NHS
Wiltshire
Clinical Commissioning Group

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

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

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

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| **Agenda Item and title:** | **GOV/14/11/14 2014/15 Sarum Primary Care SLA Q2** |
| **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 2 report on the 2014-15 Sarum Group Primary Care SLA.<br><br>The SLA focuses on supporting CCG engagement and 5 specific work streams:<br>• Primary Care at Scale<br>• Effective Urgent Care<br>• Effective Referral Management<br>• Effective Prescribing<br>• Locally Developed Innovation and Improvement<br><br>The SLA received universal approval and all 23 practices in Sarum have signed up to the SLA. The total funds available are £1,139,293. A total of £261,670.50 was paid out in Q2<br><br>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 2 and all practices were engaged in the development of integrated teams.<br><br>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.<br><br>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 |

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| | 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 the year to date up to the end of Sept 14 were up 12 (5%) compared to the same period last year.<br><br>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. Full quarter 2 data is not available at the time of writing but spend for July and August in 2014 is down £11,361 compared to the same months last year which may be an early indication that the focused work be individual practises is starting to take effect.<br><br>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 6% April - Sept (to SFT) compared to the same period last year. Total Sarum first outpatient and first outpatient procedure activity is up 7% April – Sept compared to the same period last year.<br><br>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. Measurable return on investment will be measured in Q4. An update on how the projects are progressing can be found at appendix B |
| **Evidence in support of arguments:** | N/A |
| **Who has been involved/contributed:** | Sarum Executive led by Liz Stanger (GP Director)<br>Full membership discussion at bi-annual group event<br>Practice Manager representatives |
| **Cross Reference to Strategic Objectives:** | This SLA supports the following priority areas; 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. |

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| **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.

Payments totalling £270,540.96 were made during Q2:

- £129,277 on innovation payments (approx 50% of the annual total)
- £105,618 on effective urgent care payments (approx. 50% of the annual total).
- £35,645.96 on practice engagement (approx. 12.5% of annual total)
    - Clinical cabinet £8,870.96
    - GP engagement £26,775

## 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. Each of the three localities within Sarum have had preliminary discussions to discuss their aspirations regarding delivering Primary care at Scale. Free legal and financial advice have also been sought.

### B. Effective Urgent Care

| **Indicative group level measurement** | | |
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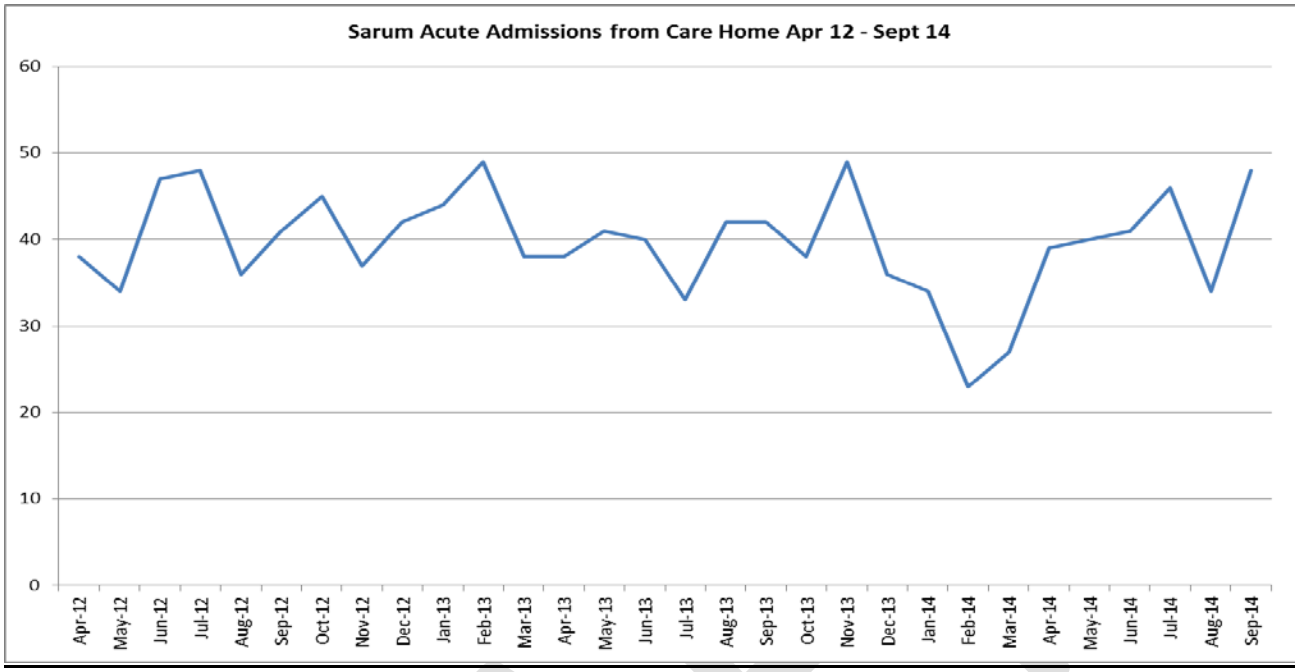
| Target | Performance | Notes |
| 80% of care home places in Sarum covered at Level 2 | 64% | |
| Decrease in number of admissions from care homes 14/15 year to date versus 13/14 year to date equivalent to at least the cost of the SLA element. Total cost to end of Q2 £105,618. | +12 (adverse variance)<br>+£135,618 (adverse variance) | Financial variance is calculated as year to date spend minus savings from reduced admissions (average cost of £2,500 per admission) |

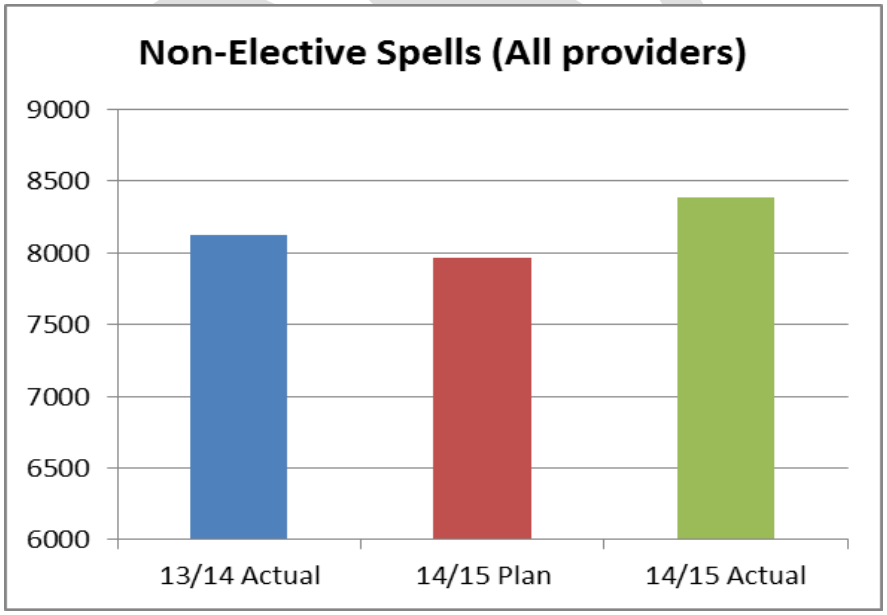
This element continues from 2013/14 providing enhanced care for nursing home/residential care residents to reduce avoidable acute admissions. Level 1 care home support has been removed this year to focus effort on level 2 care paid at £225 per patient per annum which includes a weekly visit/ward round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

In quarter two, 902 care home patients were covered at level 2 (64% of the total care home beds in Sarum). At the end of Sept, year to date Sarum Care home admissions to an acute trust were up 12 compared to the same period last year (248 vs 236).




Sarum 14/15 non elective activity

Non elective admissions for Sarum were up 3% to M6 compared to the same period last year. This is an improvement on the 4.45% increase up to M3. This compares to the CCG as a whole where non-elective activity is up 7% compared to last year.




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

## 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 April – August 2014 is up £83,048 (1.3%) compared to the same period in 13/14. However, July/Aug spend is down £11,361 compared to the same months last year<br><br>TPP housekeeping savings information for Q2 is not available. | Q2 data is not available at the time of writing the report.<br><br>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. Full quarter 2 data is not available at the time of writing but spend for July and August in 2014 is down £11,361 compared to the same months last year which may be an early indication that the focused work be individual practises is starting to take effect.

## D. Locally Developed Innovation and Improvement

| Indicative group level measurement | | |
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| Target | Performance | Notes |
| Measurable ROI of combined schemes for Sarum on activity utilisation / system costs of 50% (£142,000) | No data available | Measured at Qtr 4 |

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. Detail of approved projects and progress made in the year to date can be found in appendix B.

**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 2 and all practices continue to be engaged in the development of the Integrated Teams.

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. Dr Tim King and Dr Rachael Taubman are supporting the planned care (MSK) programme and Long term conditions (diabetes) programmes respectfully.

**F. Effective referrals**

| **Indicative group level measurement** | | |
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| Target | Performance | Notes |
| Practice level GP initiated outpatient referrals 14/15 versus 13/14 levels +1% | GP referrals up 6% (127 referrals) compared to Apr – Sept 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 7% to M6 compared to the same period last year | Data is for all 1st outpatient attendances and outpatient procedures not just GP initiated |

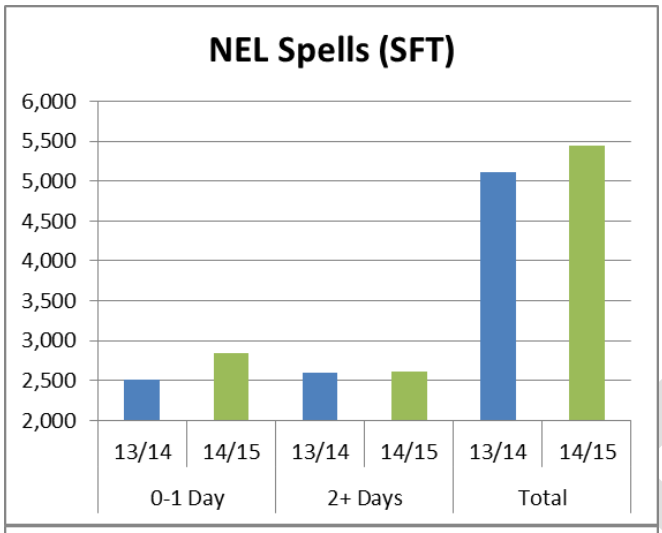
This initiative was introduced in the 2012/13 Pbc/LES to encourage practices to closely monitor referrals and influence referral behaviour. This workstream has been refined this year to focus on peer review of referrals and inclusion of the core data set on secondary care referrals. Practices are required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

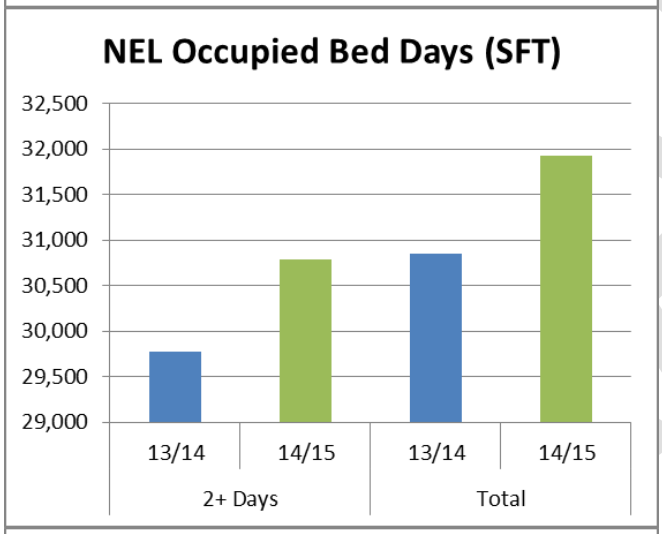
A review of the data shows Sarum first outpatient and first outpatient procedures are up 7% to M6 compared to the same period last year and up 4.9% against plan. This is significantly higher than total CCG performance which has seen an increase of 1% compared to the last period last year. Elective spells are up 7.5% against plan and up 6% compared to the same period last year.

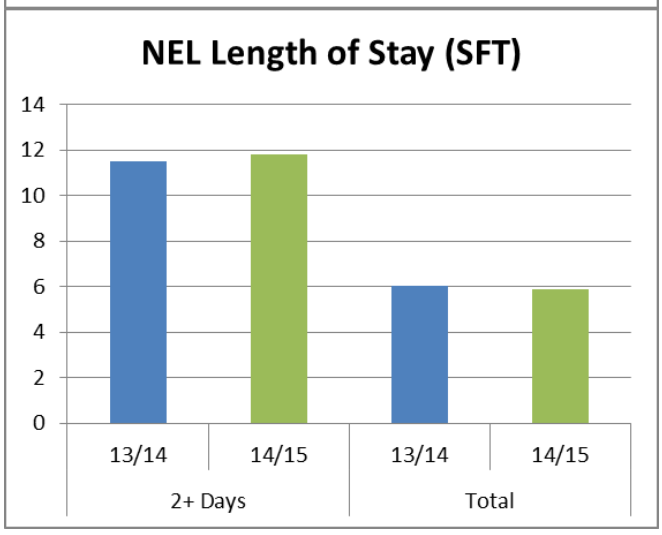
**Conclusion**

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

Appendix A: Non elective admissions data



Appendix B: Sarum Innovation and Improvement project updates April - Sept

| Project Title | Surgery | Project Summary | Update at end of Q2 | Total project value |
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| Development and Delivery of a CHAT service | MILLSTREAM<br>SALISBURY PLAIN<br>WHITEPARISH<br>ENDLESS ST | 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.<br><br>All of these CHAT workers are a continuation from 13/14 | <u>Whiteparish</u><br>13 pts with face to face contacts<br>New services developed:<br>• Coffee morning for carers<br>• Artlift programme co-ordinator<br>• Support dementia pts & carers<br>• Time to explore needs and concerns for patients over 80 without any long term conditions who request information or support<br><br><u>Endless</u><br>18 pts with face to face contacts. 21 additional pts had one of contacts<br><br><u>Millstream</u><br>New person in post. Completed training and shadowed care co-ordinator. 3 pts with face to face contacts.<br><br><u>Salisbury Plain</u><br>No information supplied | MILLSTREAM<br>£6,800 (£1.16 pp)<br>SALISBURY PLAIN<br>£5500 (0.90 pp)<br>WHITEPARISH<br>£7280 (£1.08 pp)<br>ENDLESS STREET<br>£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? | Reviewing audit data re: frequent attenders to the walk in centre and A& E and the reasons they are attending. In the process of designing a leaflet and letter to send to patients who have used the walk in centre and A&E making them aware of the surgery opening times and services. CHAT worker and/or Care co-ordinators involved as appropriate | £1,800 (£0.20 pp) |
| Strategy to address significant DNA rate | MILLSTREAM | To reduce the amount of DNAs to improve clinician availability. | Patients now contacted after second DNA. After 3 DNA's they can no longer book routine appointments. SMS text service promoted and appears to help reduce DNA's | £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. | No information supplied | £6,500 approx (£1.05 pp) |

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| 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<br><br>Continuation from 13/14 – initial project outcome: 71 patients discharged preventing referral to physio/ESP/or specialist | April to Sept 105 patients seen. 55 Pts no onward referral (52.4%) | £13,000 (£2.10 pp) |
| Promote new online physiotherapy platform | BARCROFT & ST MELOR | Promotion of on line physio web tool and audit its use/impact. | Podcasts promoted within the 2 participating Practices with patient feedback being sought. 35 pts referred from Barcroft.<br><br>Results to be reviewed shortly. | £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. | 62 patients in the clinic since 1 April 2014 | £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 | No information supplied | £3,486.26 (£0.70 pp) |
| Improve uptake of AAA screening | HINDON | Improve uptake of AAA screening | Practice letter to non-responders.<br>Working through list of non responders provided by SFT | £110 (£0.05 pp) |
| Audit all A&E attendees | HINDON | Audit A&E attendees. Produce actions for individual patients or patients in similar circumstances | Due to do a full report on all A&E attendances to understand why the activity has increased 66% | £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.<br><br>Learn from all these contacts to change | All patients contacted following A&E admission or OOHs contact | £4,420 (£2.11 pp) |

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| | | practice care as needed to reduce risks of emergency care outside the practice. | | |
| 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. | First 5 patients helped to quit | £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). | Radiology audit completed and activity reduced in line with guidelines. | £450 (20p pp) |
| Support for carers | HINDON | Improved support for carers. | Large number of carers identified on practice register and Practice awarded Gold + award from Carers Support the 'The Wiltshire Investors in Carers Award as part of the GP accreditation scheme'. | £505 (25p pp) |
| Improving uptake of national bowel screening programme | HINDON | Improve uptake of the national bowel screening programme | Uptake has increased to over 80% and better understand reasons for non attendance. | £1050 (£0.50 pp) |
| Validation of Hindon Surgery data on high cost spells on Perception+ | HINDON | Validated of all in-patient activity and costs and a sample of out-patient | Perform monthly validation highlighting and challenging usually on costs – i.e. £7K for a bunion op at New Hall | £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. | Daily review of discharged patients and calls allocated to the partners to contact them. Understand reason for the admission, identify factors that could have prevented admission and plan post discharge care.<br><br>Calls recorded using the Arden's template. | £17,298 (£2.00 pp) |
| Improved management of patients with MSK problems | SALISBURY MEDICAL PRACTICE | In house provision of osteopathy, physiotherapy and chiropractic treatment to provide faster access to short term individualised physical therapy. | No information supplied | £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 | Locality Carer team in place. 87 pts visited since April 14. New co-ordinator in post following retirement of previous post holder. 7 admissions prevented and 3 re-admissions | £8836 (£2.00pp) |

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| | | the sort of care that a "Caring Relative" might give. | prevented. | |
| 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. | Average 130 registrations per month. Practice population increase of 8% but a churn of 15% on a patient list size of 11,190. 93% of new pts have had their notes summarised and repeat prescriptions reviewed and processed in a timely manner<br>facilitated by the additional HCA and admin resource | £26,320 (£2.37 pp) |
| Audit of home visits and visiting clinicians | CASTLE PRACTICE | To review the appropriateness of use of GP time on routine home visits. | Home visits audited for 4 weeks in 2013 and compared to the same 4 weeks in 2014. All requests for home visits now triaged by duty GP and allocated to appropriate member of staff. As a result there has been an increase in visits made by locums and nurses and a reduction in the number of visits made by GP partners & salaried GPs. However 45% of visits thought to have been appropriate for a nurse were still undertaken by a GP partner or locum. | £950 (£0.09 pp) |
| Tackling Obesity | DOWNTON | Setting up nurse led lifestyle clinic on a weekly basis engaging with other health care professionals | No information supplied | £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 | Dedicated admin assistant tasked with telephoning patients to attend for their reviews and contacting patients with high HbA1C to invite to attend surgery for check.<br>Meeting arranged with consultant endocrinologist to discuss patients with high HbA1C | £2722 (£0.75 pp) |
| Improving help for carers | TISBURY | This project seeks to improve the quality of life for carers and support them looking after their family member at home. | Awarded Gold award by the Carers Association as part of the 'The Wiltshire Investors in Carers Award GP accreditation scheme'<br><br>Feedback from patients/carers has been very positive | £2178 (£0.60 pp) |
| Improving cancer | TISBURY | Look at all patients newly diagnosed with | New cancer diagnoses are discussed at weekly | £2359 (£0.65 pp) |

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| diagnosis | | cancer. Identify good practice in early diagnosis and share learning among practice GP's. Retrospective and educational. | meeting attended by all GPs. Proforma of all cancer diagnoses circulated to clinicians to report on what went well and what did not go so well. | |
| Improving help for carers | ORCHARD | To improve the quality of life for carers and support them looking after their family member at home. | Awarded Gold award by the Carers Association as part of the 'The Wiltshire Investors in Carers Award GP accreditation scheme' | £10,290 (£1.00 pp) |
| IT improvements | ORCHARD | 1) Improving online access as per the government stated objective.<br>2) Aim to improve the safety of our dispensing of medications<br>3) Trial improving patient access by using email | 3 of 4 sites are now able to order repeat prescriptions online and also book/cancel appointments. Patient feedback very positive and transcription errors reduced.<br><br>Codford site fully up and running with hand held scanners in the dispensary to eliminate human error with the second check of medications being dispensed. No dispensing errors since the system has been in place.<br><br>Limited email offering to patients that struggle to contact the surgery during office hours. | £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. Trained nurse has seen 93 patients in the surgery and 84 at home in the past 3 months, flagged issues to the GP or referring on as needed. | £23,784(£2.00 pp) |
| Heart Failure education | ST ANN'S | Plan as follows:<br>• Run educational session for medical and nursing staff here<br>• Run educational classes for patients - we have 85 currently<br>• Any new heart failure diagnosed as well<br>• Offer service to other practices within our federation<br>• End goals of weight management, less depression reduced admissions etc | No information provided | £15,642 (£2.00 pp) |
| | | Improve early cancer diagnosis through | Meeting on 17th Sept when GP's discussed the | £2,000 (£0.45 pp) |

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| Cancer reviews | MERE | detailed review of all new cancer diagnosis. | previous 9 months' cancer diagnoses. 39 pts diagnoses, 14 in depth. Learning points were drawn up from the meeting. A further cancer review meeting is scheduled for 17th December '14 | |
| 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 | Practice nurses shadow visiting diabetes nurse specialist. Visit to be arranged by Consultant diabetologist to visit the surgery to discuss challenging diabetes cases with GPs. | £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. | All patients contacted post discharge. | £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. | Visits commenced by practice nurse. | £3,000 (£0.69 pp) |
| DNA appointment follow up | WILTON | Review of DNAs and development of initiatives to reduce the number of missed appointments. | No information supplied | £3,182 (£1.00 pp) |
| Endoscopy audit | WILTON | Review of endoscopic appointments to bring Practice in line with Sarum and Wiltshire averages. | No information supplied | £1,000 (£0.31 pp) |
| Bowel cancer screening audit and follow up | WILTON | Improve Bowel Cancer Screening uptake | No information supplied | £975 |