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/13/06/15 NEW Primary Care Service Level Agreement 2013/14 (previously PBC/Secondary Care LES)**
Author:	Neal Goodwin – Commissioning Manager NEW Elaine Smith – Practice Manager New Court Surgery
Lead Director/GP from CCG:	Ted Wilson – Group Director NEW Dr Simon Burrell, GP Chair NEW Group; Dr Jonathan Rayner, GP Vice Chair, NEW Group
Executive summary:	The purpose of this report is to set out the proposals for the 2013-14 NEW Group Service Level Agreement (SLA). The SLA focuses on supporting CCG engagement and six specific activity streams that support the delivery of the operational plan and the priorities identified within the NEW work programme: A. Basic commissioning element B. Improve links with secondary and urgent care services C. Practice engagement with development of specific care pathways D. Community transformation and practice engagement E. Medicines Management F. Care home and frail elderly management The total funds available are £1,347,117 based on a total payment of £7.21 per patient for a list population of 165,338 plus an additional £155,030 from CCG funds. A contingency fund of £34,720 will be top sliced to fund any unforeseen expenditure or primary care based projects.
Evidence in support of arguments:	N/A
Who has been	• NEW Executive led by Simon Burrell (GP Exec Chair) • Discussion at Monthly NEW Executive Committee

involved/contributed:	• Locality Meetings • Practice Manager representatives
Cross Reference to Strategic Objectives:	This SLA supports the following priority areas; Planned Care and Unplanned Care and frail elderly. It also contributes to the delivery of the QIPP target for the Great Western Hospital Foundation Trust (GWHFT) contract.
Engagement and Involvement:	Discussion and agreement of work priorities with all practices via GP Executive representatives.
Communications Issues:	The NEW Group has used a number of stakeholder meetings, since its recent formal establishment in April this year, to test the importance of its priorities to various agencies, groups, forums and members of its practice population. It will continue to do so to inform this year's and future priorities and plans.
Financial Implications:	No unfunded financial implications. Payments under SLA will not exceed total funds allocated
Review arrangements:	The annual report will be presented to the Governing Body. Project plans and reports will be monitored by the NEW Executive.
Risk Management:	If the SLA is not delivered it will impact on the ability of the CCG to deliver its strategic plan for 2013 – 15. These risks will be mitigated through monitoring and review of progress using standardised audit and reporting templates. A significant increase in the number of care home patients could result in a cost pressure. A top sliced contingency fund (3% of total budget) is available to assist in mitigation.
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 sign off. Detailed SLA to be produced with specific KPIs.

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North & East Wiltshire (NEW) Group
Primary Care Service Level Agreement (SLA) 2013-14

1. Purpose

The vision of NHS Wiltshire CCG is *"To ensure the provision of a health service which is high quality, effective, clinically led and local."* At the heart of this vision is the focus on developing a model that delivers care to Wiltshire people in or close to their own homes. In order to deliver this, the CCG in its *Clear and Credible Plan 2013 – 2015* identified 7 key strategic priorities:

- Staying healthy and preventing ill health
- Planned Care
- Unplanned Care and frail elderly
- Mental Health
- Long term conditions (including Dementia)
- End of life care
- Community services and integrated care

This Service Level Agreement (SLA) replaces the old Practice based Commissioning PbC LES and the Secondary Care LES. Its purpose is to outline how practices will utilise Primary Care funding to:

- Support the achievement of the CCGs strategic priorities.
- Support the delivery of the NEW and Wiltshire CCG Quality, Innovation, Productivity and Prevention (QIPP) programme.
- Enable practices to be involved more closely in the commissioning process.
- Enable practices to work together to alter clinical pathways for the benefit of the patient.
- Help practices get involved in the development of community care.
- Benefit patient care and support effective use of resources.
- Build on previous years' PbC outcomes.
- Develop innovation from grass roots.

2. Outcomes

This SLA will support the achievement of the following outcomes:

- Reduction in urgent admissions to Acute hospitals from Care Homes
- Reduction in urgent admissions through appropriate Primary Care interventions
- Increased delivery of local services i.e. patients managed by GP or outpatient services provided in the Primary Care environment
- Support the delivery of the QIPP savings target.

3. Funding

It was agreed at the Clinical Executive meeting in May 2013 that the previous PbC LES at £3.20 and Secondary Care LES £4.01 would be combined into a single Service Level Agreement (SLA) payment of £7.21 per patient. This equates to a total of £1,192,087 based on the NEW patient list size of 165,338. An additional £155,030 has been made available by the CCG to fund the additional work being planned to support Residential Homes giving a total of £1,347,117.

From this sum a 3% contingency fund of £34,720 (£0.21 per patient) will be top sliced to fund any unforeseen expenditure or primary care based projects.

The SLA funds related to practice engagement will be held centrally at NEW Group Executive level, with the remainder of the funding being paid to each practice against agreed payment schedules as described under each work stream. This is a recurring resource with the intention that in 2014/15 this will be formalised into a 3 year SLA with annual review of the work stream requirements. These requirements will include effective referrals, prescribing and local projects/initiatives that support the CCG's planning requirements and NEW Group's pan Wiltshire service responsibilities.

4. Payment and Reporting

Practice performance against this SLA will be measured by the provision of direct evidence where indicated e.g. audits, and/or summary reports as detailed. Templates will be provided as required to each practice for all activities for the required audits, action plans and reports. Payment will be made on the production and review of the appropriate evidence at the required intervals. The Executive will be checking with each practice their involvement and actions on a quarterly basis and allocated funds accordingly. Practices will be required to report quarterly on progress.

A summary of the activity streams, expected outcomes and financial implications can be found in Appendix 1.

5. Areas of Activity

The SLA focuses on six key areas of activity:

A. Basic commissioning element – (18% of funds)
B. Improve links with secondary and emergency services – (15% of funds)
C. Practice engagement with development of specific care pathways - (18% of funds)
D. Involvement in community transformation and practice engagement – (18% of funds)
E. Medicines Management - (15% of funds)
F. Care home and frail elderly management – (12% of Funds)

A. Basic Commissioning Element

- Each practice to have a named Commissioning Lead GP
- GP attendance at 70% of regular locality meetings. Provide clinical input as requested and appropriate for the NEW Group work programme
- Carrying out 100% of audits as agreed at locality meetings, and where appropriate using Perception+ – measured by annual return
- Create a register of between 0.5 and 1.0% of patients in each practice most at risk of hospital admission – where appropriate using Perception+
- A representative from each practice to attend their appropriate local area board meeting (or health equivalent) annually
- Continue to use 'Grumpy/Pleased Docs' initiative
- Attend regular GP clinical forums

£248,006 at a rate of £1.50 per patient is available for this activity

B. Improve Links with Secondary Care and Emergency Services

- Have a dedicated phone line for use by ambulance service, A&E departments and ambulatory care. Trusts to be reminded that this service is available
- Respond quickly to requests by these providers for help in acute situations where GP input may be helpful.
- To accept urgent calls from A&E departments from Senior Clinicians who feel discussion with the GP could improve patient care and decision making which may reduce need for admission.
- To monitor and review, at least quarterly, Emergency Department (ED) patients from individual practices and explore opportunities for alternative referral pathways. Share the learning and results with the NEW GP Executive Group.

£206,672 at a rate of £1.25 per patient is available for this activity

C. Practice engagement with development of specific areas of Pathway Development

This activity is to be carried out in conjunction with other practices and will in the main be organised as part of CCG membership. The input required from practices may be in the form of a general review or consideration of ways of improving effectiveness. In some cases this may be part of a wider CCG initiative and therefore not specific to one or all practices.

Where this is the case and to qualify for the payment, each practice will be required to provide evidence that they have met, discussed and considered options as required. The evidence will be in the form of a separate stand-alone report or as part of the annual practice summary report.

All practices are expected to take part in the development of pathways and adhere to agreed outcomes.

Orthopaedics

- Use a local scoring system for orthopaedic referrals
- Consider local plan to offer weight reduction to patients with BMI >30 before referral
- Be involved with and use primary care orthopaedic service as it develops
- Monitor, audit and help development of therapy services
- Conduct a practice based audit of back pain services to inform a NEW Group pathway review

Ophthalmology

- Put in place, and refer to a primary care based ophthalmology service for all ‘not sure’ referrals and those referred from opticians - Measured by reduced referrals to secondary care Ophthalmology service
- Consider development of specialist opticians working with ophthalmologists
- Consider links of this service to diabetic retinopathy service and glaucoma follow up service
- Closer working with Referral Centre to improve management of primary care based services – Measured by audit

Therapy Services

- Consider the introduction of in-house physiotherapy in practices for simple advice

- Use of exercise sheets and recommendations for all patients before referral to physiotherapy where appropriate
- Audit and review back pain management
- Work with community reform plans to develop more appropriate falls service and back pain service.

Rheumatology

- Investigate provision of a locally based musculo-skeletal service incorporating: rheumatology, physiotherapy and orthopaedic input.

Long term Neurological Problems

- Audit of patients on practice list with long term neurological patients.
- Consider and advise on ways of integrated help between medical, social and third sector support.

Dermatology

- Investigate and introduce where appropriate ways of managing dermatology cases closer to home

£248,006 at a rate of £1.50 per patient is available for this activity

D. Involvement in Community Transformation – Practice Engagement

The CCG is undertaking a major review of community services. The agreed approach is to make all health related local services become based on practices with specialist services clearly supporting the practices.

Practices will need to alter their management arrangements and ways of working to work with this change and make it fully effective. The CCG will assist with this and practices will need to use a portion of the funding to enable suitable change to occur.

- Practices to comply with and implement plans as they are agreed by the CCG and localities
- Practices to provide representation and support at appropriate community transformation meetings and workshops
- Practices to work with neighbourhood teams to improve integration.

£248,006 at a rate of £1.50 per patient is available for this activity

E. Medicines Management

Savings in prescribing are a key component of the QIPP plans and essential to the CCG budget. With this in mind we would like the practices to continue working with the medicines management team to optimise clinically effective prescribing.

Practices to work with medicines management team to discuss practice prescribing scorecard, keep practice medication use under review to include use of pain management medication. Identify and implement improvements in clinical prescribing and cost effectiveness in conjunction with the medicines management team.

- Demonstrate progress towards the CCG and/or national average for prescribing costs concentrating on areas where practices are above average.
- Audit and improve use of opioid patches in conjunction with Medicines Management team. Complete audit in Medicines Management folder
- Work with Prescribing Advisers to continue to optimise prescribing. Continue with 'Scriptswitch' and prescribing related audits.
- Practices to meet with prescribing team on an annual basis to discuss prescribing costs to draw up plans for the year and to agree targets.

£206,672 at a rate of £1.25 per patient is available for this activity

F. Care Home and Frail Elderly Management

Secondary care clinicians report a significant number of care home residents being admitted to the District General Hospital for whom care would be been more appropriate in the care home. A pilot in the East Kennet area has demonstrated the benefits of improved contact with the care homes and as a result of this NEW plan to extend this across the whole area. See Appendix 2 for details of pilot.

The aim of this part of the SLA is to enable GP practices to commit more time working with care homes to improve the care and care planning for patients in the homes and also to support the enhanced care of frail elderly patients identified as being at risk but still managing to live at home. Practices will work with care homes to ensure that all non-elective admissions to secondary care are appropriate and discharges to homes from hospital are supported

GPs will be required to visit care homes regularly, to make sure residents have a record of their future wishes for medical care and intervention, to work with local elderly care consultants, to review all residents from a medical point of view in a timely way and to help the homes develop their own care and support for medical issues. Practices are required to coordinate care in homes where patients are from more than one practice.

£155,030 is available to be divided quarterly based on the number of registered practice patients in care homes. To qualify for the payment of £91 per patient, practices will be required to submit quarterly reports confirming the number of patients in each care home. The first payment will be payable after the first list is submitted by July 2013. Thereafter payments will be made quarterly with the final payment being subject to a summary report by each practice detailing the practice involvement and input throughout the year and confirmation that the following requirements have been met:

- Annual GP review
- Additional reviews at 3 or 6 months for less stable residents where necessary linking as appropriate with the consultant geriatrician
- Update care co-ordination and advanced care planning documentation
- Ensuring information is updated on ADASTRA
- Medication revue
- Key care home staff to participate in review
- Practice to report on each item quarterly to locality meeting
- Interim visits as needed under GMS to be carried out as usual
- Regular weekly/monthly (determined by the size of the home and the number of patients) visits / ward rounds by GP, at the same time where possible – planned and agreed with the care home. To review residents as requested by staff.
- Named GP lead per practice per home and cover arrangements in place
- New residents seen and reviewed within 7 working days of admission
- Residents returning from hospital seen within 7 days
- Clear contact protocol for homes to contact practice
- Practice process in place to triage non routine requests from the home
- Educational forums at least twice annually for residential homes between key practice and residential home staff
- Practices to report on this regularly

A finite fund of £155,030 is available for this activity. Based on current NEW patients in Care Home Beds this equates to £91 per Care Home Patient.

6. Recommendations

The CCG Board is asked to:

- Consider and note the proposed programme of work to be progressed by NEW Practices during 2013/14
- Approve the commitment of the SLA funding as detailed
- Seek progress updates as required

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Appendix 1 – Summary of Activity Schemes

Activity Stream		Action	Outcome measure	Reporting	Payment
					Population – 165,338
A.	Basic commissioning element	• Each practice to have a named Commissioning Lead GP • GP attendance at 70% of regular locality meetings • Carrying out 100% of audits as agreed at locality meetings • Create a register of between 0.5 and 1.0% of patients in each practice most at risk of hospital admission • A representative from each practice to attend their appropriate local area board meeting (or health equivalent) annually • Continue to use 'Grumpy/Pleased Docs' initiative • Practice manager and one partner to meet annually with NEW representatives to review activity data and to discuss progress of commissioning.	• List of named GPs • Attendance list produced • All audits completed • Risk Register • produced by practices • Representatives available • Meetings scheduled and recorded	Quarterly / annual reports as required	£1.50 per patient **Funding £248,006**
B.	Improve links with secondary and emergency care services	• Have a dedicated phone line for use by ambulance service, A&E departments and ambulatory care. Trusts to be reminded that this service is available. • Respond quickly to requests by these providers for help in acute situations where GP input may be helpful. • To accept urgent calls from A&E departments from Senior Clinicians who feel discussion with GP may improve patient care and decision making which may reduce need for admission.	• Reduction in inappropriate admissions	Quarterly report to the NEW Executive Annual reporting	

		To monitor and review, at least quarterly, ED patients from individual practices and explore opportunities for alternative referral pathways. Share the learning and results with the NEW GP Executive Group.			£1.25 per patient **Funding £206,672**
C	Practice engagement with development of specific care pathways	Specific actions in the following key areas in addition engagement as part of wider CCG initiatives in effective pathway design and development • Orthopaedics • Ophthalmology • Therapy Services • Rheumatology • Long Term Neurological Problems • Dermatology		Audits, project plans, project involvement and engagement and quarterly/annual reports as required	£1.50 per patient **Funding £248,006**
D	Community transformation and practice engagement	• Practices to comply with and implement plans as they are agreed by the CCG and localities • Practices to provide representation and support at appropriate community transformation meetings and workshops • Practices to work with neighbourhood teams to improve integration	• The introduction of Care Coordinators/Navigator • Support and engagement in the development of the Primary Care Teams as part of the Community Transformation delivery model • Improved integration with Neighbourhood teams. • Increased referrals to social and voluntary sector organisations	Quarterly reporting to the NEW Executive Annual Report	£1.50 per patient **Funding £248,006**

E	Medicines Management Compliance	Work with meds management team, discuss practice prescribing scorecard, keep practice medication use under review to include use of pain management medication. Identify and implement improvements in clinical prescribing and cost effectiveness in conjunction with the meds management team.	• Progress towards CCG and/or national average for prescribing costs • Audit and improve use of opioid patches in conjunction with Meds Mgt team. Complete audits • Work with prescribing Advisors to continue to optimise prescribing. Continue with Scriptswitch and prescribing related audits.	Meds Management Scorecard achievements	£1.25 per patient **Funding £206,672**
F	Care home and frail elderly management	Care of Care Home patients and the Frail Elderly currently managing in their own homes	Support the reduction in inappropriate admissions to GWH / RUH from Care Homes	Quarterly reporting to the NEW Executive End of year report summarising practice input throughout the year Provision of care plans as requested	£91 per patient based on finite allocation of and 1703 residential beds **£155,030**
				Contingency Fund	£0.21 per patient **£34,720**
				Total Funding	**£1,347,117**

Appendix 2

East Kennet Nursing Home Pilot

In 2011 the East Kennet PBC Group looked at the data for non-elective admissions and in particular the admission rates from nursing and residential homes. It was clear that a number of patients had been admitted, especially out of hours, when with improved communication and planning, admission could be avoided and the care provided more appropriately at the care home. Discussion was had about what measures would help and the following were implemented:

- Regular visits from the Community Geriatrician. The aim was for her to assess residents whose health had changed recently and to draw up plans for their medium to long term care. She would also help review the end of life wishes and the documentation of this.

- Improved IT, lap tops were put into the nursing home with access to System 1, to allow authorised clinicians access to the patients' records both in and out of hours.

This programme has been running for almost 2 years and has had definite benefits both in terms of reduced admissions but also of the care of the patients. Data on the admissions is shown below.

There was no funding for this programme which was seen as a pilot but we feel there are clear benefits and we would wish to continue this and suggest similar programmes could be used across the CCG.

CARE HOME ADMISSIONS AUDIT

The East Kennet area includes around 32,000 patients shared between five practices. The figures for the admission rates were provided by the information department as part of a wider review of admission data for the whole of the Wiltshire CCG and the figures below are taken from that. The only changes have been cross checks on the number of beds per nursing home with the homes themselves.

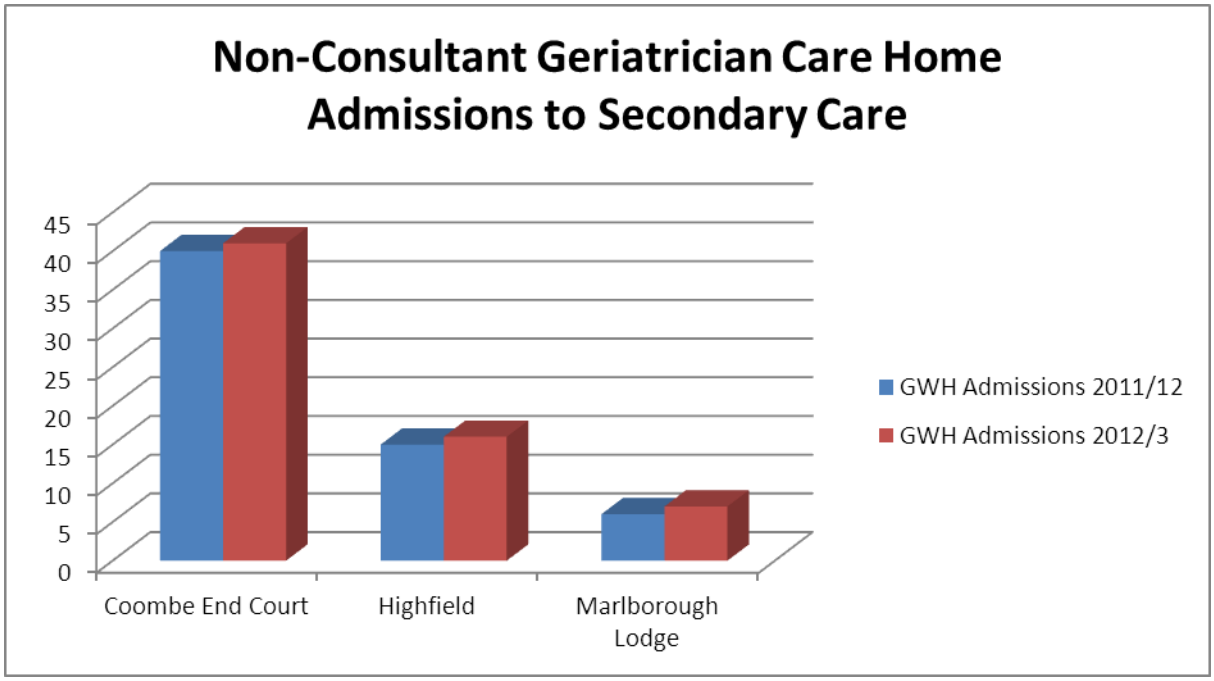
There are six care homes within the East Kennet area which are shared between the five practices and set out below. The pilot with the Geriatrician involved three out of the six care homes and so provided a good opportunity to compare the effect of the pilot with other homes that we look after.

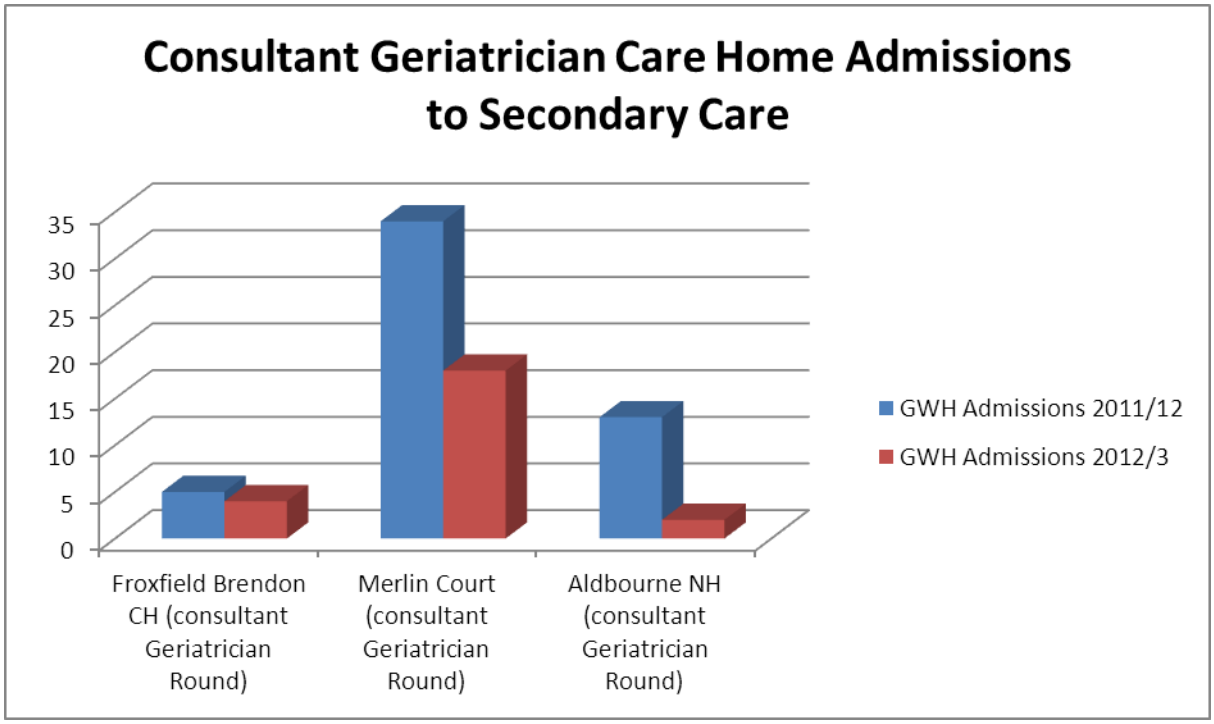
East Kennet Nursing Home Patients by GP Practice

Sep-11

PCT Code	Primary Care Trust Name	Practice Code	General Practice Name	Nursing Home Patients (A)	Total Registered List (B)	Percentage of Nursing Home patients (A/B)
5QK	Wiltshire PCT	J83017	PEWSEY SURGERY	49	6,698	0.73%
5QK	Wiltshire PCT	J83037	MARLBOROUGH SURGERY	153	11,820	1.29%
5QK	Wiltshire PCT	J83045	RAMSBURY SURGERY	75	8,543	0.88%
5QK	Wiltshire PCT	J83601	BURBAGE SURGERY	*	3,081	
5QK	Wiltshire PCT	J83615	OLD SCHOOL HOUSE SURGERY	12	3,233	0.37%
			Total	289	33375	0.87%
			NEW	1162	168432	0.69%
			SARUM	1228	134652	0.91%
			WWYKD	1093	161860	0.68%

Care Homes Admissions at GWH					
Care Home	**Total number of beds**	**GWH Admissions 2011/12**	**Rate of admission 2011/12**	**GWH Admissions 2012/3**	**Rate of admission 2012/3**
Coombe End Court	60	40	67%	41	68%
Highfield	24	15	63%	16	67%
Marlborough Lodge	17	6	35%	7	41%
Froxfield Brendon CH (consultant Geriatrician)	44	5	11%	4	9%
Merlin Court (consultant Geriatrician)	66	34	52%	18	27%
Aldbourne NH (consultant Geriatrician)	39	13	33%	2	5%
Total	**145**	**66**	46%	**68**	47%


Non-Consultant Geriatrician Care Home Admissions to Secondary Care
45
40
35
30
25
20
15
10
5
0
Coombe End Court
Highfield
Marlborough Lodge
GWH Admissions 2011/12
GWH Admissions 2012/3


Consultant Geriatrician Care Home Admissions to Secondary Care
35
30
25
20
15
10
5
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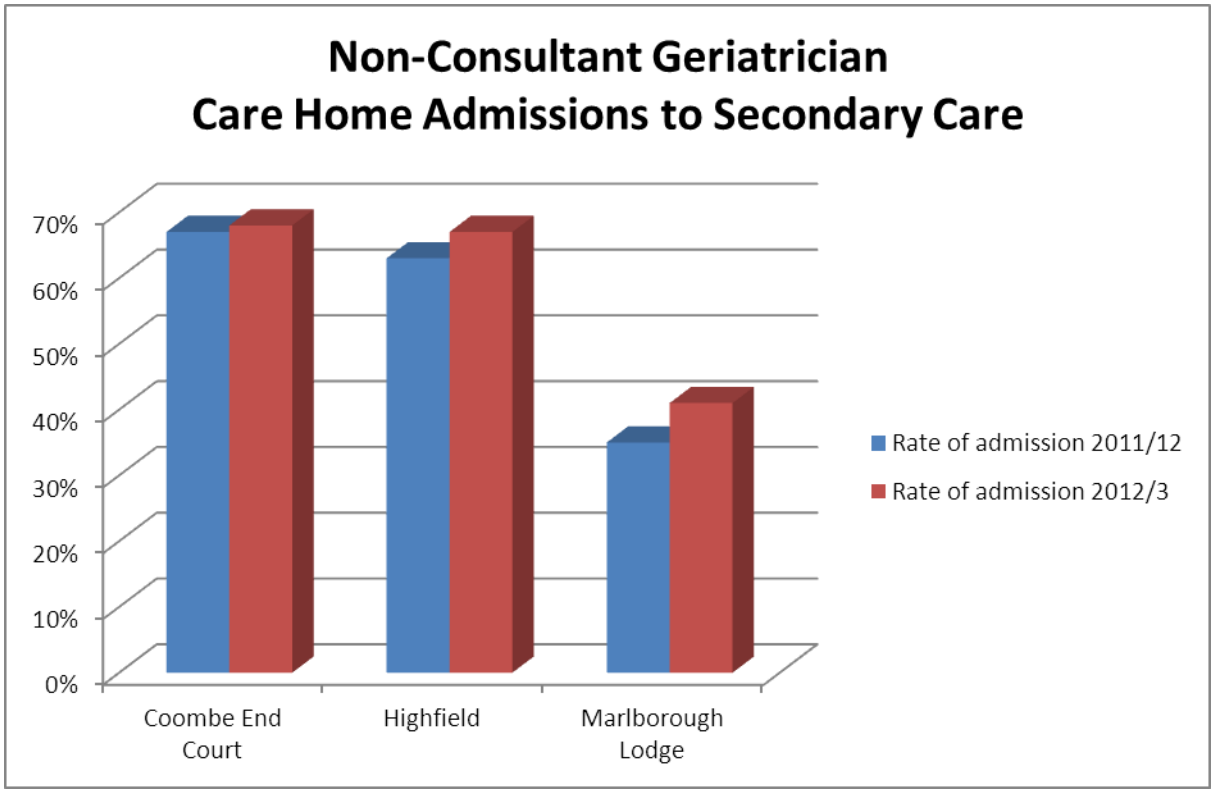
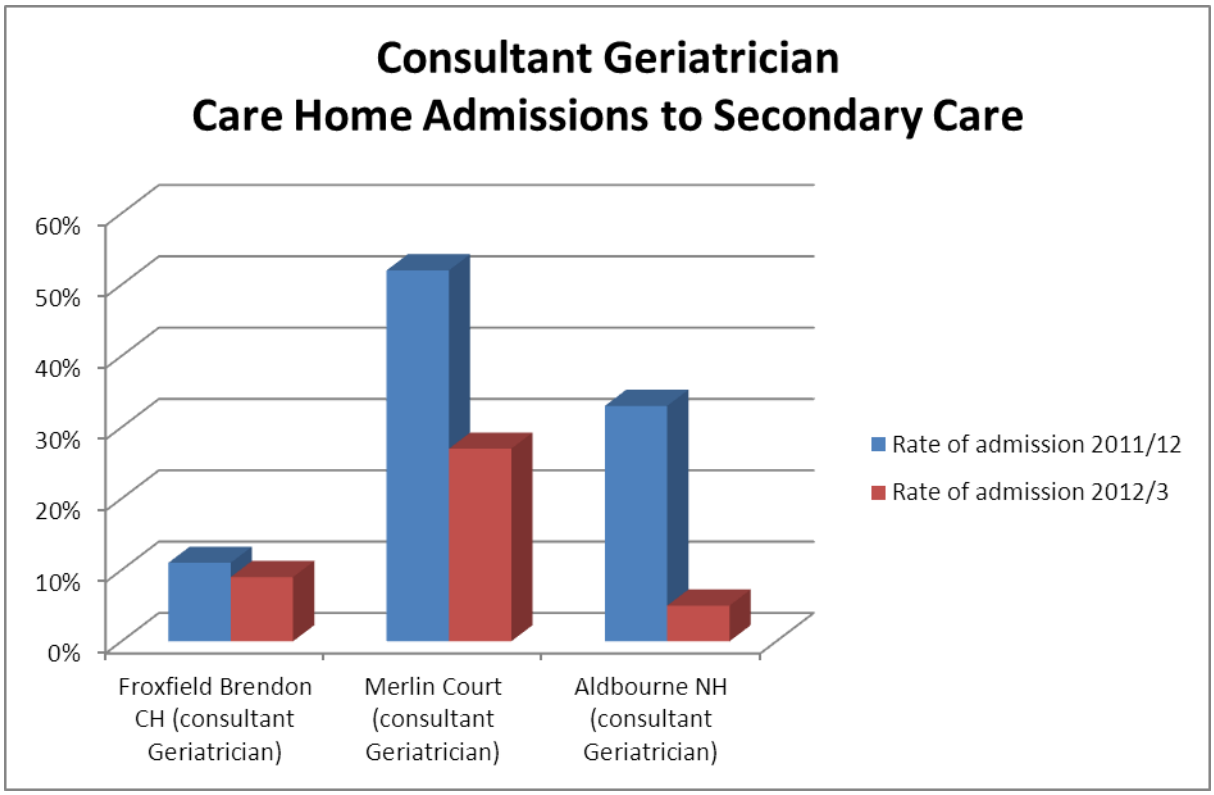
Froxfield Brendon CH (consultant Geriatrician Round)
Merlin Court (consultant Geriatrician Round)
Aldbourne NH (consultant Geriatrician Round)
GWH Admissions 2011/12
GWH Admissions 2012/3


Non-Consultant Geriatrician
Care Home Admissions to Secondary Care
70%
60%
50%
40%
30%
20%
10%
0%
Coombe End Court
Highfield
Marlborough Lodge
Rate of admission 2011/12
Rate of admission 2012/3


Consultant Geriatrician
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60%
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Rate of admission 2011/12
Rate of admission 2012/3