NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 22 July 2014

For: PUBLIC session ☒ PRIVATE Session ☐

For: Decision ☐ Discussion ☒ Noting ☐

Agenda Item and title:	**GOV/14/07/14 2013/14 Sarum SLA Quarter 4 report**
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 4 report on the 2013-14 Sarum Group Service Level Agreement (SLA). The SLA focuses on supporting CCG engagement and 4 specific work streams: • Effective Urgent Care • Effective Referral Management • Effective Prescribing • Locally Developed Innovation and Improvement The SLA received universal approval and all 23 practices in Sarum have signed up to the SLA. The total funds available were £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. 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 4 Practices signed up to care for 702 patients at level 2 and 290 patients at level 1. At year end, Sarum Care home admissions to an acute trust were down by 56 (14%) compared to the same period last year. As part of the Effective Referrals element of the SLA, practices were required to review secondary care referrals in order to help practices address the increasing pressure to make referrals to secondary care. At year end, total first outpatient attendances at SFT were down 2.6% (839 attendances) compared to 2012/13. The Effective Prescribing section focuses on 3 areas; coeliac disease, baby milk prescriptions and the new pain pathway. Improvements were

	seen in all areas of work. The Coeliac audit resulted in 45 fewer patients not compliant with the coeliac society guidelines. A reduction to just 8% of coeliac patients now not compliant. The baby milk audit led to an improvement in prescribing with the number of non-compliant patients dropping from 29 (25%) to 11 (9%). Finally the pain management audit resulted in buprenorphine patches as a percentage of all opioid analgesic items falling from 10.3% to 7.4% (with a small percentage drop in fentanyl patch use also) with a corresponding drop in spend on these items. This year's SLA allowed practices to identify areas within their current work where they were 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 worked on delivery of their projects throughout the remainder of the year. A summary of the projects undertaken and their outcomes can be found in appendix A. 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 two all member events during 2013/14. Both events were attended by about 120 GP's and their practice managers with representation 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) Full membership discussion at bi-annual group event 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 did not exceed total funds allocated
Review arrangements:	Quarterly reports were presented to the Governing Body. Project plans and reports were monitored by the Sarum Executive for sign off.
Risk Management:	There are no risks associated with the SLA. The SLA is now complete and payments did not exceed total funds allocated
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 receive and discuss the contents of the report.

2013-14 Sarum Group Service Level Agreement (SLA) Quarter 4 report

Introduction

The purpose of the 2013/14 Sarum SLA was to enable practices to explore and address areas of care where improvements and alterations in systems could improve effectiveness and efficiency of the care delivered. It also supported 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 focused on 4 work streams:

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

The desired outcomes from this SLA were:

- 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 were £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.

Practice payments for different elements of the SLA were as follows:

Workstream	Allocation	Actual spend	Underspend
Effective Urgent Care	£341,739	£188,622	£153,117
Effective Referrals	£134,102	£134,102	£0

Effective Prescribing	£70,580	£70,580	£0
Practice Innovation	£282,320	£225,773	£56,547
Practice Engagement	£310,552	£150,552	£160,000

An initial underspend from the 2012/13 PBc/secondary care LES and the Urgent Care element of the 2013/14 SLA was distributed to practices in April 2014 with a pre-requisite that they confirm compliance with Medicine Management Green Action points from Jan 12 – Jan 14 and spend the money to the benefit of patient care.

An additional underspend of £160,000 was distributed to Practices in June 2014. Practices are required to submit proposals as to how they wished to spend their allocation with a pre-requisite that funds must benefit patient care.

SLA Work streams

A. Effective Urgent Care

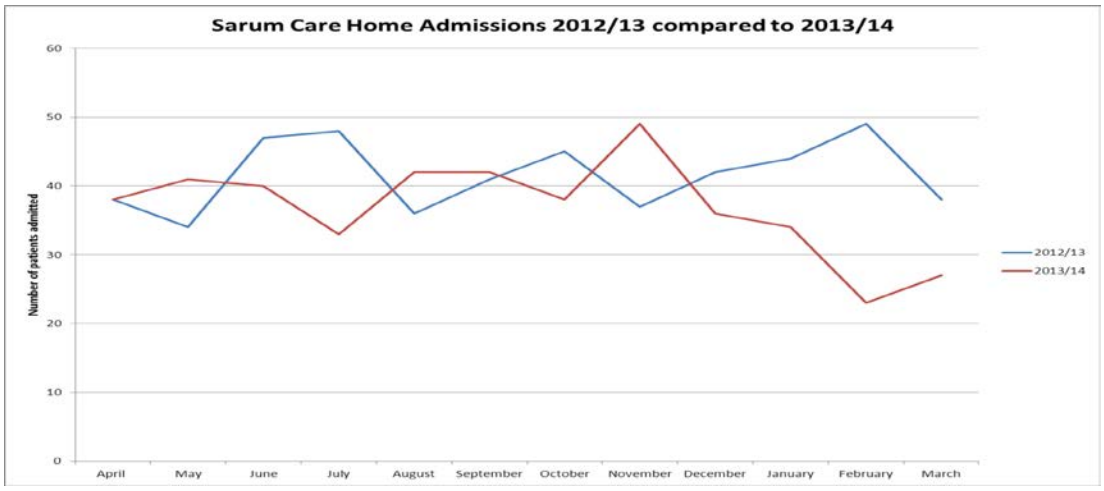
The aim of this section of the Sarum SLA was to provide enhanced care for nursing home/residential care residents to reduce avoidable acute admissions. Practices could chose Level 1 @ £50 per patient per annum or Level 2 @ £225 per patient per annum. Practices have been encouraged to participate at level 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 and in Q4 covered 702 beds at level 2 and 290 beds at level 1. During 2013/14 there were 56 fewer admissions from Care homes in the Sarum locality compared to the previous year. If an average cost of £3,700 is assumed per admission, a cost saving of £207,200 has been achieved. The spend on the scheme from the SLA funding was £188,622. Given that a number of workstreams were focused on reducing admissions, it is not possible to attribute all of the savings to the SLA but it is felt that the scheme will have made a significant contribution.

Additionally, the impact is assessed against only one source of referral and in reality there is only a saving made overall to the CCG spend if that capacity is not used elsewhere. Whilst this is a positive contribution, the impact should be viewed alongside the overall non elective position.

This project has been a success and resulted in fewer care home admissions in 2013/14 than in 2012/13. As a consequence the care homes admissions element of the Sarum SLA has been continued in 2014/15. To encourage Practices to increase their input to Care homes and thereby increase the percentage of beds covered at level 2, it has been decided to remove funding for Level 1.

The graph below shows a monthly comparison of admissions in 12/13 compared to 13/14.



B. Effective Referrals

As part of the SLA, practices were required to review secondary care referrals to help practices address the increasing pressure to make referrals to secondary care. Due to the transition from PCT to CCG the information previously provided to GPs regarding their referrals was not available to practices until quite late in the year. Individual practices were therefore not able to monitor their own referral patterns as they had done previously.

Despite this, at year end total first outpatient attendances at SFT were down 2.6% (839 attendances) compared to 2012/13.

A reduced Effective Referrals section is in the 2014/15 SLA which will focus on reviewing secondary care referrals pro-actively. A process has already been agreed to provider GP's with monthly referral data in 14/15.

Practices were also 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. Improvements were seen in all areas of work.

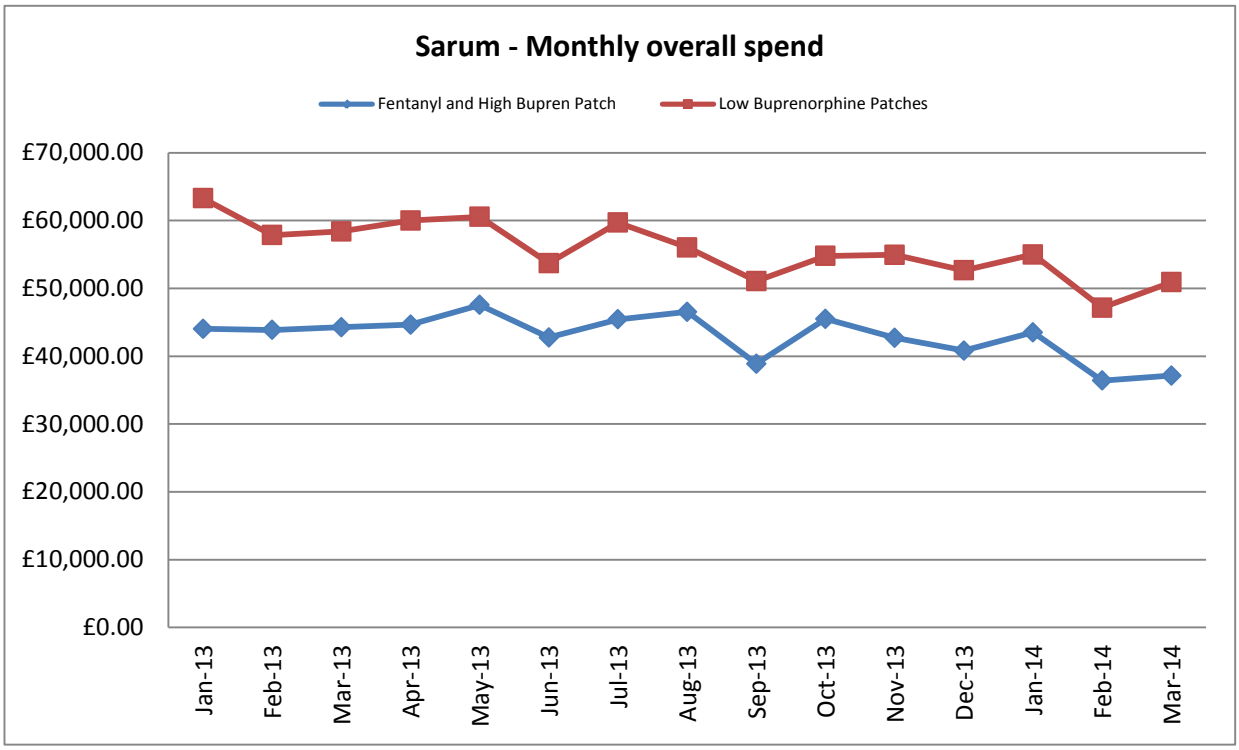
The Coeliac Baseline audit showed 66 patients non-compliant (23%) with the coeliac society guidelines. This improved to just 21 non-compliant patients (8%) in the 6 month follow up study.

The baby milk baseline audit showed 29 non-compliant (25%) patients which improved to 11 non-compliant patients (9%) in the 6 month follow up study.

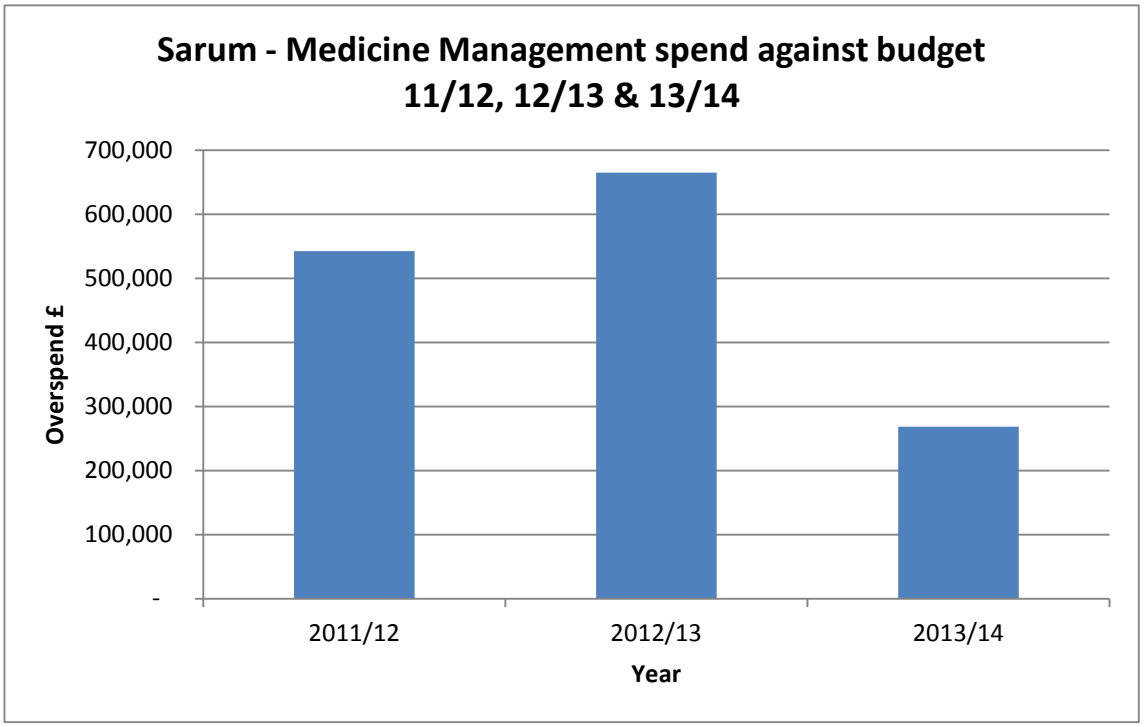
New pain pathway prescribing guidelines were issued by the CCG Medicine Management team in March 2013. Practices were required to send one clinician to the prescribing training and share training outcomes with other members of the practice as well as audit their compliance against the new pain pathway prescribing guidelines with a focus on prescribing rates of low dose buprenorphine patches (BuTrans 5mg, 10mg and 20mg). The table below shows that across Sarum, buprenorphine patches as a percentage of all opioid analgesic items fell from 10.3% to 7.4% with a small percentage drop in fentanyl patch use also.

Sarum Locality	Baseline Quarter	Current Quarter	Change	
	4th Quarter 2012/2013	4th Quarter 2013/2014		
Fentanyl patches as a % of all Opioid Analgesic (items)	4.6%	4.1%	▼	-0.5%
Buprenorphine patches as a % of all Opioid Analgesic (items)	10.3%	7.4%	▼	-2.9%

The drop in usage of both Fentanyl and Buprenorphine patches was accompanied by a corresponding reduction in spend on these items (see graph below)



Medicine management spend for Sarum over all for 2013/14 was over budget by £268,794 but this is a significant improvement on the previous year when the group overspent by £665,214 against budget (see graph below)



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D. Locally Developed Innovation and Improvement

This year's SLA allowed practices to identify areas within their current work where they were 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 worked on delivery of their projects throughout the remainder of the year. A summary of the projects undertaken and their outcomes can be found in appendix A.

E. Practice Engagement

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 two all member events during 2013/14. Both events were attended by about 120 GP's and their practice managers with representation from all the Practices within the Sarum Group. Items on the agendas included presentations by two Salisbury Consultants, a session on the CCGs 5 year plan, reviews of Sarum's achievements and presentations on successful innovation projects.

Underspend

An underspend from the 2012/13 PBc/secondary care LES and the Urgent Care element of the 2013/14 SLA was distributed to practices in April 2014. Practices were required to confirm compliance with Medicine Management Green Action points from Jan 12 – Jan 14 and spend the money to the benefit of patient care. A summary of how practices spent their allocation can be found at appendix B.

Conclusion

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

Appendix A: Locally developed innovation projects

Project Title	Surgery	Project Summary	Project outcome/evaluation
Development and Delivery of a CHAT service	AVON VALLEY MILLSTREAM SALISBURY PLAIN WHITEPARISH ENDLESS STREET	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.	Avon Valley: 19 patients. GP appointments, A&E attendances & use of OOH have all reduced for this group of patients. Some pts have also reduce their medication. SPHP: 34 patients seen. On average these patients were been by a GP 10 times in 3 months pre CHAT and just once or twice post CHAT. Attendance at A&E and OOH has also decreased slightly Whiteparish:Service only operational for 4 months so little information available but data does show positive emotional and social benefits. Endless St: 9 patients seen. Service only operational since Jan 14 so too early to show outcome.
Physiotherapy assessment and signposting	AVON VALLEY	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	71 patients discharged preventing referral to physio/ESP/or specialist
Safety around prescribing	MILLSTREAM	Recent MRHA adverse effect warning. 44 patients on this combination of drugs	Following the audit no patients are on this drug combination
Development & trial of new online physiotherapy platform	BARCROFT & ST MELOR	Development of an online physiotherapy resource (videos) for clinicians to refer patients for management of simple musculoskeletal problems.	Recently launched the use of the Medivid service with videos on 6 topics. Practices will continue to pilot for spread across Sarum/CCG. Additional videos to be developed in 2014/15.
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.	Having the register has enabled the practice to get a significant reduction in patients not complying with regular blood tests. 55% to 24% Significantly reduces potential harm to patients. Bisphosphonates: Of the 43 – 23 should probably stop treatment – 5 have appointments for review. 5 have had treatment already stopped.
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.	The practice worked with the CCG meds mgt team and undertook numerous searches to identify areas of overspend and took appropriate action. The practice made significant savings in their prescribing and whilst they unfortunately still overspend it was by 2.83% in 13/14 compared to 23% in 12/13.
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.	Nurse completed a diabetic courses and a prescribing course.

Bowel screening uptake	BEMERTON	National screening programme. National response rate is 60% and ours is only 44.92%.	Response rate improved but still below national average. Practice discovered they can improve response rate by phoning non responders. Practice plans to expand role of HCA to include this work in future
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.	Audit showed 2665 pts joined or left which was a 24% movement in practice population even though total population only grew by 17. Administrator employed to summarise notes etc.
The Churn factor (Audit)	SALISBURY PLAIN HEALTH PARTNERSHIP	High turnover of patients in Tidworth due to the MOD factor. To gain a better understanding of the impact of this on general practice.	Audit revealed interesting findings and clarified the work load linked to this unique group of patients. More detailed work would be valuable to see if proactive engagement with these families via new patient checks will reduce the number of appointments needed.
Tackling Obesity	DOWNTON	Improving patient education in diet and exercise in order to help with weight loss thus improving future health.	Practice continually and actively advertised weight loss programmes and gym sessions. More patients have enquired about weight loss through weights watchers or slimming world rather than bariatric surgery.
Supporting Carers in General Practice	SALISBURY MEDICAL PRACTICE	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,	142 carers registers compared to 26 at the beginning of the year. 30 carers had health check appointment. Joint HCA and Carer Support Wiltshire clinics held fortnightly. Carer's cafe to commence in June. 20 volunteers recruited to facilitate the carer initiative. The initiative has proved popular with carers. Both carers and patients have been signposted to various support services.
Improving help for carers	TISBURY 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.	Tisbury: Extremely worthwhile initiative with benefits to carers in the local community. The first clinic held on 26.02.14 was full and enthusiastically received by attendees. Orchard: 189 carers identified. Key carer co-ordinator appointed for each site. Patient carer information pack produced.
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.	Development of templates to improve read coding. Practice found this helps to easily monitor activity within ongoing projects and focus on areas where the practice is not doing so well.
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.	1586 pts identified and their notes reviewed. 91 patients found to have deteriorated from CKD 2 to CKD 3. The treatment plans and follow up procedures were improved for these pts hopefully preventing future hospital admissions.
2WW breast cancer & Dermatology referrals	WILTON	Wilton have a higher than Wiltshire average referral rate to the breast clinic and for urgent dermatology referrals.	Referrals assessed and GP training provided to improve appropriateness of referrals

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 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?)	A number of elderly health assessments undertaken providing an opportunity to record key information and pro-actively manage patient care. The number of A&E admissions in the over 80s fell by 50% in 13/14 compared to the previous year.
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.	144 patients seen. Patients appreciate that physio may spend 30 mins assessing condition and teaching them about its management and ongoing care. This is longer than a GP could spend with them and many find that with the extra information and explanation they are able to successfully self-manage their condition.
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.	Unfortunately the staff member employed to undertake this role was found to be unsuitable and was redeployed.
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.	The project has created debate primarily in regards diagnostic and decision-making skills. We hope that the reflective learning will lead to a fall in cancer death rates because of earlier detection rates.
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.	1388 pts reviewed. A very useful role and has aided in trying to pre-empt problems. There has been information given out about alternatives to A&E and problems can be flagged up to the GP at an earlier stage. Active screening for dementia, atrial fibrillation and depression. Also provides COPD and diabetes reviews for these patients who are hard to get in to the surgery.

Appendix B: Practice use of underspend funds

Surgery	Summary of spend
WHITEPARISH	Bariatric scales, 24hr pressure monitor, development of dispensary work environment
AVON VALLEY	Bariatric scales, baby scales, pulse oximeter (paed) Telephone system, Electonic notice boards, treatment couch
MILLSTREAM	Promote and establish a designated weight reduction and bariatric clinic in house, bariatric scales, free standing blood pressure machine
BARCROFT	COPD and oxygen audit, training on the GRASP tool , laptop, new practice leaflet, TV in waiting room, Team away morning, picture notice board, computer and colour printer, in house ophthalmology clinic
ST MELOR	Away day, community good neighbour initiative
BEMERTON	Improved IT system, bariatric scales, patient self arrival screen, audits, health promotion and staff training
ENDLESS STREET	Development of room suitable for multidisciplinary meetings with visual screen, replacement flooring to achieve CQC compliance
CASTLE PRACTICE	Extension of the back pain pilot, additional costs incurred from development of Level 2 nursing home support
SALISBURY PLAIN HEALTH PARTNERSHIP	Bariatric scales, 2 x laptops, promotion of carers group meetings, prescribing work to achieve compliance with all green action points, double computer screens for 4 consulting rooms, refurbishment of the Ludgershall premises, additional HCA time ensure new patient checks are completed for new military patients
DOWNTON	Contribution towards air conditioning system
SALISBURY MEDICAL PRACTICE	Doplex abllty ABI system, medvivo surgery Pod, training on use of social media and development of a strategy, Lloyd George record storage system, development of volunteer programme
TISBURY	PC, laptops, windows in consulting rooms, decoration of treatment & examination room, oxygen stand, phlebotomy trolley, employment of specialist asthma nurse for 1 year, employment of part time admin assistant.
ORCHARD	Staff and partner training/education, digital dictation system, bariatric scales, EEG machine, CQC preparation

THREE SWANS	Digital dictation, headsets, 2 x laptops, 3 x bariatric scales, contribution towards having a lift installed and an additional consulting room created.
MERE	New telephone system, new heating system
ST ANN'S	Additional costs incurred from development of Level 2 nursing home support, a review of admitted cases and a review of mortality to ensure that best end of life care is given.
WILTON	Train receptionist to take blood, nurse overtime to undertaken over 75 checks, ambulatory BP machine, additional home BPmonitors, spirometer, new chairs for waiting room, bariatric scales
HARCOURT	Dedicated phlebotomy room, 3 x PC's, improvements to waiting room, improvements to outside parking area
SIX PENNY HANDLEY	New telephone system; New Boiler in Broad Chalke and Six Penny
HINDON	2 examination couches, oximeter, micro-spirometer, bariatric scales, development and commencement of system to contact patients post discharge
SILTON	Bariatric scales, locum support during time of clinical system changeover, Identify and visit elderly patients to assess whether they had any unmet health needs