possible similar problem.

Key Risks to Achievement of Objective
Advance Care Planning does not take place with patients at Practice or hospital level.
Adastra is not updated by medical personnel involved in care of that patient
Adastra is not used by staff caring for that patient.

Project 3a	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Secondary care referrals.	*To review secondary care referrals monthly (this may be weekly where Practices are significantly above target) and with Practices review all GP locum and GP registrar referrals prior to sending*. ▪ Practices have developed in-house systems for this work, some of which involves prospective review and some choosing retrospective study of referrals made. ▪	**Activity levels moving to below fair shares budget.** Practices to produce quarterly reports to Localities with detail of the MONTHLY "in house" referral discussions that have taken place to discuss all routine referrals.	Continue to monitor monthly performance.

	This will help Practices address the increasing pressure to make referrals from patients, NICE guidance, allied health care professionals, contract changes in secondary care, etc.		

31.03.2013 Update

Practices report this is a useful activity; it has changed in most now from being a reactive process to a proactive process.

Clinicians report more “team” feeling within Practices and less of the “lone GP”, they feel supported by their colleagues in making decisions re patient care, and the in house specialist knowledge of their colleagues is being used more widely.

Interaction with the MoD has also started to address some of their referral habits which appears as “others” on SFT data

Most Practices now check referrals made by locums and F2 s prior to them being sent to Secondary Care.

Salisbury Independent Medical Practice has been written to by Sarum Director, with details of Sarum new referral process, encouraging them to do likewise.

Practices report a definite change in their referral behaviour.

M 11 YTD data for SFT shown below indicates a slight increase in referrals:

Total GP Referrals (to SFT) are 0.5% up (83 referrals) against 11/12 levels

Non-GP Referrals (to SFT) are up at 1.3% (147 referrals) against 11/12.

SARUM Budget report- Month 11 1213

Outpatient First Appointments

10% increase 10% decrease

Specialty	Firsts 11/12 M11	Firsts 12/13 M11	Firsts %	Follow Ups 11/12 M11	Follow Ups 12/13 M11	Follow Ups %
100 - General Surgery	866	869	0.3%	3323	3105	-6.6%
101 - Urology	811	860	6.0%	1885	1793	-4.9%
110 - Trauma & Orthopaedics	4892	4900	0.2%	12634	12937	2.4%
120 - ENT	630	639	1.4%	2111	1351	**-36.0%**
130 - Ophthalmology	3138	3345	6.6%	8745	8387	-4.1%
140 - Oral Surgery	1743	1758	0.9%	1557	1660	6.6%
190 - Anaesthetics	122	115	-5.7%	6	21	**250.0%**
301 - Gastroenterology	512	511	-0.2%	1351	1186	**-12.2%**
320 - Cardiology	1509	1536	1.8%	2377	2225	-6.4%
330 - Dermatology	1460	1444	-1.1%	5481	3927	**-28.4%**
340 - Respiratory Medicine	481	508	5.6%	2282	2075	-9.1%
400 - Neurology	458	473	3.3%	683	763	**11.7%**
410 - Rheumatology	747	766	2.5%	3880	4156	7.1%
420 - Paediatrics	1863	2147	**15.2%**	2392	2596	8.5%
502 - Gynaecology	1136	1072	-5.6%	1762	1729	-1.9%
Other Specialties	11517	12241	6.3%	33088	31145	-5.9%
Grand Total	31885	33184	4.1%	83557	79056	-5.4%

Next steps :

All Practices to continue this close monitoring of referrals
Local and Wiltshire wide pathway development and service redesign to ensure that appropriate care options are available

Key risks to achievement of Objective
Lack of Practice engagement
Difficulty in monitoring against fair shares if these budgets are not available at the start of the year.
Appropriate services may not be accessible.

Project 3b	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Consultant – to – Consultant referrals	Consultant to consultant referrals are known to occur, when this is about an opinion on the original complaint this is valid. In some cases referrals have been made in-house to colleagues when the condition is different to that originally referred, and could have been seen in Primary Care first. To report unusual Consultant to Consultant referral requests to Locality Leads, for them to be discussed at the Primary Care Forum	To report unusual Consultant to Consultant referral requests to Locality Leads, for them to be discussed at the Primary Care Forum Practices to devise systems to identify these and bring to the attention of Locality Leads via monthly reports.	On-going

31.03.2013 Update
Practices detail using a task box on TPP as a useful place to note these referrals prior to bringing them to locality meetings or sending to Sarum admin email.
In addition some report them to Alison Herod at SFT which enables her to be aware of trends within specialties at SFT.

PLAN
Final wording on CPP document agreed and circulated to Practices in Dec 2012
Practices to continue to be aware and to report them.

Key risks to achievement of Objective
GPs do not “spot” these type of referrals
Consultants are not willing to change their practice re in house referral to colleagues for non associated conditions of the original referral.

Project 3c	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Clinical Priorities Policy	To comply as a Practice with NHS Wiltshire Clinical Priorities Policy	All clinicians to be fully aware of the latest Clinical Priorities Policy and to refer accordingly, Recent documentation has included a revised Exceptions Committee Application Form & specific information for Grommets (adults) and Bunions ▪ Monitor procedures of limited clinical value (tonsillectomy, grommets, varicose veins, hysterectomy , lower back procedures, D & Cs) ▪ Be aware of contract variations and report back to SFT and PCT when problems arise. ▪ Critically evaluate any hospital recommendation for referral	On-going

31.03.2013 Update
There have been multiple changes to the CPP document, and the latest version has been circulated to practices.
Practices have placed this document on GP computer desktop via link so that it is easily available to them and can be easily updated with each issue of the document.
Concerns raised that in some cases the consultant refers to exceptions committee and the GP is unaware of this until letter arrives back from the exceptions committee with their decision. This prevents prior critical evaluation.
As part of QiPP all Practices have used webtool data to check referrals in 5 areas on the CPP as listed above

PLAN
The CCG will be asked (BM) to provide data per Practice and per consultant re requests to the exceptions committee.

Key risks to achievement of Objective
Practices will find it difficult to keep up to date with a constantly changing document which is due for major review. This risk will be mitigated by the use of Map of Medicine as the document can be updated centrally.

Project 3d	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Quality of information on all referrals (routine or non-elective)	Recipients report sub-optimal communication from some GPs. This may delay patient referral too correct department, or incur extra secondary care costs	Audit in Practices	Changes noted between the 2 audits

31.03.2013 Update
Sarum Data Centre checks for data and returns referral to surgery for full information prior to sending, this is rarely happening now.
Template has been produced for all TPP Practices to use, improvements to this have been made so that it contains more coded information, reducing the need for free text.
All Practices using MAU template for admissions to MAU

PLAN
Re-audit showed fewer referrals being "bounced" by the referral management centre due to lack of data on the referral

Key risks to achievement of Objective
Practices do not engage in doing the audits
Practices do not make any changes identified after audit 1

Project 3e	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Prescribing Work	Medicine Management team to agree with the 3 Sarum localities areas where change in practice would benefit patients and improve cost effectiveness. Prescribing team to continue to support as in 2011/12 with monthly information around spend and comparative performance, Scriptswitch support and visits to agree action plans/review performance practice. Each Locality will choose an appropriate area in discussion with Medicines Management that is most likely to lead to quality improvement and associated cost savings for their Locality. These will be different to the work streams for Medicines Management in QOF that have already been agreed	Continue to use Scriptswitch. Areas to be addressed will require an audit, an action plan and change of Practice activity (or continuation of good practice identified) and a re-audit.	Practices within prescribing budget

31.03.2013 Update
Scriptswitch continues to be used
West and North Sarum groups have asked PCT for assistance with data and information for work on sip feed prescribing which is expensive, and not always necessary.
Discussions under way with prescribing team re appropriate areas of work.
Some practices have had visits from the prescribing team to identify and address particular areas of overspend

PLAN
Reports on sip feed work in Q4 awaited
Sarum South decision needed re area of work to be completed.

Key risks to achievement of Objective
Practices do not address issues of overspending
Scriptswitch continues to cause difficulties

Project 3f	PRINCIPLE AND REASON	APROACH TO MONITORING	MEASURE OF SUCCESS
Optimisation of outpatient follow-up appointments	Aim to reduce ratio levels especially in the specialties detailed. Current ratio for 1st Outpatient appointments to Follow-up appointments is 1:1.6, which is above the national and SHA average. n.b. costs are such that a re-referral into a specialty may be cheaper than 2 or 3 follow-up appointments.	Practices to monitor follow-up appointments at Out Patients To undertake a one month audit of follow-up outpatient appointments and develop in house systems to reduce unnecessary follow-ups, especially in areas listed below To be repeated 4 months later. Localities to create plans to aim to reduce the following high level areas of follow up outpatient attendance for Sarum by the stated amount:- Colorectal surgery -385 Trauma and Orthopaedics -2028 ENT -423 Gastroenterology -299 Dermatology -265 Thoracic medicine -684	

		Rheumatology -430 Gynaecology – 85 Total :4,599	

31.03.2013 Update
Audit highlighted that some FU appointments are unnecessary and information fed back to CCG
Various in house systems developed depending on processes in place at each surgery.
GPs looking more closely at Consultant letters re the next FU appointment
GPs discussing FU with patient and consultant and doing this if appropriate in Primary Care, but GPs finding these discussions do take significant time.
M11 reports shows sustained decrease in OP follow up appointments, with a reduction year on year of 5.4 % (4501 attendances) against a full year planned reduction of 4,599.

PLAN
GPs to continue to be aware, and once more audit data is available plans to be developed in each locality to address the highest clinical areas as listed above.
Work with SFT to review consultant practice.

Key risks to achievement of Objective
GPs do not consider the possibility of changing FU arrangements when reading consultant letters
Consultants do not agree to some OP FU being done in Primary Care

Project 3g	**PRINCIPLE AND REASON**	**APROACH TO MONITORING**	**MEASURE OF SUCCESS**
Intensive Service Users (A and E high attenders)	To reduce the attendance in secondary care of those patients identified as Intensive Users by Information Team at NHS Wiltshire.	Audit on A&E frequent attenders to be undertaken in June 2012 and reported to locality meeting Care plans written for these patients and shared with all necessary agencies, including Out of Hours, Walk-In Centres and to consider uploading to Summary Care record (with patients' consent) Peer review of audit findings at locality meeting Re-audit in November 2012	Audit 1 June 2012 Audit 2 November 2012

31.03.2013 Update
Audits undertaken and reported:-

PBC web tool provides excellent on going data re these patients

Audit highlighted to GPs these patients, in some surgeries there was not the awareness of the frequency with which these patients attended A and E as reports filed by different GPs, patients seen by different GPs etc,

Frequent attenders from some Nursing / Rest Homes identified and GPs / surgeries working both with these patients and with the homes to ensure that a visit to A and E is really necessary.

GPs felt it was more appropriate to discuss with some patients their frequent attendances at A and E, and develop a plan with the patient / parents rather than with other agencies. This was particularly with younger patients.

It was identified that these users often attend A and E out of GP hours, and may be directed to A and E by OOH.

A named GP to manage these patients within a practice was also found to be helpful.

Adastra was updated when appropriate.

Audit 2 identified similar areas as above, with few changes to numbers as those who attend frequently are patients who need significant input to change their thinking and actions. GPs continue to work with these patients to try and effect change that is clinically safe.

PLAN
Surgeries to continue to be more aware of these patients
Nursing Home Care LES to be developed
Information links and support to the community transformation programme

Key risks to achievement of Objective
Complexity of making at Nursing / Rest homes
Practices stop addressing the issues with frequent attenders