NHS
Wiltshire
Clinical Commissioning Group

Wiltshire Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 25 March 2014

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

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

Agenda Item and title:	**GOV/14/03/16 Third Quarter Report on NEW Primary Care Service Level Agreement 2013/14 (previously PBC/Secondary Care LES) October - December 2013**
Author:	Sue Rest – Commissioning Manager, NEW Emmy Butcher – Practice Manager, Beversbrook Medical Centre Sarah Simpkins – Practice Manager, Ramsbury 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 third 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 October - December 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 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 (£91 per patient) from CCG funds for additional care homes work. A contingency fund of £34,720 has been top sliced from the baseline sum to fund any unforeseen expenditure or primary care based projects. The first payment of approximately half of the available funds (£578,683) was paid to practices in July 2013. The contingency fund of £34,720 was also paid into a central NEW account.
Evidence in support of arguments:	N/A
Who has been involved/contributed:	• NEW Executive • Practice Managers • Practices
Cross Reference to	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

Strategic Objectives:	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?	This paper is to be discussed and noted.

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North & East Wiltshire (NEW) Group
Primary Care Service Level Agreement (SLA) 2013-14
3rd Quarter Report October - December 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.

In July 2013 an initial payment from the SLA fund was made to practices. Approximately half of the available monies (£578,683) were paid into practice accounts to support the continued efforts towards the range of initiatives outlined in the SLA. The contingency fund of £34,720 was also paid into the central NEW account.

It was further agreed that to support the work by practices to improve the care of the frail elderly in care homes and to support where possible the reduction of inappropriate admissions, that a first payment of half of the available additional funding would be made in October based on the numbers of patients in care homes from the respective practices as at 1st April 2013.

The remainder of the SLA fund will be paid out to practices in March 14 (£578,683). The contingency sum of £34,725 and the remainder of the money allocated to care home support, £101,158, will be paid out to practices following 4thqtr/annual reports from practices demonstrating satisfactory achievement against the LES requirements.

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

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.
  Regular attendance from the practices remains at a level of excellence. On those occasions where Practice Commissioning Leads are not able to attend meetings, a replacement clinical colleague is often sent in their place. GPs and Practice Managers who attend the locality meetings are regularly feeding back developments to their individual Practices. This assures understanding of commissioning issues within NEW and promotes a whole Practice approach to achieving goals set out in the NEW work programme.

- Carrying out 100% of audits as agreed at locality meetings, and where appropriate using Perception+ – measured by annual return.
  All Practices have taken an active role in reporting information back to the CCG in agreed formats. This includes the new 24 hr. ECG initiative and using the Perception+ tool. In addition, Practices are currently reviewing care home patients who are admitted to hospital and are working with the CCG, Care Co-ordinators and individual care homes to ensure this data is audited and submitted in a timely fashion.

- 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+.
  Practices are referring to the Perception+ tool to assist the coding and review of at risk caseloads. North Locality Practices report meeting at least monthly to review at risk patients and some as frequently as weekly. These meetings are in many cases MDT and focus on coordinating all care through information sharing and clinical learning. All Practices report that at risk patients are being managed by their Care Co-ordinator who has access to Practices own lists and those generated through Perception+. It is clear that Practice clinical teams are working collaboratively with Care Co-ordinators and information sharing on a weekly if not daily basis.

  The surgeries in East Wiltshire also use Perception+ to analyse information regarding at risk patients. This mechanism of investigation is constantly changing and therefore the surgeries do not use a static register. There is a 'virtual' list known by all GPs and the Care Coordinators, through using Perception+, Adastra and local knowledge of patients.

For example, Great Bedwyn has found huge benefits in this mechanism recently which has resulted in MDT meetings to identify problems. The patients on Perception+ are reviewed weekly by the Practice Manager and the surgeries dedicated Care Coordinators. High risk patients are also discussed at Partner meetings on a weekly basis. GP Registrars are also involved in these meetings to coordinate care planning.

- A representative from each practice to attend their appropriate local area board meeting (or health equivalent) annually.
  Area board meetings continue to have been attended by the NEW Group Director and/or a Senior Manager and an Executive GP. GPs are also attending their local health and social care forums, MP Panels and stakeholder workshops across the NEW area.

- Continue to use 'Grumpy/Pleased Docs' initiative.
  Over the period October to December 2013, the NEW team received a total of 57 grumpies and 5 pleased emails from 19 practices across the locality. NEW internal processes for dealing with these e-mails are being improved, building closer links with the CCG Quality Team and linking with providers to whom issues relate. The service redesign leads will continue to raise relevant grumpies with providers and the CCG's quality team where required.

  The 3 most common themes identified were: Acute provider pushback (hospitals asking GPs to do secondary care work), delayed paperwork (in particular outpatient letters) and physiotherapy waiting times. As a response to the physiotherapy waiting times issues, GWH have implemented a recovery plan which continues to be monitored at the GWH Adult Community Contract Performance meetings. MSK Physiotherapy waiting times are anticipated to meet their target waits in March 2014. Grumpies related to NHS 111 have improved during this quarter compared to the position at the end of September 2013.

- Attend regular GP clinical forums
  The NEW Group has organised two GP forums so far this year; the first on the themes of Community Transformation, Care Coordination and Dementia was held on the 25th April 2013. The forum was held off site and attended by close to 80 delegates with the majority of them (70) being GPs or consultants. The second NEW GP forum themed 'The Frail Elderly' was held on the 9th October 2014. Attendance at this was also excellent with 65 delegates and 50 GPs or consultants. Presentations were given by Brian Deeley, Chief Executive of AgeUK Wiltshire, Jonathan Rayner, Dabesh Murkhajee and Rachel O'Toole. There was a strong consensus amongst delegates that elderly patients in secondary care would benefit from being under the care of a Geriatrician, with a view to supporting earlier and more appropriate discharges. There was also a call for a more pro-active approach to admission avoidance by placing geriatricians in the community. In addition the forum took part in group discussion and learning which led to a plethora of ideas to support future development and commissioning, including a GP flying squad to support the Ambulance Service in frail elderly assessment and OOH TPP access. Further forums are being planned for 2014/15.

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.
  All Practices have provided a dedicated phone line for use by emergency clinical colleagues and consultants. However, there are varying levels of use of these dedicated lines. Some Practices report that their lines are used frequently and result in successful interventions. These Practices can provide evidence to show that GPs have been able to attend to patients instead of ambulance services and have avoided inappropriate admissions. Examples of admissions avoidance can be cited, such as Pewsey Surgery who were contacted to discuss a hypotensive patient and, as a result, the admission was avoided. However, some Practices have reported that their dedicated lines are rarely used and there is also concern that ambulance crews continue to use Practice's main numbers instead of their dedicated lines. There is no clear evidence to support why there is such a variation, however, these issues have been reported to the Providers. It is understood that ambulance services are trialling a new triage system and it is hoped that this may increase the use of dedicated lines accordingly.

- Respond quickly to requests by these providers for help in acute situations where GP input may be helpful.
  All Practices report having systems in place so that calls can be dealt with promptly by a Duty Doctor. Practices are enthusiastic about increasing dialogue to successfully avoid admissions via information sharing and Primary Care input.

- 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.
  All Practices report that dedicated lines are available for this service but again some report that it is not used frequently. Availability of a Duty Doctor to deal with these calls promptly is demonstrated and when used has proved beneficial to patient care. The effectiveness of this method of collaborative communication will be evaluated as part of the focus on NEL QIPP in 14/15.

- 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. Practice data packs have been created and distributed quarterly which contain data on emergency attendances and admissions. The data in these packs is also the subject of in-depth discussion at a programme of executive practice visits conducted in NEW. These visits were scoped and agreed early in the period and were aimed at enhancing communications and reinforcing the relationships between the executive, its non-clinical officers and the practices. An executive GP, the NEW Group Director, Commissioning Manager and Service Redesign Lead visited every practice and are setting up a further visit programme for 2014/15. The practice data packs, containing details of performance in a number of areas (non elective activity, elective activity, cancer 2 week wait data, RSS usage etc) are sent to practices in advance and are discussed in detail at the visits. The

visits, however, also offer practices the opportunity to raise any concerns or issues they may have related to commissioning. All visits have been welcomed enthusiastically with attendance by large numbers of Doctors and staff keen to give up their time to engage with the group executive. They have also highlighted some specific issues which are being addressed by the executive which otherwise might have gone un-reported for some time. These visits will be continued on a rolling programme given their success and inherent value.

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 continue in the coming year and there are a number of pathways within the work programme that are yet to be developed. GPs are keen to support the development of new pathways and this is actively promoted at the Executive meetings, locality meetings and particularly practice visits. A list has been compiled of GPs and practice managers with an interest in being involved in any new pathway work. Lead GPs are chairing meetings of stakeholders within their specific areas and this work is being dovetailed into the CCG wide work towards the work programmes in the 2 year plan.

Dermatology - These very popular clinics run twice a month from East Kennet practices: Ramsbury and Marlborough Surgeries, seeing approximately 10 patients in each clinic. These clinics also provide popular and vital Educational Clinics as GPs and GP Registrars sit in with the consultant during the sessions. Of particular note is that these clinics have shown proven reductions in overall dermatology referrals and importantly significant cost savings. A separate report has been prepared to support the wider roll out of this initiative. In the North, Dr Andrew Girdher is leading this piece of work and has recently met with key stakeholders to agree a number of local actions.

Orthopaedics - 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. After a tentative start, access to them has been extended to the Calne based practices. The clinics are on the verge of being rolled out to Practices in the North following agreement on wider protocols and the availability of GWH consultants. It is envisaged that these clinics will also be available on Choose and Book. To date, evidence form the Marlborough clinic has shown that, on average, 60% of the referrals

to the clinic have avoided referral to secondary care. Although the numbers are currently low, this still equates to six avoided referrals per month. **Ophthalmology** – Originally envisaged as a community clinic running from Ramsbury surgery by Guy Smith Consultant Ophthalmologist, this situation is now being reviewed. Discussions are ongoing about the scope of the clinics and the associated costs. GWH are also keen to discuss the provision of support with the CCG to address the ophthalmology 'hold file' waiting list and this has also become part of the wider discussion. All parties remain keen to progress this given the backlog issues in ophthalmology.

Rheumatology - The CCG is working on a joint initiative with BANES CCG and Rheumatology Commissioning Support Alliance (independent organisation) to understand what the current situation is a across Wiltshire. Rheumatology Alliance have organised various stakeholder events to collect patient and organisational views on current Rheumatology services and pathways. Dr Nick Brown is leading this work and attending the rheumatology strategy group; from which a number of national and best practice recommendations have been proposed.

Dr Brown will present the national best practice recommendations back to the GP reference group.

Therapy Services – Dr John Petit is leading this work-stream and has held two meetings with key stakeholders and other lead GPs in NEW. After clarifying the relevant local issues in detail, the group have agreed priorities for future action.

Agreed priorities for a way forward for therapy services are:

1. Data requirements, including sharing current referral criteria and practice-level referral rates and DNA rates.
2. To agree what could usefully be communicated back to referring GPs, and how. We felt we could develop the letter sent to the patient at the point of triage and copy this to the GP, to minimise the extra admin and clinical work. This could include information re where and when the patient will be seen, and by whom/in which part of the service.
3. Develop the service step-by-step, rather than making wholesale changes to e.g. a Pennine Model approach. This would involve developing the "menu" of available treatment options, possibly including telephone advice, provision of on-line exercise information or apps, self –referral by telephone after GP suggestion (not open), and "ring and rebook" processes to minimise DNAs and empower patients. GPs would refer to a one-stop triage service. Time would be well spent researching models and processes used successfully elsewhere.
4. Look at the possibility of twilight and weekend Physiotherapy sessions.
5. Improve the transition of patients from secondary to primary care. Consider telephone follow-up from MSK or Community Physiotherapists.
6. Progressing Community Specialist and Neighbourhood Team Physiotherapy will sit best with the Community Transformation team, where there is already GP and CCG input.

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 report actively engaging neighbourhood teams in regular MDT meetings. In addition, most have an open access policy for District Nurses to discuss patients with clinicians on an ad-hoc basis where required.

Several Practices are taking part in a pilot scheme which is hoped will promote better working relationships and professional understanding within the District Nursing and Practice Nursing teams. This project came about following discussions at Community Transformation Change Management Group meetings. An educational exchange is being organised with GWH whereby DNs and PNs have the opportunity to shadow each other.

Care Co-ordinators are being utilised in Practices to full advantage and have established themselves as a valuable link between GPs and at risk patients. CCs are dealing with a range of patients including the elderly and vulnerable; signposting to local organisations, charities and agencies and keeping abreast of health initiatives in the locality to ensure patients are benefiting from these accordingly. Practices report that CCs are also instrumental in alerting OOH of at risk caseloads. Discharged patients are benefiting from initial CC involvement to help avoid re-admission. The increasing proportion of patients currently being dealt with by CCs is indicative of the necessity for this role and it is felt that this ever evolving position will prove of great benefit to Practices and patients.

In the East of Wiltshire, Practices have excellent, regular communication with the Neighbourhood Team, especially Ella Purvis the Community Matron, and a couple of the District Nurses. They have a full time Care Coordinator based at Ramsbury Surgery and also manage their other part time Care Coordinator from the practice. There have been some teething issues with one of the Care Coordinators workload increasing beyond her capacity. To address this, practices are in the process of reshuffling the surgeries to assign work at the two smaller surgeries to the part time Care Coordinator, leaving the full time Care Coordinator with the three larger Surgeries. It is believed that this will work more efficiently and benefit all concerned. The first Carers Day at Ramsbury is being organised in March, solely run by the Care Coordinators. This will enable the Surgery to gain the Gold Carers Award. Some more education is needed with GPs about what sort of patient to refer, but this is an ongoing project and learning curve.

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.

Practices in the North continue to recognise that prescribing savings are key to the NEW SLA and are making best use of Script Switch to promote prescribing savings. The work to promote awareness of prescribing in certain areas such as Opiates and Sip Feeds has been successful, with Practices continuing to monitor these areas. Practices completed a Controlled Drug Declaration and Self-Assessment Audit for Medicines Management in October 2013 to ensure practice compliance to CCG guidelines. The Community Pharmacist continues to support NEW Practices with medication reviews for Care Home residents and is attending meetings to raise awareness of this valued role. Medicines Management are consulted regularly where there are queries over prescribing and the swiftness and ease of communication is well valued.

One practice in the East of the County who are both a training and a dispensing practice regularly runs audits on prescribing and their GP Registrar uses these as Audits to feedback to the Partners. Scriptswitch is used widely when it is feasible across the East of the NEW area. Practices have started to use electronic prescribing attached to their clinical systems (ETP) for patients. Ramsbury Surgery is significantly under its prescribing budget. A controlled drug audit has been run at Burbage and Great Bedwyn Surgeries too. One GP Registrar attended a Medicines Management workshop on 10th February 2014 and will be cascading that information back to the Clinical Team.

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

Practices are clearly pro-active in undertaking the key elements, set out above, of managing frail elderly patients and promoting effective communication and working relationships with care homes. There is improved dialogue between Practices and Care Homes, with reports that this has enhanced the appropriateness (and in some cases a reduction) of visits and efficiency of Care Home/GP working practices. Opportunities to discuss patients with Dr Chris Dyer and Dr Paul Bowen are being exploited and Practices report that this input is valuable. Reviews of care home patients are being undertaken by all Practices, except Cricklade who, not having any patients who reside in care homes, have adopted measures to support their elderly at home and report that this is sufficiently meeting patients' needs.

Following the success of the Chippenham workshops, Calne Practices have held the first of a planned succession of meetings with the Care Homes in their area. The meeting proved very successful and provided the opportunity to address learning needs, share information and to ensure that both GPs and Care Home staff are working effectively together. A subsequent meeting in January 2014 had an educational element with scenario learning to improve understanding of those resources which are available to both GPs and Care Homes in order to prevent unnecessary admissions. This meeting also provided the opportunity to raise awareness of the key elements set out in the SLA so that both Care Homes and Practices can work collaboratively to achieve them. Box Surgery are also in the early stages of planning their first educational forum with care home staff and hope this will go ahead in April 2014.

Malmesbury Practice carried out a thorough audit on care home activity to establish the existing workload and demand. This provided a platform which was used to implement the SLA model. It is hoped that this will enable them to establish workload efficiencies and continually tailor the service to better meet the needs of their elderly and frail patients.

Practices have been supplied with numbers of care home patients admitted to hospital and will be reviewing these over the next quarter. The outcome of which will be reported to the CCG by the 1st April 2014.

Ramsbury practice currently covers three major Nursing Homes, Brendoncare Froxfield, Aldbourne Nursing Home and Florence House (was Southdown Nursing Home). Each home has weekly GP rounds, and also has the benefit of a Consultant Geriatrician round (Debbie Finch) – this has always proved significantly beneficial to both GPs and the Home staff. It has demonstrated a greater knowledge of the needs of care homes patients who are admitted to Secondary Care. They have also recently engaged their Care Coordinators in going into the Nursing Homes to introduce themselves and ask for monthly reports on any Secondary Care admissions. All Nursing Homes are engaging with the practices. Two other Care Homes are looked after by Great Bedwyn Surgery but are only visited when necessary, not on a regular round basis.

Consultants can contact our GPs each day and on Saturday mornings and now they have the ability to schedule a ‘Proactive’ call through the Care Coordinator with the Roaming GP for any “At Risk” patient.

Conclusion

It is clear that GP Practices have been pro-active in meeting the requirements of the SLA and working with CCGs to promote better patient care during this quarter. Care Co-ordinators have become well established in Practices and there is a general consensus that they are helping to improve patient care and avoid admissions where appropriate. Dual management of the CC role encourages Primary Care and Neighbourhood Team integration; although, it is understood that more work is required in this area to promote better relationships. Initial efforts to promote improved working with Care Homes have gained momentum. This has had a positive effect on

elderly patient management in all Practices. This quarter has seen Practices working together to implement the 24 hr. ECG Pilot, ensuring clinical and administrative staff are adequately trained and systems are in place. There is a stronger and more concerted move toward integrated working within NHS teams for the benefit of patient care. Medicines Management, Community Geriatricians and Neighbourhood Teams continue to provide valued input and information sharing with Secondary Care has improved. Excellent attendance and engagement at CCG locality meetings, GP involvement in clinical projects/pathway development and involvement in the recent Forum evidence the undoubted commitment of NEW Practices to improving NHS services.

The pressure placed on Primary Care in an ever changing climate should be noted. Practices are tested daily in meeting fresh challenges imposed on us through new NHS developments such as EPS, CQC, care.data, enhanced data sharing, and CQRS. In addition, Practices have a pressing requirement to meeting QOF targets in preparation for end of year, which adds extra stress to an already stretched system. Ongoing workforce sustainability and planning is a concern for Practices and a growing awareness that working in Primary Care can be both challenging and stressful; consequently, some Practices report finding it difficult to recruit GPs and Nurses.