LES for reducing hosp admissions

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The Primary Care Transformation Scheme (PCTS)

- • Improving primary care access is key to reducing secondary care activity (Breaking the mould without breaking the system, 2011)
- Scheme falls into two sections.
- Practices applying for -the scheme must undertake both aspects:
- — Reducing A&E attendances
- — Care Planning for Long Term Conditions

Reducing A+E attendance

Options available to practices for the approach taken:

- — Increased walk-in: early mornings, late evenings, weekends etc
- — Additional acute appointment slots made available for same day attendance
- — Implement the ‘Doctor First’ Scheme
- — Additional appointments slots to be directly bookable by A&E (It has been agreed in principle that A&E contacts will not be chargeable and negotiations are ongoing)
- — Other approach suggested by the practice

Care planning for long term conditions

- Personalised and integrated care planning is about addressing the individual's full range of needs, recognising other issues in addition to medical needs that may impact on health and wellbeing

- . Providing quality, timely and relevant information, self management advice, risk management and crisis/contingency planning

- • Practices must review all registered patients with a long term condition and develop an explicit care plan in partnership with the patient, if one does not already exist

- • Range of tools such as care planning and self management templates, education events and direct support to practices to develop action plans

Performance Targets

- • 8% reduction in A&E attendances — as an illustration this was 9,317 attendances in 2010/11
- • 5% reduction in emergency admissions — as an illustration this was 1,886 emergency admissions in 2010/11 ‘ Measured at CCG level
- • Measured each quarter, compared to same period in previous year
- • Final quarter based on full year’s data compared to the previous year (i.e. 2012/13 compared to 2011/12)
- Continuation of the project into 2013/14 depends on CCG achieving the targets **(CALCULATION BASED ONLY ON THOSE PARTICIPATING PRACTICES**)

FINANCIAL MODEL

- • Up to 60% pump primed (by 31 March 2012), with 40% payable on achievement of performance targets
- . 4 year model provides £12.8m savings on secondary care budget
- • Years 1 and 2 funded from non-recurrent Strategic Investment Fund
- • Continuation of the scheme in years 2-5 dependent on activity not increasing by more than 2% on the levels achieved in 2012/13
- • Ceiling Limits

— costs set at £7.50 per patient

— Activity 2% threshold per annum

What does this mean ?

- FOR OCMC - Maximum £90,000
- 60% or £54 000 guaranteed and paid up front – first instalment 19th Feb
- 40% or £36000 depends on the district collectively achieving the target – paid 10% per quarter in 4 bands from 0-100%

Practice plans

- Plans will be reviewed by a Steering Group:

— Clinical leads for Unplanned Care and Long Term Conditions, Head of Public Health (LTC), Head of Contracting, Senior Commissioning Manager, Hospital consultant

Plans will be approved by Executive Approval Group:

— Shadow Accountable Officer, Director of Finance, Non-Executive Director, Senior HR Advisor

Applications will be assessed for:

- — Detailed costed plans for deploying the investment
- — Evidence of value for money
- — Robust and realistic timetable for implementation
- — Volume and type of additional capacity to be created
- — Evidence of significant progress (i.e. 80%) towards implementing the plan by 31 March 2012
- — Evidence of the investment made and that additional capacity and care planning is ready to commence from 1 April 2012

Short time line

- 13th January 2012: LES to be provided to practices
- . 23rd January 2012: Completed action plans and signed LES returned
- 27 January 2012: Steering Group review & Executive approval with notification back to practices ;
- • l5 February 2012: I 30% payment made to successful practices
- • 20th March 2012: Evidence from practices of significant progress towards implementing the plan by 31 March 2012 along with evidence to be submitted of the investment made and that additional capacity and care planning is ready to commence from 1 April 2012
- . 26th March 2012: Steering Group review & Executive approval with
- notification back to practices
- • 31st March 2012: 2nd 30% payment made for successful practices15tI May 2012: First monthly report to be received

What will it involve (1)

- Not just about taking money and employing nurse practitioner
- Opportunity to review whole working practice
- Need to cover both A+E reduction/availability of appointments and management of Long term conditions

What will it involve (2)

- Making appt available from 8- 8pm
- Lunchtime drop in clinics
- Appts available for A+E to book pts who attend with minor illness with duty dr
- Dr First scheme – meeting Fri pm 1:30-4pm 13/1/12
- Visit requests in over 75 – within 30m of call

What will it involve (3)

- Additional nurse practitioner and minor illness nurse time
- NOT directing pts to A+E from triage bt assessing first – visit or surgery
- NOT admitting pts for social problems but looking at all options available.

What will it involve (4)

- Managing long term conditions better
- Better use of community matron
- Stricter review of pts who have had admissions with exacerbation of long term conditions
- Sharing good practice with neighbouring practices