NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 25 June 2013

For: PUBLIC session ☒ PRIVATE Session ☐

For: Decision ☐ Discussion ☒ Noting ☐

Agenda Item and title:	**GOV/13/06/14 WWYKD Service Level Agreement 2013/14 (previously PBC/Secondary Care LES)**
Author:	Andy Jennings, Commissioning Manager (WWYKD)
Lead Director/GP from CCG:	Mike Relph, Group Director (WWYKD)
Executive summary:	The purpose of this report is to set out the 2013-14 WWYKD Group Service Level Agreement (SLA). This comprises: • The work to be undertaken by the WWYKD Group of practices in 13-14 • How the SLA will be used • How this SLA links to the QOF QP series of indicators The work to be undertaken is based on the requirements of the Clear and Credible Plan and the 2013-2015 Strategic Plan. 4 specific types of activity will be funded through the SLA: • Engagement with Projects (covering community transformation; elective care; public health; mental health; care homes; meds management) • Continuation of 12-13 Secondary Care LES actions • Engagement with CCG commissioning • Data validation and challenges Total funding available is £1,311,400 based on a list population at 31 March 2013 of 168,523. This includes a CCG contribution of £123,441 ring-fenced for care homes support. The detailed requirements for each project along with the reporting requirements and payment mechanisms are described elsewhere.
Evidence in support of arguments:	N/A

Who has been involved/contributed:	WWYKD Executive led by Helen Osborn (Chair) & Mike Relph (Group Director).
Cross Reference to Strategic Objectives:	This SLA supports all seven of the CCG's strategic objectives / priorities.
Engagement and Involvement:	Discussion and agreement of work priorities with practices via existing structures (GP Forum, WWYKD Exec, Locality meetings).
Communications Issues:	None
Financial Implications:	No unfunded financial implications. Payments under SLA will not exceed total funds allocated.
Review arrangements:	This paper was agreed by the CCG Clinical Executive on 11th June 2013. Quarterly reports will be presented to the Governing Body. Project plans and reports will be monitored by the WWYKD Executive / Project Governance Group/ WWYKD Commissioning Review Meeting.
Risk Management:	If the desired outcomes are not achieved, the CCG's delivery of its strategic plan will be compromised, and resources may therefore have been wasted. Risks of non-delivery will be mitigated through monitoring and review of progress.
National Policy/ Legislation:	N/A
Equality & Diversity:	No adverse impact identified.
Other External Assessment:	N/A
Next steps:	Paper to be sent to LMC for information. Details of the SLA with supporting detailed project level documentation and reporting requirements is to be disseminated to WWYKD GP Practices.

2013-14 WWYKD Group Service Level Agreement (SLA)

(Previously PBC and Secondary Care LES)

Introduction

Wiltshire CCG aims to commission the highest quality of care for our patients as close to their home as possible. It has identified 7 priority areas in the strategic plan 2013 – 2015. The overarching strategy, to support patients in being treated at, or closer, to home, underpins all programmes of work, including this SLA.

The purpose of this SLA is to enable practices to contribute to the process of designing and making improvements and alterations to local healthcare systems and processes, in order to improve the effectiveness and efficiency of the care delivered. In doing so, this will help to achieve the Community Transformation programme; elements of the WWYKD and Wiltshire Quality Innovation Productivity and Prevention (QIPP) programme; and the WWYKD practices' Quality Outcomes Framework (QOF) requirements.

It is intended that the work in the SLA should:

- support and/or supported by but not duplicate other initiatives including (National) Enhanced Services and QOF
- be useful to those undertaking it
- benefit patient care, and support the effective use of resources
- build on previous years' LES outcomes
- support the development of innovative solutions from across the Group

Types of Activity Funded by the SLA

4 specific types of activity will be funded through the SLA; details are shown at Appendix 1:

- Engagement with Projects (covering community transformation; elective care; public health; mental health; meds management) (Appendix 2)
- Continuation of Secondary Care LES actions (Appendix 3)
- Engagement with CCG commissioning
- Data validation and challenges

Projects Summary

Appendix 2 is a summary of the project work which WWYKD will specifically seek to progress during 2013/14. This table also shows the related CCG Operating Plan references. Each project has been chosen because either:

- It is a CCG priority for 13/14 and contributes to community transformation

- WWYKD benchmarks high based on JSNA (Joint Strategic Needs Assessment) data
- Improvements in pathway can be achieved which may result in both a patient experience/quality improvement and reduced cost
- Potential for financial savings has been identified without detriment to patient care
- Issues have been identified with the availability of current service provision
- It is required in order to help achieve the CCG-wide QIPP programme
- It is a continuation of projects begun in 2012-13

Desired Outcomes

A number of inter-related outcomes are expected to be achieved, in full or in part, as a result of successfully progressing the projects and other areas of SLA work outlined. These include:

- Reduction in acute attendances
- An increase in the average age for hip/knee replacements
- Maximising the use of the most appropriate provider for patients, first time, in line with patient choice and provider availability
- Improved management of dementia patients within the community setting
- More patients cared for in the community, kept out of crisis and out of hospital
- Reduction in urgent admissions through implementing risk stratification, care coordinators, and care co-ordination for those patients at greater risk of non-elective admissions
- Improved management of patients in care homes, resulting in continuing reduction in emergency admissions to acute trusts from Care Homes
- More effective and efficient use of the full range of community beds
- Increased delivery of appropriate services locally i.e. patients managed by GP or outpatient / community services provided outside the acute setting – initially diabetes patients
- Agreed way forward for MIU services
- Improved uptake for health checks; and improved opportunities for GPs to positively influence patient behaviours
- Improved access to diagnostics in community setting e.g. community radiology
- Increased proportion of people able to die in their place of choice
- Improved accountability of acute provider coding and costing
- Continued improvement in effectiveness and value for money of prescribing activity

Funding

It was agreed at the Clinical Executive meeting on 14th May 2013 that:

- £7.21 per capita would be available to Groups, matching the amounts available (through the combined PBC LES and secondary care LES) in 12-13.

- An additional £400K allocation would be made to Groups, specifically to fund care homes work. This has been allocated to Groups based on the proportion of care homes beds to total Group population, resulting in an allocation to WWYKD of £123,441.

The net result is an SLA value for WWYKD of £7.78 per capita inclusive of the additional care homes funding for a population of 168,523 at 31 March 2013.

Funding Breakdown

Appendix 1 shows the allocation of funding.

Reporting

Practices will be expected to provide appropriate reports and audit data for each area of funding.

QOF Pathways

Appendix 3 lists the QOF QP pathway proposals for 13/14. These are included here to confirm that they are closely related to the areas of work that will be carried out by Practices under this SLA.

Detail of WWYKD Care Homes Project

Details of the WWYKD Care Homes Project are shown at Appendix 5

Recommendations

The CCG Governing Body is asked to:

- Consider and note the proposed programme of work to be progressed by WWYKD Practices during 2013/14;
- Note the commitment of the SLA funding as detailed;
- Seek quarterly updates on progress together with a performance scorecard

Appendix 1: WWYKD Allocation of SLA Funding 13/14 by Type of Activity

Population: 168,523 (WWYKD population, 31 Mar 2013)
Total SLA available: £1,311,400

Type of Activity	**Details**	**Funding available: £123,441 ring-fenced for care homes; AND** **£7.21 per capita £1,215,050; AND** **£27,091 balanced to other Groups** **= £1,311,400** **= £7.78 per capita**
Projects	Engagement with: Community Transformation: • Continuation of Hip and Knee Pathway • Implement care co-ordinators and associated processes (MDTs etc) • Contribute to further development of Neighbourhood Teams • Community beds review • Care homes pilot (year 2) – see separate entry below • Develop options for diabetes • Improved utilisation of community geriatrician • Review of and potential changes to community diagnostics • MIU review • Developments in improving End of life care Elective care: Continued use and development of the RSS Public health: staying healthy: falls pathway/passport proposals Mental health: input to work aimed to improve full range of MH services Medicines Management: prescribing initiatives	£1.39 comprising: £0.77 from recurrent resource attributed to projects £0.62 in 2013/14 from non recurrent resources (based on anticipated under utilisation of care home LES funding) to support community transformation engagement £234,250
Care Homes Project	Continuation of WWYKD Care home beds project (started in 12/13 covering 900-1,000 residents) Practices paid according to level of engagement with project, either £50, £200 or £225 per resident. Based on numbers of patients and values claimed by practices in 12-13, £200K is expected to be sufficient unless there are significant additional numbers of care homes patients eligible under the pilot but for whom no	£1.19 / £200,000 comprising: £0.73 / £123,414 additional CCG funding plus £0.46 / £76,600 SLA funding

	additional activity has been conducted or claimed for, so far; and/or an increase in the level of funding claimed per resident. Any additional funding required, will need to be found from "projects engagement".	
Continuation of 12/13 Secondary Care LES actions	• Minimising risk of growth in secondary care activity budgets • In-practice referral reviews, budget and activity • Referral quality review • Practice to sign off locum referrals • Telephone access for paramedics and consultants • Requests for visits reviewed within 60 mins	£2.00 (no change from previous years) £337,000
Engagement with CCG commissioning	Engagement with: • Attendance at Locality meetings & WWYKD GP Forums • Work to improve whole-system outcomes and processes, where not already listed above (eg. RUH discharge project; A&E review) • Attendance at Locality Leads meetings • Attendance at Community Transformation steering group meetings / workshops / other events	£2.20 (consistent with Sarum) £370,750
Finance activity review , data validation and audit	Continuing audit work and validation of high cost spells and specific other audits, as in 12/13 (which identified £5M in data challenges)	£1.00 (no change from previous years) £168,500
Projects funded elsewhere	Projects where practice engagement is funded via other streams, but which are part of the overall work programme: • Mental Health – funded by Dementia LES • Staying Healthy – Public Health screening / health checks; motivational interviewing – funded by Public Health • Implement Risk Stratification Tool	Not applicable
Totals	Per capita Total (rounded)	£7.78 £1,310,500

Appendix 2: Summary of WWYKD Project Work for 2013-14

Project	Notes	CCG Plan refs
Community Transformation: Elective care: Hip & Knee OA pathways	Continuing work from 12/13, as WWYKD still benchmarks high. Physiotherapy interventions and hip/knee classes	PC1b PC1c
Community Transformation: Management of High Risk patients and Care Co-ordinators	Introduce a risk stratification tool, Care Co-ordinators to help manage higher risk patients, MDTs to manage those patients, and engage with further development of neighbourhood teams in line with Community Transformation Project	UPC1 PC5b UPC4e UPC3c
Community Transformation: Community Beds	Embedding work started in 2012/13 and working with LA to develop the STARR project and integrate into the Community Transformation Project	UPC1 PC5b UPC4e UPC3c
Community Transformation: Care homes	Second year of two year care homes pilot, improving links between practices and care homes, and improved management in the community of care home residents	UPC1 PC5b UPC4e UPC3c
Community Transformation: Community based services: Diabetes; community geriatrician	Develop use of diabetes chronic disease clinics in the community; link to delivery of community geriatrician support; develop options for other services that are currently delivered in a secondary care setting, which may be possible to deliver in a community setting outside of PbR	PC1b UPC3a PC2b UPC1a
Community Transformation: Community Based Services: Community Diagnostics	Identify and if approved implement improved access to diagnostics in the community e.g. walk-in radiology; lab samples	PC1b UPC3a PC2b UPC1a
Community Transformation: Community-based services: MIU review	Review use of MIU by practices; review and improve management of patients who are frequent users of MIU; review MIU opening hours and service provision	PC1b UPC3a PC2b UPC1a
Community Transformation: End of Life Care	Investigate options for improved access to non-acute beds (link to community beds project). Use of Gold Standard Framework for EOL care. Continued focus on use of Adastra and EOL care planning.	UPC3e
Elective care: Referrals and outpatients (RSS)	Develop options for Advice and Guidance Services, further roll out and recording of referrals, continuing improvements to the quality / completeness of referrals	PC1a PC3a
Public Health: Staying healthy	Increasing uptake of health checks; GP training in motivational interviewing and brief interventions; investigate options for falls passport/pathway improvements	JW1-4
Mental Health:	Working with mental health portfolio of projects i.e. input to work aimed to improve full range of MH services – separately described in CCG Mental health strategy and workplans	MH
Medicines Management:	Prescribing initiatives (details to be confirmed)	

Appendix 3: Continuation of WWYKD Practice Actions from 2nd Care LES 11/12 & 12/13

1	**Minimising risk of growth in secondary care activity budgets** ➢ Practice engagement in WWYKD wide, Locality and Practice based peer review, referral, admission and attendance analysis, activity and costs
2	**In-practice review of referrals and activity budget information, and RSS summary referral information** ➢ Review in practice and report to locality group ➢ Practice to use PBC Web tool
3	**Quality of patient information in individual referrals** ➢ RSS to feedback to practices individually throughout the year, common themes fed to locality ➢ Practices to action accordingly, and report on actions to locality
4	**Practices to sign off locum referrals prior to sending**
5	**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
6	**Requests for emergency home visits** ➢ Ensure that requests are reviewed within 60 minutes, and respond where appropriate

Appendix 4: QOF QP PATHWAYS for WWYKD practices 13/14

QP 8, 11 and 14

QP 8

Pathway 1: Use of the Referral Support Service for all suitable Orthopaedic, Ophthalmology, ENT, General Surgical, Urology and Gynaecology, Dermatology, Cardiology referrals

Pathway 2: Addressing threshold issues for Hip and Knee referrals – use of Physiotherapy Hip and Knee classes for appropriate patients

Pathway 3: Support compliance with INNF and Prior approval processes through use of RSS for all eligible referrals

QP 11

Pathway 1: Familiarisation and use of a Risk Stratification Tool

Pathway 2: COPD Admission Avoidance

Pathway 3: Care Co-ordination for Care Home residents

QP 14

Focus 1: MIU attendances, all ages

Focus 2: Frequent attenders, all ages

Focus 3: Frequent attenders at high risk of admission, all ages

Appendix 5: WWYKD Care Home Project

FUNDING: – Trowbridge, Devizes and Westbury / Warminster localities

Level	Services to be provided
A **£50 per resident**	a) Annual GP review (this will be at least twice during the pilot project) b) Additional review at 3 or 6 months for less stable residents where necessary c) Update care co-ordination and advanced care planning documentation d) Ensuring information is updated on ADASTRA e) Co-ordinating review alongside pharmacist review, where pharmacist reviews are already in place f) Key care home staff to participate in review g) Practice to report on each item quarterly to locality meeting
B **£200 per resident**	h) All services from Level A provided i) Minimum weekly visit / ward round by GP, at the same time where possible – planned and agreed with the care home. To review residents as requested by staff. *(See notes below re: small homes*)* j) Named GP lead per home and cover arrangements in place k) New residents seen and reviewed within 7 working days of admission l) Residents returning from hospital seen within 7 days m) Clear contact protocol for homes to contact practice n) Practice process in place to triage non routine requests from the home o) Repeat prescriptions processed within 24 hours
C **£225 per resident**	p) All services from Level A and B provided q) Community involvement with MDT meetings, if possible with practice GPs, practice manager, community matron, care home representatives r) Education and development sessions to be developed for care home staff (or joint sessions for smaller homes)

Funding: Melksham Locality

Services to be provided	Funding
All the services listed above, provided by a Locality Nurse practitioner, employed by one practice on behalf of the locality and in liaison with all practices in the locality.	£225 per resident as with other localities

Project notes:

- Project to run for 2+ years from start (e.g. January 2012 till April 2014 if not continued)
- Mid project evaluation by each locality in September 2012 and 2013
- Key measures: Admissions by home and place of death / desired place of death
- Additional measures: Number of care plans in place – approx. 80% by December 2012
- Monitoring will be undertaken through feedback and review at locality meetings
- * The expectation is that a weekly visit will be required for all care homes initially in order to deliver the aims of the project. The requirement for a weekly visit will remain for all practices with over 20 residents. The requirement for a weekly visit in small care homes (less than 20 residents, or less than 20 residents per practice), could, once care plans and EOL plans are in place and if there are well established relationships with the care home staff, alter to a minimum of weekly telephone contact and a monthly visit to review residents.

Funding notes:

- Number of residents as determined by number in homes registered to the practice at the start of each quarter
- Full payment per resident will be made at the start of each quarter
- Practices who do not undertake the services required will be required to return payment
- Some pharmacy reviews are already being undertaken by the medicines management team, and this project requires coordination between staff.