Dorset Clinical Commissioning Group

Clinical Commissioning
Local Improvement Plan 2014-15

Author(s): Dr Patrick Seal
Dr Andy Rutland
Dr Simon Watkins
Jane Pike

Issue Date: 1 April 2014
End Date: 31st March 2015

Version no: 4
Status: Draft

Review date: 31 December 2014

Clinical Commissioning
Local Improvement Plan 2014/15

Introduction

1. In 2014/15, work will continue to further develop the Clinical Commissioning Group (CCG) for Dorset, incorporating 100 member GP practices.

2. GP practices are the constituent parts of the CCG, the Dorset CCG Governing Body has set out its intention to maintain strong localities as a means of involving clinicians in the commissioning process, as well as addressing local needs. To achieve this, it will seek to incentivise and reward GP engagement in commissioning at practice, locality and CCG level.

3. At the same time, the NHS continues to operate with limited resources in challenging financial circumstances. Clinical engagement must therefore be seen to offer value for money by delivering real change in pathways and services. Including reviewing and reducing, where appropriate, secondary care activity. This requires practices to scrutinise their own service provision and referral behaviour to consider how care might be better organised for their patients.

Principles and Purpose of the Clinical Commissioning Improvement Plan

4. For 2014/15, the Clinical Commissioning Improvement Plan will build on the achievements of practices in previous years.

5. The Improvement Plan is designed to support the strategic aim of shifting the delivery of care closer to home, building strong local integration of care, focusing on supporting improvement in the management of frail elderly and complex patients; building on the requirements to support people >75 contained in the core primary contracts, as well as the new admission avoidance Directed Enhanced Service.

6. It will provide resources, both for active participation in commissioning, pathway redesign, proactive referral and urgent care management and peer review, to enable care provision to be refocused.

7. The focus will be to develop strategies and services in primary and community settings which will support a reduction in variation in referral/urgent care admission rates between practices. In respect of urgent care we recognise the principle of ‘earlier is better’ and proactive management and support to frail, elderly and complex patients.

Objectives

8. The objectives of the Improvement Plan are:

    - to recognise and incentivise the development of clinical leadership for commissioning at practice level
    - to support the continuing development of localities and their collaborative working as the building blocks of the CCG by promoting all levels of engagement in the commissioning services;

- to incentivise and encourage peer review and continuing practice level work including scrutiny of referrals/admissions, multi-disciplinary team working.;
- to encourage practices to manage a greater proportion of demand within a primary care/community based setting, where it is appropriate to do so;
- to achieve a reduction in variation in referral/urgent care admission rates between practices;

Improvement Plan Requirements

9. In order to participate in the Improvement Plan practices are expected to:
    - Continue to support a practice GP lead for clinical commissioning who will act as the CCG contact point in the locality and will work to an agreed role including:
        - attendance at locality meetings;
        - attendance at quarterly CCG cluster/membership events;
        - expressing practice views at, and feeding back to, the practice from locality meetings;
        - participation in locality commissioning and development activities ;
    - Develop the use of available communication methods to ensure individualised care planning, working in a multi-disciplinary way, is delivered for frail, complex patients and that these patients have improved local management. This will include the increased use and delivery of anticipatory care planning and 'special' messages to support continuity of care for these patients.
    - Continue internal processes for effective management of elective referrals, making best use of internal expertise in individual specialities. To reduce variation within practices, localities and the CCG.
    - Further develop locality based peer review. This should involve an inter-practice peer review during the year and may be done on a locality basis or by pairings of practices. During these, practices will undertake a detailed look at a selection of referrals from, and with, another practice (or with the wider locality) to enable reflection and learning It will be for participating practices to determine both how to carry out peer review and also what the focus should be. They should be linked to areas of referral where the practice is identified as an outlier.
    - Maintain current Choose and Book usage rates and ensure that patients are offered primary care choices where available;
    - Each practice should engage with locality review of prescribing and medicines optimisation through meetings and engagement with the locality prescribing lead and locality pharmacists

Payment

10. The payment structure set out below aims both to incentivise practice and locality engagement in commissioning as well as rewarding achievement.

Improvement Plan Elements – Inputs/Process/ Aspiration	**Proposed Funding**	
GP or Practice Lead attendance at locality meetings	£1000	Per practice
GP attendance at cluster/membership events	£1000[1]	Per practice
Peer review work proportionate to the practice size	£0.50	Per patient
Individualised anticipatory care plans and special messages – practices will use reporting system for high	£1.00	Per patient

risk patients for unexpected events; care plans to include how they will provide improved access to practice services for this group of patients		
Completion of three audits as set out by the Medicines Optimisation Group, with sample size to be 5 per 1000 registered patients.	£0.25	Per patient
Total Input Funding	**£2.00[2]**	
Improvement Plan Elements Outcomes[3]		
Implement prescribing QIPP plan issued by Medicines team and demonstrate activity to achieve the measures	£0.15	Per patient
Achievement of 2% adult practice population over 18 years with individual anticipatory care plan, developed by multi-disciplinary team with demonstrable improved management of this group	£0.40	Per patient
Special messages in place, of good quality, for 1% of practice population (i.e . those patients that have the highest level of risk – see below for how this will be measured)	£0.45	Per patient
Total Outcomes Element	**£1.00[3]**	
GRAND TOTAL	**£3.00**	

[1]Funded at £250 per event attended by a GP
[2]this is an average figure per practice. All practices that participate will have £1.75 per patient plus up to £2000
[3]Outcome payments are expected to be used towards improving patient care in 2015-16 – these plans to be signed off by the Locality Chair. Where possible these should encourage joint working between practices within the Locality.

Performance Reporting and Payment Arrangements

Aspiration Payment

11. For the purpose of the aspiration payment of the Improvement Plan, the practice population will be that on 31st March 2014.

12. Each practice will have an initial allocation of £2000 for its lead GP, and attendance at quarterly CCG membership meetings (this will be monitored).

13. In addition, each practice will be allocated £1.75 for the activities set out in the Improvement Plan, as well as the prescribing elements. However, where a locality, through its agreed decision-making process, determines a different method of allocation to practices per patient – for example, a flat rate per practice, or a mix (e.g. a proportion based on flat rate and the rest on a per patient basis – then this should be notified to the CCG.

14. Practices will receive quarterly payments in relation to the input payments of the Improvement Plan. Claims will be made through the improvement plan claim sheet.

15. At regular intervals, practices with their localities will consider how the actions implemented have influenced the volume of elective and urgent care referrals for their patients.

16. Practices should note that they ***will not be paid twice for the same piece of work***. For example, an activity that is incentivised by another enhanced service.

17. The final aspiration quarterly payment will be made at the end of the year upon receipt of a report from the practice, signed off by the locality lead, which summarises:

    - the actions taken against each element of the CC Improvement Plan outcomes

Outcomes

18. Payment of the outcome element requires practices/localities to implement the actions required in the Improvement Plan. The payment is made in acknowledgement of the effort required by practices to work towards or maintain expenditure/activity within their indicative budget; this will be in the form of a prescribing QIPP plan to manage prescribing growth. The practice will need to demonstrate implementation and activity against the measures outlined in the plan.

19. Outcomes regarding the individualised anticipatory care plans and special messages will be validated with the urgent care service and other providers, based on numbers of plans available and whether they supported continuity of management of the patient. **Evidence of effective multi-disciplinary working for the identified 2% (Read-coded) of 2% adult over 18 practice population, including confirmation that regular review meetings are taking place; a patient feedback report for 5% of the patients in receipt of individualised anticipatory care plans, to include understanding of how the patient accesses care.**

20. Outcome payments will be expected to be used towards enhancing patient care/services with the practice or locality in 2015-16 – these plans to be agreed with the Locality Chair.

21. For the purposes of the outcomes elements of the Improvement Plan, the practice population will be as at 31st March 2014.

General

22. The CCG reserves the right to undertake post payment verification of any aspect of the Improvement Plan, including those aspects not explicitly monitored. Practices/localities are advised to retain minutes of meetings/action plans to provide evidence or other aspects of the Improvement Plan.

23. Practices should be aware that, if they receive a payment under this Improvement Plan but cannot demonstrate that they are participating fully in all aspects of it, the CCG reserves the right to withhold and/or request return of payments. This includes evidence that the practice has not fully engaged in processes to improve demand management and managing care outside of hospital for both elective and urgent care. Similarly, significant reductions in Choose and Book usage may also result in the CCG withholding or requesting return of payments.

24. Before taking such action, the CCG will give appropriate notice and seek to agree an action plan with the practice concerned to address the CCG's concerns.

Disputes – Conciliation, Arbitration, and Appeals

25. In the event of disagreement or dispute, the CCG and the GP practice will use best endeavours to resolve the dispute without recourse to formal arbitration. If unsuccessful, the matter will be determined in accordance with the normal contractual dispute resolution procedure.

Variations

26. Both parties may agree to vary the terms of this Agreement by mutual consent.

27. No variation to the terms of this Agreement shall have effect unless set out in writing and signed by both parties.

Termination

28. The CCG or practice may terminate this Agreement immediately if they consider, and can demonstrate, that the other party is in serious and major breach of any term of this Agreement.

29. Either party may withdraw from the arrangements entered into as part of the CCG's Clinical Commissioning Improvement Plan by giving 28 days notice in writing to the other party.

30. The termination provisions in relation to this scheme are in addition to any other termination provisions under the practice's contract with the NHS Commissioning Board.

Duration

31. The Clinical Commissioning Improvement Plan shall commence on 1 April 2014 and continue to subsist until 31 March 2015 unless terminated earlier in accordance with the terms of this Agreement.

Local Enhanced Service for Clinical Commissioning 2014/15: Practice Signature Sheet

Name of Practice:

(please print) .....

Name of Clinical Commissioning Lead

Signature on behalf of the Practice:

I confirm that the above practice is capable of meeting its obligations under the Clinical Commissioning Improvement Plan 2013/14 and will adhere to all requirements of the service specification.

Signature to this agreement constitutes a variation to your primary medical services contract with NHS Commissioning Board as follows:

- GMS Contractors: Part 11 Enhanced Services and Schedule 7 of your General Medical Services contract with Dorset Primary Care Trust.
- PMS Contractors with the BBC contract: Schedule 5 of your Personal Medical Services contract
  PMS Contractors with the Lockharts contract: Schedule 3 Part 3C of your PMS contract

Practice Signature	Name	Date

Signature on behalf of the NHS Dorset Clinical Commissioning Group:

Signature	Name	Date

Date of Improvement Plan 1st April 2013 to 31st March 2014