NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 23 September 2014

For: PUBLIC session ☒ PRIVATE Session ☐

For: Decision ☐ Discussion ☒ Noting ☐

Agenda Item and title:	**GOV/14/09/13 2014/15 Sarum Primary Care SLA**
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 1 report on the 2014-15 Sarum Group Primary Care SLA. The SLA focuses on supporting CCG engagement and 5 specific work streams: • Primary Care at Scale • 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 are £1,139,293. No payments were made in Q1. The SLA supports membership engagement in localities. This element of the SLA has been reduced to £1.30ph compared to £2.20ph in previous years. Practice representatives attended locality lead meetings in quarter 1 and all practices were engaged in the development of the 20,000 population clusters and the Transforming Care for Older People bids. In addition, the Sarum group held an all member event on 29 April 2014 at Salisbury Golf Club. The event was attended by over 100 GP's and practice managers with representatives from all the Practices within the Sarum Group. Members are also engaged as commissioners through a new workstream called 'Developing primary care at scale. This workstream supports the CCG strategy and national policy and provides time and pump priming for practices to develop locality plans based on the future care model.

	The Effective Urgent care workstream of the SLA builds on the work established in last year's SLA and aims to provide enhanced care for nursing home/residential care residents to reduce avoidable acute admissions. The scheme has been refined this year by removing Level 1 care to focus effort on providing level 2 care which is more likely to have an impact on avoiding admissions. Care home admissions in Quarter 1 were up 1 compared to the same quarter last year. . Within the Effective Prescribing section Practices are being asked to focus on 3 areas or work following their annual review with the Medicine Management team in Quarter 1. Each practice is required to improve 'Housekeeping savings' and were free to choose 2 areas from the scorecard that required improvement. The Effective Referrals element of the SLA has been reduced compared to previous years to focus on peer review of referrals and inclusion of the core data set on secondary care referrals. A review of the data shows GP initiated referrals up 1.2% (to SFT) compared to Q1 last year. Total Sarum first outpatient and first outpatient procedure activity is up 6% compared to the same quarter last year. Within the Locally Developed Innovation and Improvement section practices were asked to identify areas within their current activity where they are an outlier in activity or cost and develop improvement project(s) to address these concerns. Practices were required to develop their bids and submit by 30th May 2014.
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; 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 2014 – 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.

2014-15 Sarum Group Primary Care SLA

Introduction

The purpose of the 2014/15 Sarum Primary Care 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 5 work streams:

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

The desired outcomes from this SLA are:

- Reduction in urgent admissions from Care Homes into SFT
- Referral growth beyond population growth levels is managed
- Membership engagement with the CCG's 5 Year Strategic Plan and A Call to Action to deliver primary care at scale.
- Demonstrable progress in specific areas of prescribing as selected by each practice.
- Measurable benefit resulting from practice improvement projects

Funding

Total funds available under this SLA are £1,139,293 based on a population of 141,918 as of January 2014. Initial payments were made to Practices in July/Aug 2014 and will be reported in the quarter 2 report.

SLA approval and sign up

The 2014/15 Sarum SLA was approved by the Clinical Executive and ratified by the Governing Body on 20th May 2014. All 23 practices in Sarum have signed up to the SLA. One practice, did not submit a locally developed innovation and improvement bid.

SLA Work streams

A. Primary Care at Scale

The Primary care at scale section is new this year and supports the aspirations of A Call to Action and the CCG 5 year strategic plan around primary care at scale and integration with social care.

Practices should use this funding to develop locality plans based on the future care model and to pump prime delivery of these plans if necessary. Q1 plans detailing the practice's/localities strategies were due for submission on 19 June 2014. However given that this was a new workstream this year the localities requested additional information as to the CCG expectations and therefore the deadline for submission was extended.

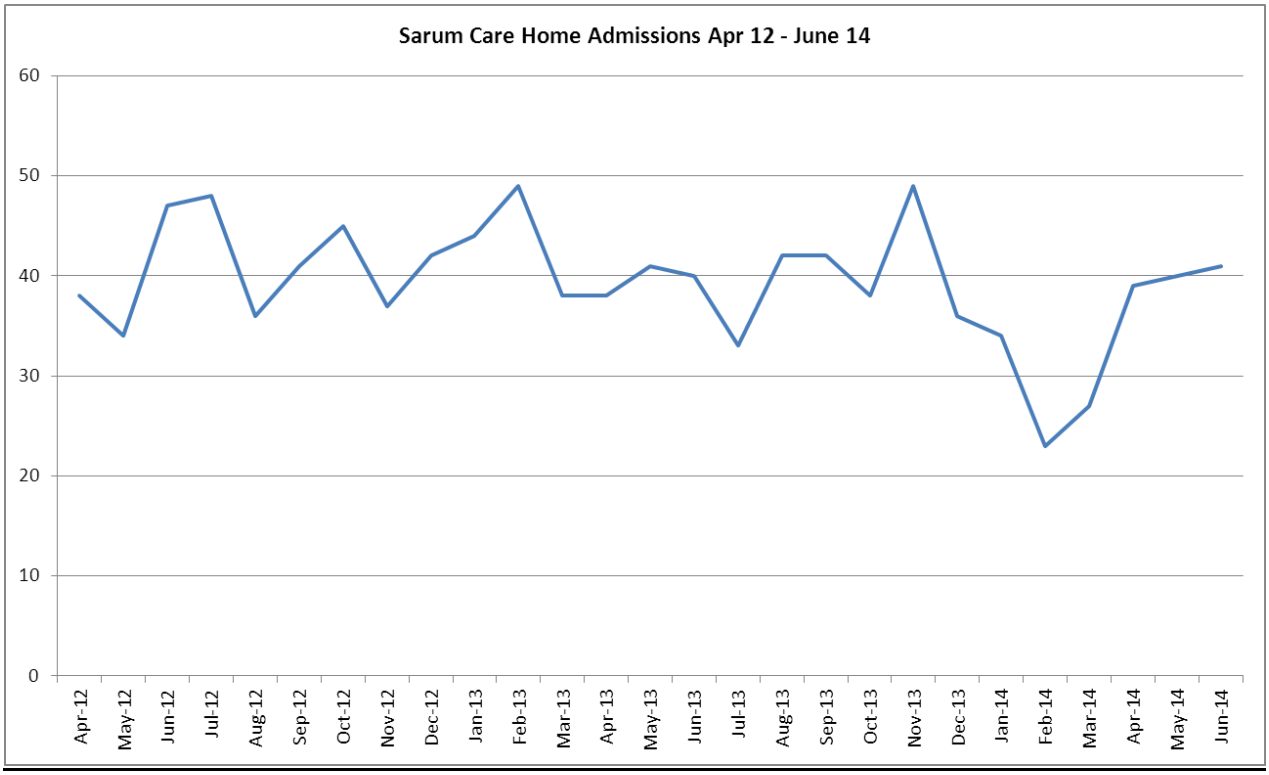
B. Effective Urgent Care

Indicative group level measurement		
Target	Performance	Notes
80% of care home places in Sarum covered at Level 2	57%	
Decrease in number of admissions from care homes 14/15 year to date versus 13/14 year to date equivalent to at least the cost of the SLA element. Total cost in Q1 £45,450.	+1 (adverse variance) +£47,950 (adverse variance)	Financial variance is calculated as year to date spend minus savings from reduced admissions (average cost of £2,500 per admission)

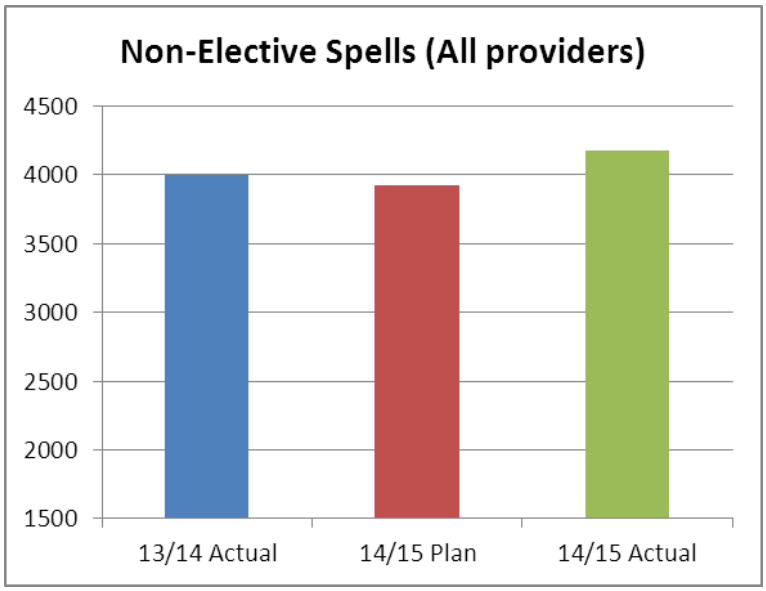
This element continues from 2013/14 providing enhanced care for nursing home/residential care residents to reduce avoidable acute admissions. Level 1 care home support has been removed this year to focus effort on level 2 care paid at £225 per patient per annum which includes a weekly visit/ward round 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.

4 Practices, who don't have care homes in their patch or already have a private agreement with their local care home are undertaking alternative urgent care projects. See appendix A for details of the alternative urgent care schemes.

In quarter one, 808 care home patients were covered at level 2 (57% of the total care home beds in Sarum). At the end of June, year to date Sarum Care home admissions to an acute trust were up 1 compared to the same period last year (120 vs 119).



Sarum 14/15 non elective activity



Non elective admissions for Sarum were up 4.45% compared to the same quarter last year and up 6.45% against plan. However, for the CCG as a whole, non-elective activity was up 7.91% compared to last year which is up 10.53% against plan.

A detailed breakdown of non elective bed days and LOS at SFT can be seen in Appendix B.

C. Effective Prescribing

Indicative group level measurement		
Target	Performance	Notes
100% of practices have agreed target areas with Medicines Management Team by 30/6/14.	100%	
Reduce variation in prescribing spend in 14/15, by at least the value of spend on this aspect of the SLA. (£70,959)	Prescribing spend is currently up £94,409 (2%) compared to Q1 13/14. TPP housekeeping savings have increased by 2.3% compared to the baseline (adverse variation)	Potential housekeeping savings identified by Meds Mgt team for March 2014 £434,658. This figure will be used as a baseline.

Practices are required to engage with the Medicines Management Team and maintain focussed on prescribing. They are specifically required to work on 3 areas from the medicine management scorecard which show room for improvement and demonstrate progress in those areas of work. One of these areas must be 'TPP Housekeeping Savings' which details specific potential savings each practice could make using data directly from TPP. For Sarum the total potential savings identified by the Medicine Management team was £434,658. Unfortunately by July 14 potential savings had increased by 2.3% to £440,875.

The Medicine Management team visited all practices during Q1 with a plan identifying their 3 areas for improvement due in quarter 2.

D. Locally Developed Innovation and Improvement

Indicative group level measurement		
Target	Performance	Notes
Measurable ROI of combined schemes for Sarum on activity utilisation / system costs of 50% (£142,000)		Measured at Qtr 4 (leading indicators being developed for draft view of progress in Q2 and Q3)

Continuing from last year, practices were asked 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. Practices were required to develop their bids during quarter 1 and submit by 30th May 2014. Detail of approved projects can be found in appendix C.

E. Practice Engagement

This element of the SLA has been reduced to £1.30ph compared to £2.20ph in previous years. Practice representatives attended locality lead meetings in quarter 1 and all practices were engaged in the development of the 20,000 population clusters and the Transforming Care for Older People bids. In addition, the Sarum group held an all member event on 29 April 2014 at Salisbury Golf Club. The event was attended by over 100 GP's and practice managers with representatives from all the Practices within the Sarum Group. The event was an opportunity to discuss the CCG 5 year plan and the Better Care Fund, to receive a presentation from a Gastroenterology Consultant from SFT as well as receive updates from the Medicine Management Team and hear about some of the successful innovation projects.

This element of the SLA will also fund up to 15 half day sessions a month to provide additional clinical involvement into wider CCG initiatives and in particular, the 2 year delivery plan.

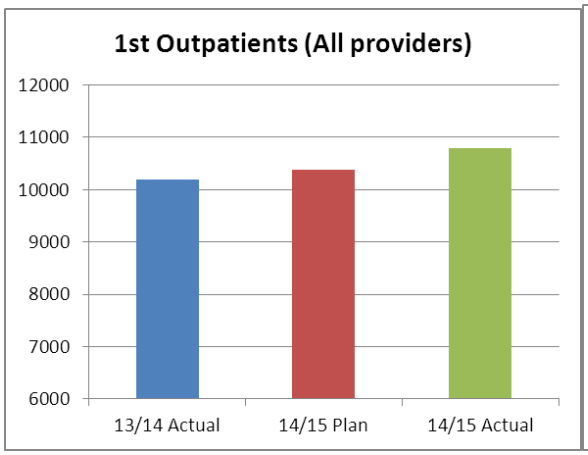
F. Effective referrals

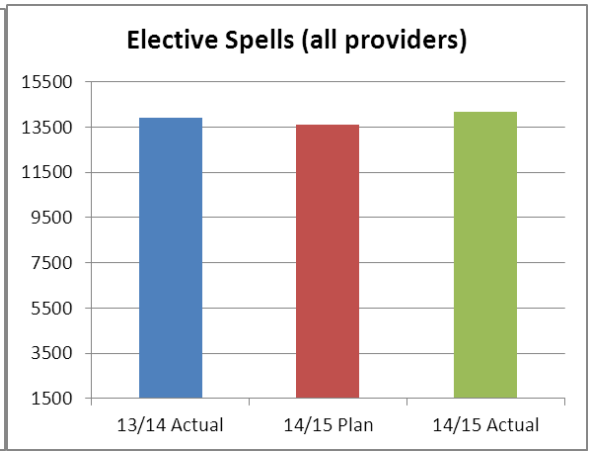
Indicative group level measurement		
Target	Performance	Notes
Practice level GP initiated outpatient referrals 14/15 versus 13/14 levels +1%	GP referrals up 1.2% (88 referrals) compared to Q1 13/14	SFT referrals only
GP initiated first outpatient appointments 14/15 year to date versus 13/14 +1%	Total 1st Outpatient attendances and 1st outpatient procedures up 6% versus Q1 13/14	Data is for all 1st outpatient attendances and outpatient procedures not just GP initiated

This initiative was introduced in the 2012/13 Pbc/LES to encourage practices to closely monitor referrals and influence referral behaviour. This workstream has been refined this year to focus on peer review of referrals and inclusion of the core data set on secondary care referrals. Practices are required to review their monthly practice packs to monitor their referral trends.

A review of the data shows Sarum first outpatient and first outpatient procedures are up 6% compared to the same quarter last year and up 4% against plan. This is slightly higher than total CCG performance which is up 5% compared to the last period last year. Unfortunately, Practices were not able to review their referral activity as planned due to a delay until the end of August in the production of Practice Packs for months 2 & 3.

Elective spells are up 4% against plan and up 2% compared to the same quarter last year.





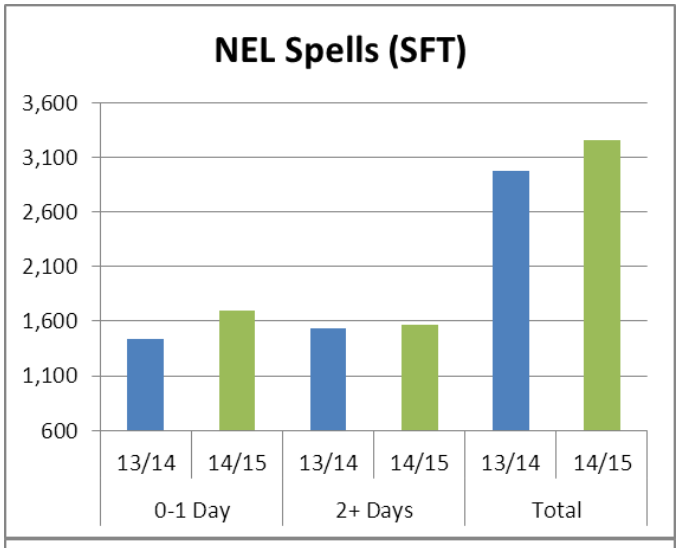
Conclusion

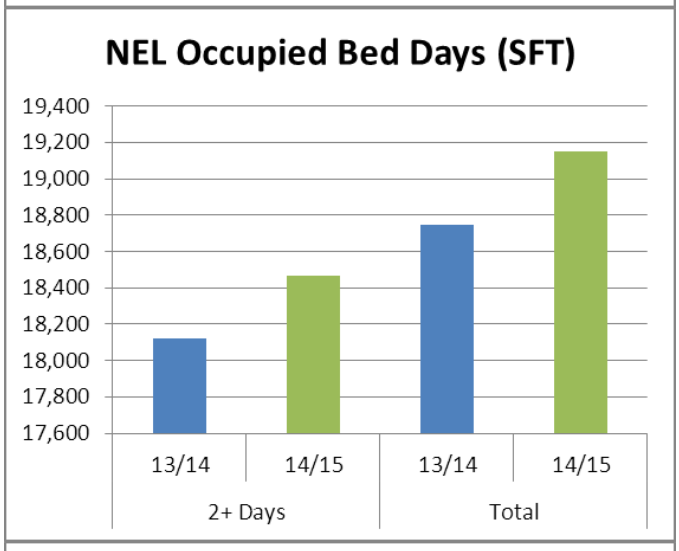
The Governing Body is asked to note the contents of this report.

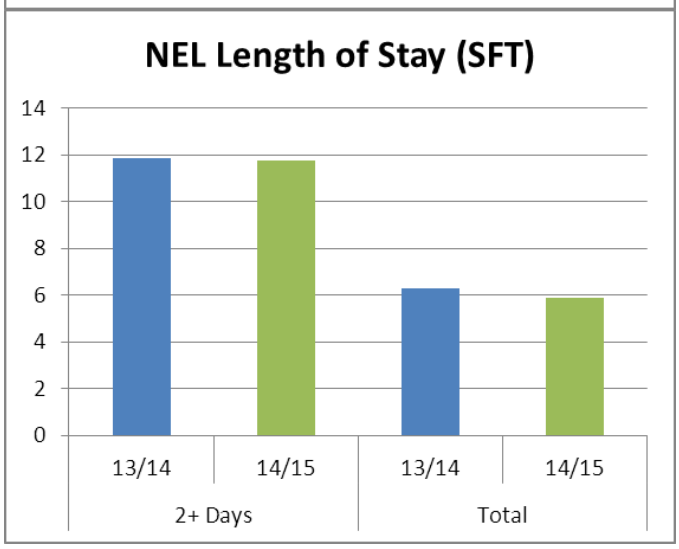
Appendix A: Alternative Urgent Care Schemes

Project Title	Surgery	Project Summary	Total project value
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 Practice will provide a training session with Pam Apsey (or equally qualified and experienced clinician is this field) for all clinicians including GPs, Practice nurses and HCAs. 224 patients on the register. Aim for discussion with 80% of pts by end of year. Continuation from last year: Developed and implementing a template and protocol to promote recording on this data. The template included factsheets, example forms for completion and direct access to documentation to enable efficient retrieval by clinicians and outside agencies. A traffic light system was also introduced using patient status markers. Discussions with 18 pts	£3,000
Post discharge contact	Orchard	To improve immediate post-discharge care and reduce readmissions by phoning all patients with major reasons for admission 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. Continuation from last year	£15,000
Nursing home audit	Cross Plain	This year it is planned to survey the homes that were not visited in 13/14 year. The return of questionnaires after the visit was poor last year, and the methodology for this will be changed this year. It is also planned to increase the amount of training available for Nursing Homes, and this may need to take place in the Nursing Homes to enable as many staff as possible to take place. Questionnaire results from this year will form part of the baseline data, along with A and E attendance and admission data. Continuation from last year.	£4020
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 3 days To provide a lead GP per site. To ensure care plans are in place and updated regularly. To process all prescription requests within 24 hours. New residents to be reviewed within 7 days of registering at the Practice.	£4252

Appendix B: Non elective admissions data







Appendix C: Sarum Innovation and Improvement projects and audits

Project Title	Surgery	Project Summary	Total project value
Development and Delivery of a CHAT service	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. All of these CHAT workers are a continuation from 13/14	MILLSTREAM £6,800 (£1.16 pp) SALISBURY PLAIN £5500 (0.90 pp) WHITEPARISH £7280? (£1.08 pp) ENDLESS STREET £10,350 (£1.18pp)
Walk in attendance	ENDLESS STREET	We will review the last 6 months data on our patient's usage and activity at the Walk in Centre, try to ascertain who and why they are using the Walk in Centre and if this use is appropriate?	£1,800 (£0.20 pp)
Strategy to address significant DNA rate	MILLSTREAM	To reduce the amount of DNAs which has significantly impacted on clinician availability. To audit the DNA rate at weekly intervals, Weekly meeting with Practice Manager, Senior Receptionist and Senior Partner, Cross reference to the regular DNA list, Any child under 5 that DNAs to be reviewed on the day by a GP due to possible child protection issues, Member of staff to follow up the DNA within 48 hours by all reasonable means (ie telephone or email) to acknowledge the DNA.	£7303 (£1.25pp)
Physiotherapy assessment and signposting	SALISBURY PLAIN	To provide physio assessment within primary care to enhance appropriateness of referrals and offer early intervention.	£6,500 approx (£1.05 pp)
Pilot: Provision of a physiotherapy assessment within the Practice	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 Continuation from 13/14 – initial project outcome: 71 patients discharged preventing referral to physio/ESP/or specialist	£13,000 (£2.10 pp)
Promote new online physiotherapy platform	BARCROFT & ST MELOR	We wish to continue to work with St Melor to promote the on line web tool and audit its use. Continuation of 13/14 project: Recently launched the use of the Medivid service and wish to have more time to establish its use and audit effectiveness.	£10,000 (£0.65 pp of joint population)

Ophthalmology	BARCROFT	Piloted with SLA underspend funds. Propose to set aside 6 appointments a week for patients requiring ophthalmology review.	£10,000 (£0.95 pp)
Safety around prescribing	ST MELOR	Continuation of audit from last year to continue to monitor patients on DMARD's and bisphosphonates Continuation of 13/14DMARDS**:** Having the register has enabled us 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.	£3,486.26 (£0.70 pp)
Improve uptake of AAA screening	HINDON	Find out the present process to invite to the service (including the information sent) and follow up of non-responders. Draft a practice letter to non-responders. Discuss with service process to inform practices of the results of screening and also non-responders (similar to the national bowel screening with data transfer electronically on pathlinks direct to SystemOne would be ideal)	£110 (£0.05 pp)
Audit all A&E attendees	HINDON	Audit A&E attendees. Produce actions for individual patients or patients in similar circumstances	£1,200 (£0.56 pp)
Contact patients after healthcare elsewhere	HINDON	Identify all patients who have had contact with health care elsewhere. Contact all these patients soon after identification (by top grade level 6 practice nurse). Pass on findings needing immediate action to duty GP. Learn from all these contacts to change practice care as needed to reduce risks of emergency care outside the practice.	£4,420 (£2.11 pp)
Check up for smokers	HINDON	To invite all patients identified on our database as adult smokers to a health check and opportunity to have help to stop smoking. This will be in the month before their birthday and will be by email or letter (with a telephone call to those who do not respond).	£2125 (1.00 pp)
Radiology requests	HINDON	Hindon Surgery benchmarks high for the use of direct access radiology (plain X Rays, ultrasound, CT and MRI). In 2013 – 2014 we audited all our radiology referrals for the year and the results showed that our use of radiology is in line with good practice guidelines. Continuation from 13/14: The quality of our requests was improved by the audit and regular monitoring. We want to make sure that this high quality continues.	£450 (20p pp)
Support for carers	HINDON	Improved support for carers with: • Better identification of carers	£505 (25p pp)

		• Improved uptake of preventative care by carers • Provision of more carers clinics in collaboration with Wiltshire Carer Support •	
Improving uptake of national bowel screening programme	HINDON	Uptake of the national bowel screening programme is around 55% and Wiltshire 62%. Last year we had an innovation scheme to increase uptake by writing to all patients identified as non-responders and this has increased uptake in our patients to 81%. We wish to continue this work and also contact the 'missing' 19% to find out why they did not participate in the programme.	£1050 (£0.50 pp)
Validation of Hindon Surgery data on high cost spells on Perception+	HINDON	Hindon Surgery has validated all of its in-patient activity and costs and a sample of out-patient activity for the past seven years. This validation has led to the identification of a number of costly coding practices that have added considerable costs with no increase in activity.	£450 (£0.20 pp)
Hospital Discharge follow up	THREE SWANS	All unplanned hospital admissions will be followed up by the patient's registered/usual doctor. This will be by a telephone call to the patient within 3 working days of receipt of their discharge summary. Rationale • To understand the reason for admission. • To identify factors that could have prevented admission • To plan post discharge care	£17,298 (£2.00 pp)
Improved management of patients with MSK problems	SALISBURY MEDICAL PRACTICE	Building on the back pain project rolled out by the CCG during 2013/14 this scheme will be developed with providers of osteopathy, physiotherapy and chiropractic treatment to provide faster access to short term individualised physical therapy. In addition, group sessions will be run to provide intervention and health prevention/promotion advice and information to prevent recurrence e.g. with back pain. To promote sustainability of the project the feasibility of self- funded options for patients will be investigated.	£33,384 (£2.00 pp)
Locality Carers	SIX PENNY HANDLEY	We would employ a small number of appropriately trained staff on Zero Hour contracts to go into patients' homes to give the sort of care that a "Caring Relative" might give.	£8836 (£2.00pp)
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	£26,320 (£2.37 pp)

		Healthcare professional to action. Continuation from 13/14: project outcome : 2665 pts joined or left (24% movement in practice population) even though total population only grew by 17	
Audit of home visits and visiting clinicians	CASTLE PRACTICE	To review the appropriateness of use of GP time on routine home visits. Could time be spent more appropriately by triaging those visits by Duty GP for targeting by other clinicians: Named GP (if appropriate), Locum GP, Salaried GP, Nurse Practitioner, Other (District Nurse, Social worker etc)	£950 (£0.09 pp)
Tackling Obesity	DOWNTON	Setting up nurse led life style clinic on a weekly basis engaging with other health care professionals This will include: • Regular long-term follow ups by trained professionals, • Ensure continuity of care through good record keeping, • Make the choice of any intervention through open discussion with the person. • Tailor the weight management programme to the person's preferences, initial fitness, health status and lifestyle. • This will give them support whilst they are attending the weight reduction programmes via telephone or post. Continuation from 13/14: project outcome: practice found it difficult to quantify outcome but more patients willing to engage with commercial weight loss programmes. This year setting up specific nurse led clinic	£3,000 (£0.45 pp)
Improving diabetic care	TISBURY	To improve care for patients with diabetes. Especially focused on patients who are not good at complying with regular check ups	£2722 (£0.75 pp)
Improving help for carers	TISBURY	Continuation of project in 13/14. This project seeks to improve the quality of life for carers and support them looking after their family member at home. Future plans include: attendance by Mrs. Sharon McGookin (Practice Carer's lead), Sister Wacher (practice nurse) and Rosie Eacott (practice manager) at the Carers lead meeting on 01.04.14. This will facilitate networking and discussion with other surgeries of best practice; A second clinic to be held on 13.05.14, Continual monitoring of carers register, Possible amendment of surgery registration form to glean more detail of person being cared for Work towards the Gold level in 'The Wiltshire Investors in Carers Award GP accreditation scheme' Continuation of 13/14: This has been an extremely worthwhile initiative with obvious benefits to carers in the local community. The first clinic held on 26.02.14 was full and enthusiastically received by attendees.	£2178 (£0.60 pp)

Improving cancer diagnosis	TISBURY	Look at all patients newly diagnosed with cancer. Identify good practice in early diagnosis and share learning among practice GP's. Retrospective and educational.	£2359 (£0.65 pp)
Improving help for carers	ORCHARD	This project seeks to improve the quality of life for carers and support them looking after their family member at home. Involve with patient participation group and ensure their ideas are developed within the scope of the project. Improve the patient carer information pack. Invite carers in for routine health checks and have a representative of the carers agency present Continuation of 13/14:189 carers identified	£10,290 (£1.00 pp)
IT improvements	ORCHARD	The rationale for this project is three-fold currently but may be extended depending on new initiatives. 1) Improving online access as per the government stated objective. 2) Aim to improve the safety of our dispensing of medications 3) Trial improving patient access by using email Continuation from 13/14: We would like to build on our project from last year which was to improve our use of READ codes throughout the partnership. This year our 'IT champion' would like to propose a project working on many different aspects of IT within the partnership to ensure a streamlined, safe and efficient service for our patients.	£10,290 (£1.00 pp)
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. Continuation from 13/14: 1388 pts reviewed. We feel this is 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.	£23,784(£2.00 pp)
Heart Failure education	ST ANN'S	Plan as follows: • Run educational session for medical and nursing staff here • Run educational classes for patients - we have 85 currently • Any new heart failure diagnosed as well • Offer service to other practices within our federation • End goals of weight management, less depression reduced admissions etc Dr Chet Sheth will oversee with Maggie Jones (cardiology nurse at SFT) and her Team	£15,642 (£2.00 pp)

Cancer reviews	MERE	Mere surgery had the highest rate of cancer deaths in Wiltshire in 2011-12. During 2013-2014 we have detailed each new cancer diagnosis and evaluated whether the diagnosis, referral and treatment could be timelier. We think that there are continued learning opportunities in continuing this area of work and scrutinizing each cancer presentation case by case. Continuation of 13/14: 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.	£2,000 (£0.45 pp)
Diabetes Care	MERE	Invite a Diabetologist to go through the computer notes of our most poorly controlled diabetic patients with the doctors and then act on their recommendations. Each practice nurse to sit in with diabetic specialist nurse for education regards BM management	£1,500 (0.35 pp)
Phone call post discharge	MERE	Following the discharge of a patient with a significant hospital stay or a significant condition, phone call from named GP within 48 hours of discharge to enable better continuity of care. We hope that early interventions and contact immediately after discharge will prevent re admissions to hospital and a safer transfer of care back to the community teams.	£4,000 (£.0.92 pp)
Chronic disease management for home bound patients	MERE	We estimate over 2% of our patients are home bound. We would like our nurses to visit these patients and monitor their respective chronic disease to prevent unnecessary future complications. They are generally the very elderly with the most number of chronic diseases.	£3,000 (£0.69 pp)
DNA appointment follow up	WILTON	The number of patients who do not attend their appointments (DNA) appears to be increasing at Wilton Health Centre. Not only is a missed appointment a waste of clinician's time, but also it impacts on access to GP and capacity to proactively manage their caseload. Also patients may not make a follow up appointment or put undue pressure of the triage/duty GP after DNAing their appointment. Some of these patients may be on our 'at risk' register.	£3,182 (£1.00 pp)
Endscopy audit	WILTON	As per the M12 data. The number of endoscopic appointment had not only risen by 16% from 2012/2013, but Wilton Health Centre is an outlier in the Western locality and is above the Sarum and Wiltshire averages. We would like to understand and explore the reasoning for this upward trend and put in measures to try and reduce the number of (inappropriate) referrals	£1,000 (£0.31 pp)
Bowel cancer screening audit and follow u	WILTON	Bowel Cancer Screening has a much lower uptake than other screening programmes and last year over 43% of patients requested to have screening failed to take up the invitation. Of the 57% that chose to participate in the screening programme, just one patient showed an abnormal result. To be proactive at health screening means that patients can receive better care and planning.	£975