NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 24 September 2013

For: PUBLIC session ☒ **PRIVATE Session** ☐

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

Agenda Item and title:	**GOV/13/09/14 First Quarter Report on 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 paper is to report first quarter progress against the actions set out in the 2013-14 NEW Group Service Level Agreement (SLA). The report gives an update on progress and actions against each of the requirements within the following headings for the period April to June 2013: 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 NEW SLA was formally approved at the governing body meeting dated 25th June and has therefore only been available to practices from the beginning of July. The total funds available are £1,347,117 based on a total baseline payment of £1,192,087 (£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 from the baseline sum to fund any unforeseen expenditure or primary care based projects. No payments have been made to practices in the first quarter. It is intended to make a payment after 6 month of 50% of the funds.
Evidence in support of arguments:	N/A
Who has been involved/contributed:	• NEW Executive • Practice Manager representatives • All practices

Cross Reference to Strategic Objectives:	This SLA supports the following priority areas; Planned and Unplanned Care and frail elderly. It also contributes to the delivery of the QIPP targets for the Great Western Hospital Foundation Trust (GWHFT) and Royal United Hospital (RUH) contracts.
Engagement and Involvement:	Discussion and agreement of work priorities with all practices via GP Executive representatives.
Communications Issues:	None
Financial Implications:	No unfunded financial implications. Payments under SLA will not exceed total funds allocated
Review arrangements:	Quarterly and annual reports 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 with this and other funding shortfalls or urgent requirements.
National Policy/ Legislation:	N/A
Equality & Diversity:	No adverse impact identified
Other External Assessment:	N/A
What specific action re. the paper do you wish the Governing Body to take at the meeting?	The Governing Body is asked to discuss and note the contents of the report.

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North & East Wiltshire (NEW) Group
Primary Care Service Level Agreement (SLA) 2013-14
1st Quarter Report April – Jun 2013

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

The 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 which forms the baseline sum. 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.

A contingency fund of £34,720 (£0.21 per patient) has been top sliced from the baseline sum to fund any unforeseen expenditure or primary care based projects.

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 quarterly reports where required from practices.

Due to the lateness of the publication and distribution of the SLA to practices this first report will outline the continuing actions by practices to support the objectives and any early actions and initiatives as a result of the work done in the first quarter.

No payments have been made to practices in the first quarter against these funds.

Progress to date against the proposed areas of activity is shown in blue.

5. Areas of Activity

The SLA focuses on six key areas of activity:

A. Basic commissioning element
B. Improve links with secondary and emergency services
C. Practice engagement with development of specific care pathways
D. Involvement in community transformation and practice engagement
E. Medicines Management
F. Care home and frail elderly management

A. Basic Commissioning Element

- Each practice has a named GP Commissioning Lead as per the table below:

	Named Practice Commissioning Leads			
	Box	Dr A Girdher	Porch	Dr S Burrell

	Hathaway	Dr J Hogg	Rowden	Dr N Brown
	Lodge	Dr D O'Driscoll	Patford House	Dr P Harris
	Northlands	Dr N Ware	Beversbrook	Dr C Mowat
	Tolsey	Dr L Harris	Malmesbury	Dr J Petit
	New Court	Dr S Nelson	Tinkers Lane	Dr P Fudge
	Purton	Dr G Barron	Cricklade	Dr L DeSilva
	Ramsbury	Dr J Rayner	Marlborough	Dr R Hook
	Great Bedwyn	Dr T Ballard	Pewsey	Dr A Collings
	Burbage	Dr T King		

- GP attendance at 70% of regular locality meetings. Provide clinical input as requested and appropriate for the NEW Group work programme – This is a continuous process with excellent attendance and input to date at the group's locality meetings. These meetings are proving to be an excellent forum for addressing priority commissioning issues within NEW and give practices the opportunity to shape the delivery of the NEW work programme.

- Carrying out 100% of audits as agreed at locality meetings, and where appropriate using Perception+ – measured by annual return – Training has been received by all practices in the use of perception+ following its introduction to them in July.

- 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+ - Work has commenced across the practices with the creation and development of internal risk registers. Practices are starting to compare their own internal 'at risk' patients with those identified by the Devon risk tool and those identified by social care and raised at practice and multi disciplinary team meetings.

- A representative from each practice to attend their appropriate local area board meeting (or health equivalent) annually – GPs are also attending their local health and social care forums and stakeholder workshops.

- Continue to use 'Grumpy/Pleased Docs' initiative – GP practices continue to use the Grumpy Pleased docs. This initiative has just been reviewed and strengthened with additional resource in the NEW team and promoted through the NEWs letter.

- Attend regular GP clinical forums The first GP Forum was held on the 25th April with excellent attendance. The key themes were community transformation and care coordination and some strategic directions and outcomes were agreed which have informed the CCGs overall agenda. The next NEW GP forum themed 'Care for the over 80's ' is planned for the 9th Oct

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. Practices utilise the

dedicated/direct phone number for Hospital Practitioners and Ambulance Crews to avoid inappropriate admissions and it is fully integrated into the normal working day, both for GPs and for staff receiving the calls. This scheme works well and will be particularly beneficial in times of escalation. These numbers have already been reinforced to secondary care colleagues and will be again, including Ambulance Trusts, prior to the start of winter pressures.

- Respond quickly to requests by these providers for help in acute situations where GP input may be helpful. Most practices have systems in place that allow a Duty Doctor to take a call immediately, something which saves time and frustration for everybody working in the NHS in terms of dealing with workflow as efficiently as possible.

- 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. Discussions with GWH A&E consultants at an early NEW Exec meeting reinforced the need for both parties to actively communicate with each other at the earliest opportunity where appropriate.

- 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. This is reviewed regularly by practices at their local practice meetings and also monthly by exception at the NEW executive meetings.

  The NEW Group has also commenced a series of practice visits where The Group Director, Commissioning Manager and an Executive GP where applicable, are visiting practices to discuss the information and data in the practice packs as well as any other topical or commissioning related issues the practices may wish to raise. The visits provide an opportunity to raise issues with practices that are 'outliers' in certain data categories but has also proved useful in allowing practices to raise areas of concern and questions. It has been particularly useful in building relations between CCG head office staff and GPs and Practice Managers. There are approximately 2-3 visits per month and the first tranche have focussed on the Exec GP practices.

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.

NEW has identified several pathways that we aim to develop in the coming year and there are a number of pathways within the work programme that are yet to be developed; three pilots have been scoped and developed and two are underway in this period. GPs are keen to support the development of new pathways and this is actively promoted at the Exec meetings, locality meetings and particularly practice visits.

Dermatology Clinics - These are on-going and are a huge success. They run twice a month from Ramsbury Surgery and Marlborough Surgery, seeing approximately 10 patients in each clinic. They are always oversubscribed. These clinics also provide popular and vital Educational Clinics as GPs and GP Registrars sit in with the consultant during the sessions.

Orthopaedic Pilot - These clinics started in June 2013 and early impressions are that they are being well received. These clinics are designed for patients for whom the GPs may need additional advice, not for patients who are already known to need hip/knee replacements. They are run more for the "query" patients who need guidance on where to go or what to do next. They will also provide a useful educational opportunity for practices.

Ophthalmology Clinics - These are due to start, based at Ramsbury Surgery, but as yet, no formal start date has been confirmed. They will have a significant effect by dealing with referrals from opticians (not all of which will need to be seen) and organising glaucoma and cataract management. All the clinics will be based in Primary care and are running at well below tariff price.

Further pathways that NEW will be looking to develop throughout the year are:

- Therapy services
- Rheumatology
- Long Term Neurological Problems

Some practices are in the meantime working on additional projects such as tele-dermatology and a discharge pilot at GWH, whilst all practices continue to work on established pathways such as Hip and Knee Referrals which, it is hoped, will become embedded in practice culture.

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.

All practices are engaged in actively supporting the community transformation programme. A key part of this is the Introduction of Care Coordinators which NEW is the lead on across the Wiltshire area. Strategic direction on community transformation has been agreed with practices through locality forum GP practice meetings and engagement with practices for the recruitment of care coordinators during the summer.

Active patient lists have been implemented in some areas of the CCG and are proving a simple but effective tool for practices. Practices in collaboration with community neighbourhood teams are reviewing their active patient lists to improve their management and referral processes.

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.

Most practices have now met with Alex Davies the Medicines Management Prescribing Lead to review prescribing plans for 2013-14. Prescribing performance is a regular agenda item for many practices. They all have their own individual folders with lists of High Cost Drugs, Red Drugs, Expensive Brands and Specials.

Representatives from some practices have attended the Pain Management Workshops organised by Medicines Management, and feedback has been that it was a valuable training session. Practices are being encouraged to review Opioid patch prescribing, and feedback from practices is that this work is now being undertaken.

Sip feeds continue to cost NHS Wiltshire over £1m a year, and practices are trying hard to ensure that these food supplements are only prescribed appropriately, using the guidance from Medicines Management and using the patient leaflets that have been produced and provided to practices.

Scriptswitch continues to be a useful tool to practices, helping them identify appropriate changes as drugs come off patent, and many practices work really hard at reviewing prescribing costs themselves, looking out for switches when drugs come off patent e.g. Keppra (£60) to Levetiracetem (£3). Many practices have good links with the Medicines Management Team and use them to highlight issues regarding Red Drugs which hospitals still habitually ask practices to prescribe inappropriately.

Work continues with the Care Home Pharmacists – lots of the changes they suggest are relatively small, but overall will make an impact and most practices feels it's important to do the work they suggest given the investment being made in their time.

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

The SLA has contributed to improving the links between practices and the care homes they support; all practices now visit care homes regularly and practices are proactively looking to build on existing links with care homes to provide more support to assist in reducing avoidable admissions to secondary care whilst improving the quality of care and particularly palliative care.

There are strong links with the Community Geriatricians from RUH and there is regular input from them in support of practices and care homes. A GWH Community Geriatrician, Dr Finch, also visits Kennet nursing homes on a fortnightly basis, and there is clear evidence that this has contributed to a reduction in admissions to secondary care. These links will be further developed and expanded to other practices in the North of the area.

Increasing numbers of care home residents have care plans identified. All care homes are different, but plans are in place to simplify and standardise GP input on a locality basis and to improve medication management in homes. The aim is that all new residents are seen within 7 days of moving to the care home.

Practices are starting to work with homes to help them manage EOL care and other critical situations. Links with Dorothy House and Prospect House will help with this. This is the subject of a separate CCG initiative to refresh the EOL strategy in year.

The overall aim is to reduce unnecessary admissions for patients by ensuring medical care is delivered to them where they are living, rather than in a hospital setting. For NEW, this is a key

area of focus and practices are being encouraged to share and adopt the best practice already in place across the patch which is being done through locality meetings and practice visits. We have also asked all practices to submit a more detailed report by practice on progress and actions against the specific actions listed above.