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/14/07/16 Fourth Quarter Report on NEW Primary Care Service Level Agreement 2013/14 (previously PBC/Secondary Care LES) January to March 2014**
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Lead Director/GP from CCG:	Ted Wilson – Group Director NEW Dr Simon Burrell, GP Chair, NEW Group Dr Anna Collings, GP Vice Chair, NEW Group
Executive summary:	The purpose of this paper is to report fourth 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 January to March 2014: 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, £613,406, was paid to practices in July 2013. A second payment of £53,872 and a third payment of £578,681 were made to practices in November 2013 and February 2014 respectively. There is £101,158 remaining to be paid out to practices following year end March 2014.
Evidence in support of arguments:	N/A
Who has been involved/contributed:	• NEW Executive GPs • NEW Practice Managers • NEW 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 commissioning agenda and 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. This risk has not occurred in 2013/14. 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. This risk has not occurred in 2013/14.
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?	Governing Body to receive and discuss this Q4 report. NEW practices are now signing up to the NEW Group SLA for 2014/15 and will provide subsequent reports summarising the position as part of the quarterly reporting mechanisms.

North & East Wiltshire (NEW) Group
Primary Care Service Level Agreement (SLA) 2013-14
4th Quarter Report January – March 2014

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. Further payments of £53,872 and £578,681 were made to practices in November 2013 and February 2014 respectively. There is £101,158 remaining to be paid out to practices following year end March 2014.

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 S Church
	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.

  Engagement from the North Practices has remained consistently high throughout the year, often with a Practice Manager and a GP Lead in attendance from each practice at the monthly North Locality meetings. There is full understanding that delegates who attend the meeting represent the views of their practices and are expected to contribute to the agendas, discussions and resulting actions which assist the fluidity of discussion, decision making process and the output of the group. During this quarter, GPs have worked on reviewing the structure of community teams in their locality, an advanced care planning processes, looking at federated models of service provision and developing business cases to better support frail elderly patients.

  Regular attendance from the practices in the East Locality also remains excellent. Great Bedwyn Surgery have encouraged their GP Registrars to take an active part in this process as part of their CPD and 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. East Locality practices have also worked on a review of referrals to private service providers, discussion on the use of Scriptswitch IT system and its benefits in reducing prescribing costs and all practices had an opportunity to shape the CCG 5 year plan.

- Carrying out 100% of audits as agreed at locality meetings, and where appropriate using Perception+ – measured by annual return.

  In this final quarter practices in the North Locality have continued to work with Perception + IT system, gaining a better understanding of the complexities involved in identifying at risk patients and working with Care Co-ordinators to manage these patients in a primary care setting, reducing the need for secondary care admissions. In addition, practices have been reviewing admissions of care home patients with a view to exploring opportunities for improved clinical management and looking at how admissions can be avoided.

  A COPD audit was completed this quarter in collaboration with GWH and community team staff. This helped to both raise awareness of the provision within primary care and to feedback on the COPD service to date. All Practices have access to medicines management housekeeping audits and these are being completed at practice level.

  All East Locality practices have taken an active role in reporting information back to the CCG in agreed formats. This also includes the 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. As part of the Reduced Admissions DES and QOF 2014/2015, Great Bedwyn have identified ways of ensuring that their registers are robust by using audit tools supplied by PRIMIS (part of the University of Nottingham) which can interrogate the clinical system and highlight anomalies in data recorded. This will ensure highly accurate prevalence figures on which to base 2014/15 audit work.

- 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 report a cultural shift over the past year from a reactive to a pro-active approach to managing at risk patients. The process of identification of those patients who are at risk of emergency admission has developed with reports of a variety of methods used to ensure that

registers are relevant and valuable. In most practices, a 'virtual' list known by all GPs and the Care Coordinators has been developed using Perception+, Adastra and local knowledge of patients.

Great Bedwyn has found huge benefits in using this patient management process, which has resulted in MDT meetings to identify problems and discuss cases. 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. The Care Co-ordinator role is developing and evolving this is seen as an integral part of the wider practice team moving forward.

At the Marlborough Practice, the register of at risk patients is reviewed weekly by one of the administration staff to identify changes in patient circumstances and patients on the register are identifiable by an icon in the clinical notes when they are accessed by a clinician. The overall list is reviewed monthly by the doctors in a clinical meeting.

North Locality practices have established robust methods to raise awareness of at risk patients within their own clinical teams too, with the opportunity to feedback observations of patient deterioration and pre-empt possible episodes. This approach ensures a whole practice approach to ensuring that adequate support is in place. Most notably, there has been an increase in MDT and clinical meetings held within North Locality practices. These are reported as being essential to raising awareness of those patients who are at risk, providing the opportunity to update all clinical teams involved in the patient's management and ensuring a care plan is established and acknowledged. Care Co-ordinators are now embedded in North Locality practices and have active caseloads, supporting patients through personal contact, signposting and acting as a conduit of information to relevant primary care and community team members accordingly. Practices report that Care Co-ordinators have a direct influence in reducing emergency admissions and they are popular with the patients that they are supporting. However, the ongoing review of Perception+ will help to ensure data is accurate and up to date and practices can report effectively.

- 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. All seven Area Boards in the NEW Group area have seen GP representation during the year and 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.

Practices in the North and East Localities continue to report issues and suggestions via the 'Grumpy and Pleased' e-mail system and report an improved response rate from the CCG.

Grumpies by Practice Jan14 – Mar14

Row Labels	Jan-14	Feb-14	Mar-14	Grand Total
Beversbrook Medical Centre	2	2	4	8
Box Surgery	2	2	1	5
Lodge Surgery	1	1	4	6
Marlborough Surgery		1		1
Northlands Surgery	1	6	3	10

Patford House Surgery P'ship	2	2		4
Pewsey Surgery		1		1
Porch Surgery	3		2	5
Purton Surgery		1	1	2
Ramsbury Surgery	2			2
Rowden Surgery	4	8	4	16
Tolsey Surgery	2	1	1	4
Grand Total	**19**	**25**	**20**	**64**

Learning is fed back to practices and reported via quarterly reports to the NEW Executive meetings. Involvement from the CCG Referral Support Service (RSS) is recognised as being a positive influence to helping ensure issues are dealt with promptly, as is effective liaison with partners, including secondary care providers. The four key issues identified as trends in 'Grumpy and Pleased' e-mail reporting which have been addressed this quarter are discharge arrangements from secondary care, acute provider pushback to primary care providers, private provider patient pathways and triage delays through SWAST and NHS111.

- Attend regular GP clinical forums

There has not been a GP Clinical Forum during this 4th quarter 2013/14 in the NEW Group. However, the high levels of attendance at forums held earlier in 2013/14 are expected to continue into 2014/15. The next forum is due in May 2014 and plans to cover ways to improve communication between primary and secondary care providers.

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.

Practices in the North Locality report an increased use of the dedicated number by ambulance crews, rather than the main patient lines as reported in the previous quarter. Calls are made prior to attendance or whilst in situ at the patient's home and have in some cases avoided admission through GP involvement.

Encouragingly, Practices have responded favourably to the new SWAS triage system and it's felt that there is scope for this to develop further, especially as there are still reports of varied utilisation of dedicated lines. Malmesbury Primary Care Centre, for example, report that their dedicated line is infrequently called. Whereas, in comparison, Hathaway Medical Partnership report receiving 253 direct calls in quarter four. Despite the increased use of dedicated lines by the ambulance service it's disappointing to note that the service is still underused by secondary care consultants. It's hoped that CCG involvement and discussion at the next GP forum will help to raise awareness within A&E departments.

All Practices in the East Locality 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. Secondary care clinicians have been known to use these dedicated lines also to discuss patient care. However, some practices (e.g. Marlborough Surgery) 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.

- Respond quickly to requests by these providers for help in acute situations where GP input may be helpful.

  North Locality practices report that, in cases where requests for GP input have been made, a duty doctor or named clinicians have responded swiftly and effectively. It is clear that this service is not utilised to its full potential and hoped that the situation will improve over 2014/15.

  All East Locality 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. All practices are working on improving communication with secondary care and emergency providers for the benefit of their patients.

- 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.

  Whilst this service is available and supported by practices it is disappointing to note that it's use by secondary care colleagues has been limited. This could be due to unawareness of the availability of the dedicated phone lines and a lack of an embedded system within the secondary care Trusts. The scope of use for this service is not being fully exploited and further promotion is ongoing.

- 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.

  Practices report having established methods of reviewing ED patients regularly to identify any who would benefit from improved management. Practice data packs are continually distributed to practices on a quarterly basis and are discussed in practice meetings accordingly to identify trends. A healthy understanding of bench marking both in the locality and nationally is promoted through these reports. Activity is reviewed regularly by practices at their local practice meetings and all practices have had the opportunity to meet with the NEW GP Executive and Management Teams for further explorative discussions during practice visits.

  Some practices have acknowledged where increase in ED activity is evident and have been keen to explore further. Although overall reports show a difficulty to establish clear patterns, practices remain committed and open to implementing measures for improvement. Practices utilise Care Co-ordinators to ensure that patients being discharged are contacted swiftly post discharge and care plans are in place where appropriate in order to understand why ED attendances have happened and what can be done to prevent them in the future. Initiatives resulting from this audit work have included improved care planning, multi-disciplinary team approaches to patient care and involvement in the future development of the community team clusters.

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.

GPs and practice staff have been involved in the development of clinical pathways in a number of areas this year. Work on a new ophthalmology pathway with a focus on provision on services in local communities has developed plans to set up pre-referral clinics and consultant led triage of optician referrals as well as addressing capacity issues at GWH. This project has become an integral part of the CCG ophthalmology programme and will be developed to provide a county wide solution.

Evaluation of the community orthopaedic pre-referral clinics is starting and the pilot will link into the CCG MSK programme with a view to using valuable learning from the pilot to develop more community based services.

A review of physiotherapy provision is progressing and GPs have linked into the South West Strategic Clinical Network, bringing advice and best practice ideas into the CCG commissioning process.

NEW is leading the diabetes programme across the CCG and local NEW GPs are involved in developing a new pathway for diabetic patients, working with secondary care consultants, community providers, Wiltshire Council and other local commissioning CCGs with the aim of developing an improved patient pathway.

Work on all these areas will continue into 2014/15 with local GPs, Executive GPs and NEW commissioning staff becoming fully engaged in CCG work programmes and local projects.

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 NEW practices have actively engaged in discussions and feedback with the CCG to assist plans for the community services restructure at locality group meetings, workshops and at individual practice meetings. They have been involved in designing locality clusters and discussing what services should be provided for their local patient populations to feed into the staff and structural modelling work.

Throughout the year practices have demonstrated a commitment to developing integrated working relationships with community providers and this has helped to establish strong links between primary care and community services. Regular MDT meetings have developed involving a wide range of community team members including district nurses, midwives, occupational and COPD therapists and the community matron. Not all MDT meetings are patient centred focused. Purton Surgery, for example, held a meeting in this last quarter with Practice Nurses and District Nurses to discuss outstanding issues and promote a healthier affiliation.

Successful development of relationships is dependent on community team engagement, with New Court Surgery reporting a decreased rate of engagement due to having no community matron for much of the quarter. A redesigned service will help to ease such issues and indeed Calne Practices report excellent and effective relationships which are actively promoted by the new Community Team Leader, Caroline Davies.

Care Co-ordinators have developed into a valuable and essential resource in practices, although Hathaway Surgery has been unable to operate fully due to inefficient provision to cover sick leave. It is noted that over the course of the year the role has developed and expanded. Co-ordinators now have full and active caseloads, monitoring hospital activity, identifying and visiting vulnerable patients and liaising with the relevant teams. It is widely acknowledged that one of the most valuable aspects of the role is to signpost and refer patients appropriately, having a wide and up to date knowledge of available local charities and agencies. This essential service promotes joined up care within the locality and makes best use of health and social resources available for the direct benefit of patients.

In East Wiltshire, practices have excellent, regular communication with the Neighbourhood Team, especially Ella Purvis the Community Matron, and the District Nurses. Pewsey Surgery was recently actively involved in the recruitment process of a District Nurse. 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 have reshuffled 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 was in March 2014, solely run by the Care-Coordinators and the Practice Managers – this was a huge success and well received by the patients, carers and stallholders. This will enable the surgery to gain the Gold Carers Award (Great Bedwyn already hold the Gold Award for Carers). 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.

Much progress in this area has been seen over the past year and regular and effective engagement with the medicines management team is reported from all practices (see Appendix 1 and Appendix 2 – medicines management scorecard for NEW practices). This is especially assisted through the individual practice annual review meetings, held with Alex Goddard. Assistance from the medicines management team remains consistently efficient with improved access to information and practice performance data via the new interactive website. Practices who are System One users can identify prescribing savings using online tools and searches embedded in System One. Practices can contact the medicines management team on how to use this data as guidance is available. TPP Practices have a range of housekeeping and targeted drug searches available which have been built by the medicines management team and non-TPP Practices are being supported accordingly. These systems are being regularly interrogated by NEW Group practices.

Practices report being pro-active in managing prescribing budgets in general, often involving a whole practice team approach. This is evidenced in the promotion of refresher training for prescription clerks on DACS management, held at Beversbrook Medical Centre, but available for all North Locality Practice staff and equivalent training in the East Locality practices.

Local audits have been carried out based on practice improvement needs such as batch switching, red drugs monitoring, high cost drugs audits etc. Scriptswitch is used widely when it is feasible across the NEW Group. Cricklade Surgery has recently agreed to have this installed to help manage their prescribing costs more accurately. Ramsbury Surgery is significantly under its prescribing budget and has chosen to opt out of using Scriptswitch, but clinicians continue to monitor their prescribing and use their Dispensary Manager in a fully engaged role making sure of prescribing savings on a daily basis. A controlled drug audit has been run at Burbage and Great Bedwyn Surgeries. Burbage Surgery will continue to optimise prescribing with the assistance of Scriptswitch.

In all practices, prescribing audits are performed as requested and on an ad-hoc basis if new clinical information indicates that medication needs to be changed, e.g. long term use of metformin resulting in low B12, the report was run and patients with low vitamin B12 identified by blood test were called in for a vitamin B12 injection.

Practices report regular engagement with the Care Home Pharmacist engaging in discussions regarding medication reviews. After the successful pilot of the new Wiltshire Formulary this is now being installed into every NEW surgery and has been met with enthusiasm from clinicians to date.

Following completion of the medicines management team audit on opiate prescribing, North Locality practices report a continued effort to review and monitor this area, ensuring clinicians are aware of pain management pathways and adopting policies of prescribing oral opiates over patches.

Practices have started to use electronic prescribing attached to their clinical systems (ETP) for patients, making the system quicker and more effective for patients and reducing administration time for practices. This allows more time for prescribing reviews and audits to be completed.

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 review
- 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

All Practices Report making conscientious efforts to meet the above targets. It has been generally agreed that this area of development has been the most beneficial and rewarding to both patient management and efficient working practices over the past year. Practices report greatly improved relationships with Care Homes and CCG involvement has helped with non-compliance.

Practice policies on care home management have developed both organically and strategically within practices, using a variety of methods for pro-actively case managing patients. These methods range from improved visit management such a 'ward' rounds to better use of the Community Geriatrician. Hathaway Surgery, for example, have gone to the lengths of employing the services of a care home nurse, who will be responsible for liaising with the lead GP and Geriatrician for improved patient care.

Area cluster groups are working collaboratively to ensure a uniformed approach to care home management. Chippenham and Calne areas individually promote effective working through regular care home meetings which are well attended by home managers, practice GPs, PMs and clinicians such as Chris Dyer, the community matron and relevant agencies as appropriate.

Purton Surgery benefits from quarterly meetings with their Care Home Manager and they have collectively agreed and designed a form and policy to help manage patients. Improved relationships have been enhanced by the opportunity to share learning and provide education to Care Home staff. Porch Surgery, for example, is working with their care homes to improve the use of the OOH services and inappropriate admissions and Box Surgery have held several educational workshops for Care Home managers.

An audit has been carried out by practices to review the list of care home patients admitted to hospital. Some practices have reported that where they have disappointingly seen a rise in care home admissions, however, they have identified some of the causes of this such as limited availability of STARR beds at certain times of the year. It is expected that continuation of the efforts invested over the past year will provide notable improvement over 2014/15.

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 to staff and patients and to develop monthly reports on any secondary care admissions for review. All Nursing Homes are engaging with the practices.

Overall, practices are convinced that management of care homes patients, both in terms of intra-practice administration and clinically within the care homes is easier with the consistent approach possible through a named doctor for each large care home. Practices have moved towards the same principle for the smaller care homes locally, and it is hoped that this will continue to pay dividends with the 2014/15 SLA and the Unplanned Admissions DES.

Conclusion

Much progress has been made over 2013/14 through the implementation of this SLA in NEW practices, working together with the CCG to improve services to patients and to reduce costs. When asked to reflect over the progress made, practices have reported the most beneficial improvements in the management of their vulnerable and frail elderly patients. Better working relationships with care homes and district nursing teams and the integration of Care Co-ordinators has helped practices to enhance the service they offer to these patient cohorts. Adopting joined-up and collaborative working methods to co-ordinate patient care has promoted engagement and fresh thinking.

Practices have remained enthusiastic and open to the idea of initiating beneficial changes to patient management. There is a clear commitment to developing this further in 2014/15. In addition, practices are working hard towards the CCG objectives through effective use of medicines management tools and involvement in pathway development.

Appendix 1

Medicines Management Score Card - 2014/15

NEW Locality

		Baseline Quarter 3rd Quarter 2013/2014	Current Quarter 4th Quarter 2013/2014	Change		4th Quarter 2013/2014 CCG	4th Quarter 2013/2014 National
QIPP	3 days Trimethoprim ADQ/item	6.43	6.08	▼	-0.34	5.74	5.87
	ACE inhibitor % of all RA drugs (items)	70.3%	70.3%	▲	0.0%	69.5%	70.5%
	Antibacterial items/STAR PU	0.29	0.29	▼	-0.00	0.32	0.32
	Antidepressants: ADQ/STAR PU	1.96	1.93	▼	-0.03	1.98	2.02
	Cephalosporins & Quinolones % of all Antibiotics (items)	7.2%	6.7%	▼	-0.4%	7.2%	5.0%
	Hypnotics ADQ/Cost based STAR PU	1.96	1.84	▼	-0.12	1.63	1.77
	Hypoglycaemic Agents: Metformin and SU's % of all Diabetic Drugs (items)	82.7%	82.6%	▼	-0.00	83.5%	83.5%
	Laxatives ADQ/STAR PU	1.46	1.42	▼	-0.04	1.42	1.79
	Lipid Modifying Drugs: Ezetimibe % of all Lipid Drugs (items)	2.9%	2.9%	▲	0.0%	2.7%	2.7%
	Long/Intermediate Insulin Analogues as a % of all Insulins (items)	80.2%	79.6%	▼	-0.5%	77.2%	81.0%
	Low cost Lipid Modifying Drugs as % of all Lipid Drugs (items)	91.5%	91.5%	▼	0.0%	92.9%	93.4%
	Minocycline ADQ/1000 patients	13.48	15.59	▲	2.11	13.69	14.44
	NSAIDs: ADQ/STAR PU	1.89	1.82	▼	-0.07	1.71	1.50
	NSAIDs: Ibuprofen & Naproxen % of all NSAIDs (items)	66.6%	68.6%	▲	2.0%	72.2%	74.6%
	Omega-3 Fatty Acid Compounds	0.37	0.32	▼	-0.05	0.26	0.31
	Antidepressants First Choice	63.9%	64.0%	▲	0.1%	64.6%	63.8%
	Wound Care Products NIC/Item	18.48	16.24	▼	-2.24	17.94	25.29
LOCAL	Fentanyl and high dose buprenorphine patches as a % of all opioid analgesic items	6.9%	6.5%	▼	-0.4%	5.4%	5.3%
	Low dose buprenorphine patches as a % of all opioid analgesic items	10.2%	9.9%	▼	-0.3%	9.1%	6.6%
	Inhaled Corticosteroids ADQ/STAR PU - new indicator	0.59	0.55	▼	-0.04	0.57	0.69
	Temazepam % of Benzodiazepine and 'Z' Drugs (items) - new indicator	23.1%	22.8%	▼	-0.3%	23.3%	19.5%

		To Dec 2013	To March 2014		
SAFETY	Unopposed oestrogen, no progestogen or mirena, intact uterus *	19	15	▼	-4
	Citalopram more than 20mg in over 65 (MHRA)*	30	37	▲	7
	Simvastatin ≥ 40mg + Calcium Channel Blockers etc (MHRA)*	23	241	▲	218
	PD5 (e.g. sildenafil) plus nitrates or nicorandil (contraindicated)*	6	2	▼	-4
	NSAID on repeat and over 65 *	810	724	▼	-86

		Dec-13	Mar-14			% of Budget
TPP	TPP "Housekeeping" Savings	£ 627,133	£ 545,273	▼	-£ 81,860	2.6%

* Non TPP sites will require Medicines Management support to identify these figures
Amber is within 5% of the target (the National rate) for the current quarter.

Appendix 2

Medicines Management Score Card - 2014/15

4th Quarter 2013/2014

		BEVERSBROOK MEDICAL CENTRE	BOX SURGERY	BURBAGE SURGERY	CRICKLADE SURGERY	HATHAWAY SURGERY	LODGE SURGERY	MALMESBURY PRIMARY CARE CENTRE	MARLBOROUGH SURGERY	NEW COURT SURGERY	NORTHLANDS SURGERY	OLD SCHOOL HOUSE SURGERY	PATFORD HOUSE SURGERY PARTNERSHIP	PORCH SURGERY	PURTON SURGERY	PEWSEY SURGERY	RAMSBURY SURGERY	ROWDEN SURGERY	TINKERS LANE SURGERY	TOLSEY SURGERY	Locality	CCG	NATIONAL
GPP	3 days Trimethoprim ADQ/Item	6.69	6.82	6.98	6.55	6.26	5.32	5.65	6.17	5.01	4.73	5.22	6.87	6.94	5.91	6.94	6.24	5.75	7.72	5.49	6.08	5.74	5.87
	ACE Inhibitor % of all RA drugs (Items)	72.8%	64.8%	73.4%	69.6%	73.6%	67.8%	70.9%	70.5%	73.8%	74.4%	63.2%	74.7%	63.1%	63.7%	63.1%	69.0%	72.2%	69.8%	67.8%	70.3%	69.5%	70.5%
	Antibacterial Items/STAR PU	0.19	0.31	0.32	0.54	0.24	0.28	0.26	0.32	0.36	0.34	0.29	0.23	0.29	0.40	0.29	0.29	0.25	0.27	0.27	0.29	0.32	0.32
	Antidepressants: ADQ/STAR PU	1.64	1.68	1.25	1.95	2.14	2.18	1.62	2.06	2.45	2.30	2.33	1.80	1.73	1.83	1.73	1.80	1.74	2.28	0.97	1.93	1.98	2.02
	Cephalosporins & Quinolones % of all Antibiotics (Items)	5.1%	10.2%	3.7%	6.8%	8.2%	3.8%	7.1%	4.7%	6.8%	5.8%	3.7%	6.8%	6.5%	5.5%	6.5%	7.5%	7.7%	9.8%	8.4%	6.7%	7.2%	5.0%
	Hypnotics ADQ/Cost based STAR PU	1.33	1.23	0.95	7.43	2.00	1.58	1.48	1.66	1.74	1.43	1.65	2.15	1.81	3.34	1.81	1.17	1.66	2.41	1.63	1.84	1.63	1.77
	Hypoglycaemic Agents: Metformin and SU's % of all Diabetic Drugs (Items)	80.0%	89.6%	82.7%	71.0%	84.1%	83.2%	86.4%	81.5%	87.7%	86.1%	77.7%	78.4%	90.3%	76.9%	90.3%	88.2%	73.5%	83.6%	79.6%	82.6%	83.5%	83.5%
	Laxatives ADQ/STAR PU	1.04	2.28	1.23	1.84	1.38	1.58	1.47	1.30	1.85	1.52	0.80	1.05	1.16	1.51	1.16	1.31	1.56	1.30	0.99	1.42	1.42	1.79
	Lipid Modifying Drugs: Ezetimibe % of all Lipid Drugs (Items)	1.7%	3.6%	3.9%	2.5%	3.0%	2.0%	3.3%	2.1%	1.9%	0.7%	2.4%	2.5%	1.9%	4.7%	1.9%	0.5%	6.0%	2.9%	2.3%	2.9%	2.7%	2.7%
	Long/Intermediate Insulin Analogues as a % of all Insulins (Items)	78.0%	87.0%	88.9%	95.7%	69.5%	85.1%	81.7%	88.0%	76.1%	70.1%	85.3%	64.2%	70.7%	89.5%	70.7%	93.2%	73.5%	86.6%	82.1%	79.6%	77.2%	81.0%
	Low cost Lipid Modifying Drugs as % of all Lipid Drugs (Items)	93.3%	88.2%	84.0%	77.1%	94.4%	93.2%	93.6%	88.6%	95.8%	98.5%	90.3%	92.9%	92.6%	91.9%	92.6%	90.9%	87.6%	95.2%	91.1%	91.5%	92.9%	93.4%
	Minocycline ADQ/1000 patients	22.71	8.58	-	228.88	-	-	-	42.08	-	16.00	-	6.54	73.11	17.83	73.11	-	14.28	15.56	16.33	15.59	13.69	14.44
	NSAIDs: ADQ/STAR PU	1.78	1.66	2.70	4.05	1.57	1.71	1.70	1.83	2.18	2.03	1.96	2.12	1.57	1.96	1.57	1.28	1.74	1.92	0.95	1.82	1.71	1.50
	NSAIDs: Ibuprofen & Naproxen % of all NSAIDs (Items)	71.3%	67.5%	61.1%	55.1%	71.5%	76.7%	71.6%	62.9%	63.9%	80.4%	62.1%	64.6%	48.7%	62.7%	48.7%	72.3%	78.1%	68.5%	68.5%	68.6%	72.2%	74.6%
	Omega-3 Fatty Acid Compounds	0.15	0.82	-	0.14	0.13	0.10	0.13	0.34	0.36	0.16	0.17	0.91	0.32	0.43	0.32	0.48	0.38	0.14	0.71	0.32	0.26	0.31
	Antidepressants First Choice	68.2%	62.9%	39.0%	55.8%	64.9%	59.2%	65.2%	65.5%	69.5%	67.3%	49.7%	69.7%	67.5%	69.7%	67.5%	64.4%	63.9%	59.2%	57.7%	64.0%	64.6%	63.8%
	Wound Care Products NIC/Item	19.71	20.82	14.56	5.99	14.04	38.90	36.27	26.20	24.48	63.80	9.17	9.55	9.67	16.39	9.67	8.29	14.00	37.63	3.25	16.24	17.94	25.29
LOCAL	Fentanyl and high dose buprenorphine patches as a % of all opioid analgesic Items	2.9%	4.4%	0.6%	2.4%	6.9%	1.9%	7.6%	8.0%	5.3%	3.0%	2.6%	3.5%	7.0%	14.2%	7.0%	21.8%	5.6%	5.2%	3.1%	6.5%	5.4%	5.3%
	Low dose buprenorphine patches as a % of all opioid analgesic Items	5.2%	22.7%	6.3%	3.1%	13.2%	13.3%	6.5%	8.7%	6.5%	2.8%	4.5%	7.7%	11.9%	12.9%	11.9%	6.1%	13.6%	6.2%	3.1%	9.9%	9.1%	6.6%
	Inhaled Corticosteroids ADQ/STAR PU - new indicator	0.54	0.63	0.41	0.71	0.58	0.67	0.49	0.53	0.62	0.62	0.52	0.56	0.53	0.51	0.53	0.51	0.47	0.58	0.42	0.55	0.57	0.69
	Temazepam % of Benzodiazepine and 'Z' Drugs (Items)new indicator	0.41	0.37	0.06	0.20	0.24	0.17	0.32	0.28	0.18	0.25	0.16	0.14	0.20	0.14	0.20	-	0.17	0.32	0.15	0.23	0.23	19.5%
SAFETY	Unopposed oestrogen, no progestogen or mirena, intact uterus *	2	-	-	1	2	-	2	-	-	1	-	-	-	-	1	2	3	-	1	15		
	Citalopram more than 20mg in over 65 (MHRA)*	-	-	-	-	4	-	1	4	-	11	-	2	3	-	5	1	5	-	1	37		
	Simvastatin≥ 40mg + Calcium Channel Blockers etc (MHRA)*	24	4	6	22	32	8	9	35	-	12	9	6	6	-	9	13	16	-	30	241		
	PDS (e.g. sildenafil) plus nitrates or nicorandil (contraindicated)*	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	2		
	NSAID on repeat and over 65 *	23	18	49	54	71	30	82	67	-	48	33	39	66	-	33	29	77	-	5	724		
TPP	TPP "Housekeeping" Savings	15,775.00	17,431.00	17,845.00	19,436.00	59,022.00	24,351.00	48,381.00	59,279.00	16,012.02	34,013.00	16,465.00	28,850.00	31,853.00	19,352.11	20,477.00	57,518.00	41,580.00	2,643.80	14,989.00	£ 545,273		