NHS
Wiltshire
Clinical Commissioning Group

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

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

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

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| **Agenda Item and title:** | **GOV/14/03/17 2013/14 Sarum SLA (previously Pbc and Secondary Care LES)** |
| **Author:** | Louise Sturgess, Commissioning Support, Sarum |
| **Lead Director/GP from CCG:** | Mark Harris, Group Director (Sarum) |
| **Executive summary:** | The purpose of this report is to provide a quarter 3 report on the 2013-14 Sarum Group Service Level Agreement (SLA).<br><br>The SLA focuses on supporting CCG engagement and 4 specific work streams:<br>• Effective Urgent Care<br>• Effective Referral Management<br>• Effective Prescribing<br>• Locally Developed Innovation and Improvement<br><br>The SLA received universal approval and all 23 practices in Sarum have signed up to the SLA. The total funds available are £1,139,293 based on a payment of £7.21 for a list population of 141,160 plus an additional £121,529 allocated to Sarum from additional resources available for the SLA.<br><br>Payments totalling £106,012 were made in quarter 3.<br><br>The Effective Urgent care section of the SLA was to provide enhanced care for nursing home/residential care residents to reduce avoidable acute admissions. In Quarter 3 Practices signed up to care for 657 patients at level 2 and 240 patients at level 1. At the end of December, year to date Sarum Care home admissions to an acute trust were down 14% compared to the same period last year.<br><br>The Effective Prescribing section focuses on 3 areas; coeliac disease, baby milk prescriptions and the new pain pathway. All practices submitted baseline audits for coeliac disease and baby milk prescribing. 434 coeliac disease patients were audited. Of the 297 receiving gluten free foods on prescription, 44% of those prescriptions were not compliant with the latest guidance. In addition, 118 babies with a baby milk prescription were |

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| | reviewed of which 25% were found to be non-compliant with the latest guidance. Practices have been asked to write an action plan in light of their audit results and to re-audit in 6 months.<br><br>A proportion of the SLA fund is held centrally to cover the cost of practice engagement as well as key infrastructure and development work. The Sarum group held an all member event on 22 October 2013 at Salisbury Golf Club. The event was attended by 119 GP's and practice managers with representatives from all the Practices within the Sarum Group. |
| **Evidence in support of arguments:** | N/A |
| **Who has been involved/contributed:** | Sarum Executive led by Liz Stanger (GP Director)<br>Full membership discussion at bi-annual group event<br>Practice Manager representatives |
| **Cross Reference to Strategic Objectives:** | This SLA supports the following priority areas; Planned Care and Unplanned Care and frail elderly |
| **Engagement and Involvement:** | Discussion and agreement of work priorities with all practices via GP event. |
| **Communications Issues:** | None |
| **Financial Implications:** | No unfunded financial implications. Payments under SLA will not exceed total funds allocated |
| **Review arrangements:** | Quarterly reports will be presented to the Governing Body. Project plans and reports will be monitored by the Sarum Executive for sign off. |
| **Risk Management:** | If the SLA is not delivered this will impact on the ability of the CCG to deliver its strategic plan for 2013 – 15 and will have been an ineffective use of resources. These risks will be mitigated through monitoring and review of progress using standardised audit and reporting templates. |
| **National Policy/ Legislation:** | N/A |
| **Equality & Diversity:** | No adverse impact identified |
| **Other External Assessment:** | N/A |
| **What specific action do you wish the Governing Body to take?** | The Governing Body is asked to note the contents of the report. |

# 2013-14 Sarum Group Service Level Agreement (SLA) (Previously PBC and Secondary Care LES)

## Introduction

The purpose of the 2013/14 Sarum SLA is to enable practices to explore and address areas of care where improvements and alterations in systems can improve effectiveness and efficiency of the care delivered. It will also support the delivery of the Sarum and Wiltshire Quality Innovation Productivity and Prevention (QIPP) programme and the Commissioning for Quality and Innovation (CQUIN) work.

The SLA focuses on 4 work streams:

- Effective urgent care
- Effective referral management
- Effective prescribing
- Locally developed innovation and improvement

The desired outcomes from this SLA are:

- Reduction in urgent admissions to SFT from Care Homes
- Reduction in urgent admissions through appropriate use of rapid access clinics
- Increased use of best practice pathways as identified on Map of Medicine
- Increased delivery of local services i.e. patients managed by GP or outpatient services provided outside District General Hospital
- Improved pre-admission management through inclusion of minimum data set in referral letters
- Availability of timely data for all Sarum Practices through increased usage of the Sarum Data Centre

## 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.

Total funds available under this SLA are £1,139,293 based on a population of 141,160 as of January 2013 plus an additional £121,529 allocated to Sarum from additional resources available for the SLA.

Payments totalling £106,012 were made during Q3:

- £56,439 on innovation payments (25% of the annual total)
- £49,573 on effective urgent care payments (approx. 25% of the annual total).

## SLA Work streams

### A. Effective Urgent Care

The aim of this section of the Sarum SLA was to provide enhanced care for nursing home/residential care residents to reduce avoidable acute admissions. Practices can chose Level 1 @ £50 per patient per annum or Level 2 @ £225 per patient per annum. Practices have been encouraged to participate at level 2 which includes; a weekly visit/ward round by a GP, new residents and residents returning from hospital to be seen and reviewed within 7 working days and repeat prescriptions processed within 24 hours.

16 practices signed up to the care home element of the SLA covering 597 beds at level 2 and 350 beds at level 1. At the end of December, year to date Sarum Care home admissions to an acute trust were down 57 (14%) compared to the same period last year.

### B. Effective Referrals

Practices were asked to integrate Map of Medicine (MOM) and 19 re-designed care pathways into everyday activity from May 2013 as part of a 6 month pilot and feedback on their experience. Due to a number of technical issues with the software, the system was only fully live from August 2013 and throughout Q2 and Q3 Practices tested the system and provided feedback to the Sarum commissioners and the MOM support team.

At the conclusion of the pilot the evaluation showed that due to ongoing technical issues, Map of Medicine has not met expectations and there was no evidence it had influenced referral patterns or behaviours. The Sarum Executive therefore decided to withdrawn from Map of Medicine at the end of 2013.

Despite the disappointment with the MOM system, development of the maps by primary and secondary care clinicians was seen as a positive outcome of the project as it had fostered relationships and simplified a significant number of pathways.

### C. Effective Prescribing

The Effective Prescribing section focuses on 3 areas; coeliac disease, baby milk prescriptions and the new pain pathway. During Q3 all practices submitted baseline audits for coeliac disease and baby milk prescribing.

434 coeliac disease patients were audited. Of the 297 receiving gluten free foods on prescription, 44% of those prescriptions were not compliant with the latest guidance.

In addition, 118 babies with a baby milk prescription were reviewed of which 25% were found to be non-compliant with the latest guidance.

Practices has been asked to write an action plan in light of their audit results and to re-audit in 6 months.

**D. Locally Developed Innovation and Improvement**

This year's SLA allowed practices to identify areas within their current work where they are an outlier in activity or cost and develop improvement project(s) to address these concerns. Projects were approved by the Sarum Exec in July 2013 and Practices have been working on delivery of their projects throughout Q3. Practices will give a verbal report at their February locality meeting and submit a final written report in April 2014.

**E. Practice Engagement**

£2.20 of the SLA fund is held in a centralised fund to cover the cost of practice engagement as well as key infrastructure and development work. The Sarum group held an all member event on 22 October 2013 at Salisbury Golf Club. The event was attended by 119 GP's and practice managers with representatives from all the Practices within the Sarum Group. Items on the agenda included an interactive presentation by a Salisbury MAU Consultant, a strategic planning session and a six monthly review of Sarum's achievements.

**Conclusion**

The Governing Body is asked to note the contents of this report.

## Appendix A: Alternative Urgent Care Schemes

| Project Title | Surgery | Project Summary |
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| Improving patient care and liaison after hospital discharge | ORCHARD SURGERY | All patients who have had a hospital admission for either elective or non-elective reasons will be contacted within 24 hours of discharge (or as soon as possible after a weekend/bank holiday) by a GP partner to ensure appropriate care is in place and that patients are fully up to speed with the consequences of their admission. Seemingly inappropriate A&E attenders will also be contacted. Initially by telephone but undoubtedly some of these contacts will result in visits. |
| Capacity and Consent | AVON VALLEY | To ensure power of attorney, advance directives and do not resuscitate status is discussed with patients and is recorded within medical records succinctly. The information should be easily retrievable and shared with outside agencies, e.g. OOH, so that patients avoid admission in accordance with their wishes. |
| Urgent Care pilot for patients residing in Pembroke Court and Wylye Lodge | WILTON | To identify, liaise and proactively manage patient health conditions to reduce acute admissions/inappropriate A&E attendances. To offer weekly telephone support and fortnightly site visits to review patient care and to provide better access to a GP. To follow up and review all patients discharged from Hospital within 7 days. To provide a lead GP per site. To process all prescription requests within 24 hours. New residents to be reviewed within 7 days of registering at the Practice. |

## Appendix B: Sarum Innovation and Improvement projects and audits

| Project Title | Surgery | Project Summary |
|---|---|---|
| Development and Delivery of a CHAT service | AVON VALLEY<br>MILLSTREAM<br>SALISBURY PLAIN<br>WHITEPARISH<br>ENDLESS STREET<br>HINDON | Practices will employ and train a practice CHAT worker. The Practice CHAT Worker will signpost, support, encourage and enable such patients to engage with the most appropriate services and support for that individual patient, either from within the NHS or within their community. This may include finding appropriate support services for them, finding activities for them to do or helping them to find volunteering/work opportunities. Outcomes in line with strategic measures will be assessed during the project. |
| Development and trial of new online physiotherapy platform to complement existing services. | BARCROFT | Development of an online physiotherapy resource (videos) for clinicians to refer patients for management of simple musculoskeletal problems. |
| Prescribing Overspend | BEMERTON | The Practice was 23% over budget last year. Time is needed to look into the causes in more depth in order to reduce this overspend and endeavour to maintain costs at budget once again. |
| Nurse Training | BEMERTON | Practice nurses require further training to maintain the service offered to patients in order to help prevent poor performance, especially in diabetes.<br>1. |

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| Streamline New Patient Registration (CHURN) | CASTLE PRACTICE | Streamline new patient registration process. A HCA currently summarises new patient notes. The practice wants to employ a dedicated full time administrative assistant to undertake note summarising this will release HCA time to undertake new patient reviews, identifying new patient needs and alerting the relevant Healthcare professional to action. |
| Tackling Obesity | DOWNTON | Improving patient education in diet and exercise in order to help with weight loss thus improving future health. |
| Supporting Carers in General Practice | NEW STREET | This project is setting out to deliver an innovative and improved service for carers. It will encourage people to register on the GP carers register, to recognise the value of their contribution, refer them on and work in partnership with other services that could alleviate the impact of their caring role and involve them from the outset in planning a care package for the person/s they care for,<br><br>In particular the project will expand the pilot specialist carer support worker sessions held jointly with partner agencies, set up a mini carer café in the new practice café with links to the city carer cafés, develop a volunteer service in conjunction with partner agencies and develop training for staff . |
| Improving help for carers | TISBURY<br>ORCHARD | This project seeks to improve the quality of life for carers and support them looking after their family member at home. It is hoped that this will improve care for patients allowing them to stay in their own homes longer. |
| Re-evaluating our usage of read codes for improved patient care | ORCHARD | Improve the read coding of patient events on a daily basis – both during consultations and on administrative encounters such as hospital letters etc. Rationalisation of read coding throughout the partnership. |
| Provision of physiotherapy assessment and appropriate signposting within the Practices | SALISBURY PLAIN | To provide a physiotherapy assessment within the primary care setting in order to enhance the appropriateness of referrals to the physiotherapy outpatients service and to offer early intervention to patients to reduce severity of symptoms. |
| To sort out service supply during the move from Dorset PCT to Wiltshire CCG | SIXPENNY HANDLEY | To cover the cost of GP input to smooth the transition between Dorset PCT and WCCG. . |
| Improving baseline health targets in high risk population | ST ANN'S | To proactively seek out patients who are smokers (currently 14.2% of our population) or with high BMI (currently 8% of our population) and invite them in for a meeting to bring them up to date with all options available to them in Wiltshire CCG. |
| Improving patient care for those with CKD | THREE SWANS | The Renal Association Chronic Kidney e-guide published in 2010 goes further than current QOF requirements. This project will enable to delivery of care as suggested by the Renal Association. |
| Cancer reviews | MERE | The practice has a highest death rate from cancer 2011-12 in WCCG however their 2WW referrals were low and the 2WW referrals that ended up having cancer were high. The practice will review all cancer diagnosis retrospectively over the previous 12 months and then on a 3 monthly basis in 2013/14 to identify learning points. |
| Elderly Health Assessments | WILTON | To identify, invite and follow up all patients aged over 80 to attend an annual elderly health assessment. This will identify basic numerical readings (minimum data set as well as sats, MRC score, peak flow etc), key contact |

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| | | information (NOK, carers, key codes for entry, known to hospice, DN team, PC team, details on ADASTRA, end of life planning, DNAR status, lives alone or with family etc), falls prevention information (accommodation suitability, mobility aids, personal alarm, message in a bottle, ICE, referral to Brown St exercise class and medicinal information (chemist, use of dossette boxes, can swallow?) |
| Regular nursing assessment of at risk patients aged 75 and over. | HARCOURT | A regular medical community review of patients over the age of 75 by a trained nurse. These patients are at increased risk of hospital admission and health problems. Screening and identifying these problems earlier and before 'crisis-point' should lead to reduced admissions and better community health. |

| Audit Title | Surgery | Project Summary |
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| Direct access radiology requests | HINDON<br>TISBURY | These Practices benchmark high for the use of direct access radiology (plain X Rays, ultrasound, CT and MRI). The Practice wants to review all requests over a defined time period and compare with best practice guidelines from the Royal College of radiologists and assess whether the investigation either avoided a referral or improved the quality of a referral. The aim is to make sure the Practice are requesting radiology appropriately and identify good and poor practice, making changes as and when required. |
| Validation of data on web tool | HINDON<br>TISBURY | The Surgery has validated all its in-patient activity and costs and a sample of out-patient activity for the past seven years. The anomalies identified have led to changes beneficial to all and have improved the quality of coding, especially for in-patient data where the process has been more extensive. The data validation process has been undertaken by all practices but it is onerous and the returns reduce over time. The process of identifying new coding practices can be done by just one or two practices and Hindon & Tisbury are well placed to do this effectively and efficiently. |
| Combination of Amlodipine and Simvastatin Alert – MHRA | MILLSTREAM | This audit will identify those patients on Amlodipine and Simvastatin which were identified in a recent MRHA report as having an adverse effect when used in combination and take appropriate action. |
| The Churn factor in more depth | SALISBURY PLAIN | It is recognised that in this geographical area the movement of patients through the registration system of the surgery is significantly higher than in other areas due to the MoD.<br><br>The purpose of the audit is to investigate more thoroughly the impact of churn to the practice |
| Safety around Prescribing | ST MELOR | The practice have concerns regarding how effectively patients on certain drugs eg. DMARD's are monitored by primary and secondary care. |
| 2WW Dermatology Referrals | WILTON | A dermatoscope was purchased by the Practice in October 2012 and we will investigate the 6 months preceding this purchase as well as monitoring 6 months post purchase (and training) to see if this had any impact on the referral rates. |
| 2WW Breast Cancer Referrals | WILTON | The practice has a high referral rate in suspected breast cancers and they will audit these referrals to identify learning or improvement that can be made. |