Lambeth
PBC Collaborative

PBC Plan
2009-10

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1. Introduction

Pan Lambeth PBC Collaborative (LPBCC) is set up to ensure the patients served by the four consortia making up the group have access to the highest quality healthcare, within the most appropriate setting for the level of care they require. At the heart of the process lie five key drivers for all work:

- improve the quality of service we offer our patients
- improve the equity of the services available
- improve the outcomes achieved by our patients
- improve the health and wellbeing of our patients
- embrace the principles of cost effectiveness and improve overall value for money, in order to ensure we deliver an overall budget efficiency which can then be reinvested in improving, further, patient care

LPBCC will achieve this through clinical, managerial and business governance, involving patients, staff and clinicians in an equitable, transparent and needs based commissioning process.

Where LPBCC is not the originator of a commissioning idea/decision our desire is that, as key stakeholders, we are invited by the PCT to play a full and active role within the commissioning process. This will be facilitated through the Commissioning Strategy Group.

Included within our work is a desire to develop new, and improve existing, relationships with all service providers; in part this will be driven by the requirement for "tradeoffs" between PBC and the Providers; commissioning more of the existing services we require in return for decommissioning those services we no longer require. All work will be undertaken in partnership with Lambeth PCT and the Service Providers to ensure pathway specifications are developed on the basis of quality, outcomes and needs. On implementation LPBCC, via the consortia and the GPs will be expected to comply with new pathways and will be held accountable.

The Business Support Unit, in partnership with the Board of LPBCC will facilitate the commissioning process through excellent clinical engagement and communication, sharing data and ideas in an open and ethical fashion. **The work required of Practices, is funded through the Local Enhanced Service (LES).**

This plan is focused upon the next 12 months, commencing 1st April 2009. It is based upon analysis of the LPBCC hospital data, and consultation with the Consortia making up the Pan Lambeth PBC Collaborative. Our local priorities, for the purpose of this plan, where we will develop strategies to manage patients in Primary Care, have been categorised as follows:

Out-patients	**In-patients**
➢ Trauma & Orthopaedics ➢ Gynaecology / colposcopy ➢ Dermatology ➢ Diabetes ➢ ENT ➢ Consultant to consultant referrals (prior approval) ➢ HRG Code N12 (2008/09 Tariff)	➢ Intermediate Care (three specific projects)

Practices understand that LPBCC, working with Lambeth PCT, will continuously monitor both the Collaborative, and individual practices, against the objectives set out in this plan.

2. Anticipated outcomes

LPBCC is set up to ensure the patients served by the consortium have access to the highest quality healthcare. We will achieve this with sound clinical, managerial and business governance, involving patients, all healthcare professionals and Lambeth PCT in an equitable, transparent and needs based commissioning process, focused on commissioning for health outcomes.

The Strategic Board of LPBCC will facilitate the Commissioning process through clinical engagement and communication and sharing data and ideas in an open and ethical fashion. The work required of Practices will be funded through the Local Incentive Scheme and will underpin directly the overarching PBC Plan, and any Pathway Redesign work we undertake.

The PBC Plan will fulfil the following core principles:

- Commission within the DoH Operating Framework for 2009/10 and PCT Operating Plan
- Meet agreed national/local targets
- Achieve financial balance
- Reduce health inequalities
- Shift to health outcomes focus
- Work in Partnership
- Involve Patients and Public
- Identify and acquire World Class Commissioning competencies, jointly with Lambeth PCT
- Reduce overall demand
- To reduce first attendance at outpatients by 10% from 2008/9 outturn, in the specialties identified within this plan
- To reduce follow-up attendance at outpatients by 20% from 2008/09 outturn, in the specialties identified within this plan
- Full adherence to and implementation of the "checklists for referral" by *all* member practices (currently 22 as highlighted below)

Specialty	**Phase I checklists (launched Nov 06)**	**Phase II checklists**	
ENT	❖ Nasal obstruction ❖ Discharging/painful ears	❖ Combined voice clinic ❖ Vertigo (dizzy)	
Dermatology		❖ Acne vulgaris ❖ Chronic plaque psoriasis ❖ Childhood Eczema	
Musculoskeletal	❖ Knee replacement ❖ Hip replacement	❖ Anterior knee pain ❖ Lumbar spine surgery ❖ Cervical spine surgery	❖ Paediatric orthopaedics
Gynaecology	❖ Chronic pelvic pain ❖ Menorrhagia	❖ Contraception & sterilisation	❖ Vaginal discharge
Ophthalmology	❖ Cataract		❖ Gritty eyes
Hypertension		❖ Hypertension	
Neurology			❖ Headache ❖ EMG Carpal tunnel

Subject to relevant business case approval, LPBCC will produce service specifications for Lambeth PCT to commission services, with local providers to be contracted based on these service specifications.

A capacity plan assessment, including overall management of the waiting lists, will be undertaken in partnership with Lambeth PCT, to inform any commissioning decisions. In time this will become the sole remit of LPBCC.

The contracts will be put in place by Lambeth PCT.

LPBCC understands and accepts, for most secondary care pathways, one Lambeth contract will be produced; however, greater flexibility reflecting local need, will be required with public health, community services and all provider contracts.

3. Clinical Engagement

Each Member Practice is required to appoint a GP PBC Lead who, along with the Practice Manager, is responsible for driving the PBC agenda within the Practice and providing any requested feedback to the Business Support Unit/Pan Lambeth Board.

3.1 Patient Engagement

As Practice Based Commissioners we hold a statutory obligation to provide the PCT with patient experiences, preferences and outcomes; however, to date this is an area we have still to develop.

With that in mind, and in order to drive forward our patient/public engagement, LPBCC intends to have a "Friends of LPBCC" forum; this will be made up of **up to** 500 patients who are willing to receive regular updates and are prepared to feedback and input to the consortium.

Plans for this will be developed, in partnership with the PCT and a fully costed proposal agreed. At that point LPBCC and Lambeth PCT will work collaboratively to identify resources.

As part of this process we must understand the health needs of our population and plan and prioritise accordingly. Additionally, we must define services to meet those needs and seek to commission them from the most appropriate providers.

In order to achieve this we must ensure we have strong patient / public engagement, and that each subgroup will use each of the following methods of consulting on proposals:

- Identify existing relevant patient engagement work
- Questionnaire
- Website
- Telephone
- Patient groups
- External company
- Face to face

4. Financial Balance

LPBCC, via the four consortia, retains its accountability for its allocated budget.

Practices/consortia will work together within LPBCC in order to improve patient care, patient outcomes and to achieve, as a minimum financial balance.

LPBCC will work with Lambeth PCT on an ongoing basis to:

1. Continue to improve patient care
2. Analyse our hospital, referral and budget data on a monthly basis
3. Understand the reasons for any over-spend
4. Take action with our member practices to ensure any unwarranted over-spend is brought back under control, or underwrite, from efficiencies, any warranted over-spending (random variation etc).
5. Share best practice, including choose and book
6. Develop new community based services as an alternative to hospital treatment
7. Expand patient choice

4.1 Hospital Coding

LPBCC understand that incorrect coding of procedures can lead to increased charges for some procedures, and with the introduction of Payment by Results, there is further potential for practices to be charged the incorrect amount for hospital treatments.
On the assumption Lambeth PCT provides LPBCC with a data analysis tool; the collaborative will carry out monthly audits of non elective hospital admission codes. The audit will be focused on trends within coding and coding validation based upon the procedure and diagnosis codes set against the hospital discharge letters.

Financial information efficiency will allow informed debate for individual patients, specialties and procedures; this provides a platform for pathway redesign.

In delivering the data management at collaborative level the collaborative will be able to have continued confidence in the data; this includes confidence money deducted from practice indicative budgets reflects the work undertaken.

Improved data quality will lead to a reduction in overall error rates in the short, medium and long term.

The collaborative does not have an expectation that Lambeth PCT will challenge every minor error; however, where LPBCC can identify patterns within the data, and provide Lambeth PCT with this evidence; our expectation is that Lambeth PCT will challenge hospital providers in order to reclaim the money.

The collaborative will also use Xiom to examine follow up ratios for outpatient specialties to see whether the profile in our practices is different from the average in London.

Additionally we will develop internal reporting systems to look at referrals to individual specialities by doctor and to review these regularly within the practices alongside Lambeth PCT referral guidelines

5. Demand Management Proposals

In addition to analysing our data and skill sets, LPBCC will work with Lambeth PCT, member practices, service providers, and out-of-hours providers, in a constructive and supportive manner, in order to develop new patient pathways, around Demand Management.

Included within this work LPBCC will identify the number of routine GP appointments per 1000 patients and benchmark these against an agreed minimum standard of access. Markers that may suggest under-resourcing will include high levels of A&E attendance, walk-in centre attendance and GP out-of-hours attendance.

With this in mind we have the following specialties, which, using NHS Comparators data for out-patients first and follow up attendances, we will redesign the demand portion of the pathway, before going on to redesign entire pathways.

5.1 Outpatients

Within this process Practices are required to sample First and Follow-Up Attendances at outpatients. This may be followed later by sampling on elective and non elective in-patient data.

Each Practice, upon request, each month, will provide 3 First and 3 Follow-Up Attendance summaries, for the **requested** specialty (one per month), for every 1000 patients they have (e.g. a Practice with 5,000 patients will provide 15 of each). **Practices will be provided with a list of NHS numbers for patients who were referred in the last 12 months** ; this will reflect a random sample of patients at the appropriate rate for each Practice.

Where necessary, a separate flow chart will be developed to ensure uniformity in reporting mechanisms.

Each sample will include the initial referral letter for all attendances; it will also include the discharge summary for all First Attendances and the discharge summaries, for all Follow-Up Attendances.

The samples will be sent to one central point for collation; they can then be reviewed by one clinical sub group, made up from two or three GPs with an interest in the specialty. They will keep in mind best Practice, the level a good GP would be expected to work at, and, if there is any guidance from them, NICE. **All data must have the patient details anonymised.**

- Each referral will then be reviewed / analysed, within the sub group; is the referral appropriate or inappropriate?

  LPBCC is likely to find some could fit either category; these will be put to one side and reviewed again at the end of the session; a firm decision will be made.

- Those referrals deemed as inappropriate for outpatients are then used to develop a new patient flow for Primary Care.

- These in turn are used to drive work on management of referrals in order to ensure we follow through and reduce inappropriate First and Follow-Up appointments in out-patients.

- The following specialties, which will be the main focus for LPBCC between April 2009 and March 2010, have been identified, in order, as:

  - **Trauma & Orthopaedics and rheumatology**
  - **Gynaecology**
  - **Dermatology**
  - **Diabetes**
  - **ENT**
  - **Ophthalmology?**
  - **Consultant to consultant referrals** (prior approval)
  - **HRG Code N12 (2008/09 tariff)**

- New demand management pathways will then be introduced; these will be consulted upon across all Practices. In short are Practices happy to work with the new pathway and if not why not.

- If required, training to improve confidence and skill sets within the group will then be agreed; it can easily be funded from the Freed up Resources the new pathway will deliver. Training / up-skilling is again designed specifically to improve overall referral rates.

In delivering this work LPBCC will agree benchmarked figures with Lambeth PCT against which outcomes (reduction in overall demand) will be measured. This will ensure LPBCC will be in a position to demonstrate an overall reduction in demand / referrals within the timeframe; once proven, the process will be used next year to deliver 12 projects which will further deliver upon the five key drivers for our work as part of the process.

With regard to the specific pathways LPBCC will develop specific plans for each specialty as a result of the data sampling. These will be agreed with the PCT before implementation.

The one exception to this is consultant to consultant referrals where LPBCC has a desire to work immediately in partnership with Lambeth PCT.

- **Consultant to consultant referrals (prior approval)**

LPBCC is looking to Lambeth PCT for support in implementing the "prior approval" system outlined in the Commissioning Framework July 2006 - (P23), which states:

> - **Prior approval; requires secondary care to confirm appropriateness (of proposed treatment) with referring GP**.

We would appreciate confirmation from Lambeth PCT of their plans to ensure this practice is implemented by all our acute sector service providers.

In addition, the Collaborative will invest time as a group, and individually at Practice level, to examine our clinical mail from the acute sector. This will include:

- Daily assessment of clinical correspondence from secondary care, and other non practice providers, will be undertaken to challenge current hospital and other community based activity for their patients.
- This will be focused on identifying patients who can move from Secondary to Primary Care management, and where efficiency gains can be made by extending patient management in-practice.
- Referral audit; weekly practice meetings to appraise referrals and promote peer review of individual referrals; this is designed to reduce overall attendance rates within the identified specialties.
- To reduce follow up appointments by looking at how follow up work could be managed in the community (part of reflective practice). It is likely that a proportion of our follow up appointments confer no clinical benefit, and these could be ended without any negative impact on patient care.
- A report will be drawn up to reflect the extent of the activity changes which can be made, along with identification of potential financial efficiency as a result.

- **HRG Code N12 (Tariff 2008/09)**

LPBCC wishes to work with the PCT to review, redesign and re-commission maternity care; in particular we wish to focus on the appropriate use of HRG code N12 (and the HRG4 replacements for this code which are more costly), in order to ensure we achieve value for money from this service.

Within the PbR Guidance, published for 2008/09, by DH it states;

The most commonly used obstetrics HRG is N12, "antenatal admissions not related to a delivery event". We have been asked to clarify when this HRG should be used. It should only be used when a woman is admitted to hospital. If there is no admission, the activity should be counted as a first obstetrics outpatient appointment, and providers reimbursed accordingly.

35. We expect commissioners and providers will want to agree, as part of the commissioning process, what an appropriate level of N12s might be. Factors that could be taken into account include:

- *The benchmarking of local providers to identify unexpected variations in the use of N12 (taking into account issues such as casemix and deprivation).*
- *The expectation that there should not be admissions for very short periods of time (under 4 hours) and that any exceptions should be justified.*
- *The need to avoid implementing costly or time-consuming criteria that will divert resources from patient care.*
- *The need to appropriately fund maternity services to help achieve Maternity Matters.*

36. *We recognise that the N12 HRG includes a wide range of cases from the complex to the routine. This is a temporary issue, as in HRG4, N12 is replaced with six different codes for clinical contacts and admissions of varying complexity. In 2008/09, providers may wish to shadow their activity against the HRG4 categories.*

In essence LPBCC wishes to work to the letter of the PbR guidance in order to ensure we deliver value for money within the maternity pathway.

- **Clinical Mail**

Alongside all London PCTs, Lambeth will move to the new national contract from April 2009. This requires

1. TRANSFER OF AND DISCHARGE FROM CARE OBLIGATIONS

    a. **The** Provider shall comply with the Transfer of and Discharge from Care Protocols set out in Schedule 2 Part 2.
    b. The Provider shall at the time of the Patient's discharge from the Provider's Premises issue to the Patient:
        i. a discharge Letter; and
        ii. any social security benefit sickness certificate requested by the Patient.
    c. The Provider shall issue the Patient's Discharge Summary to the Patient's GP:
        i. within 72 hours of the Patient's discharge from the Provider's Premises, where the Patient is discharged by the Provider on or prior to 31 March 2009;
        ii. within 48 hours of the Patient's discharge from the Provider's Premises, where the Patient is discharged by the Provider between 1 April 2009 and 31 March 2010;
        iii. within 24 hours of the Patient's discharge from the Provider's Premises, where the Patient is discharged by the Provider on or after 1 April 2010and the Provider shall at the same time as it issues the Patient's Discharge Summary to the Patient's GP in accordance with this clause 18.3 issue a copy of such Discharge Summary to the Patient.
    d. The Provider shall not discharge a Patient where discharge would not be in accordance with Good Clinical Practice or Good Healthcare Practice, and shall use its best efforts to avoid circumstances and discharges likely to lead to emergency re-admissions.
    e. The Provider shall send to the Patient a copy of each item of correspondence relating to the Provider's provision of care to the Patient that the Provider sends to the Patient's GP and/or Referrer, and the Provider shall send such copy correspondence to the Patient at the same time as the Provider sends the original item of correspondence to the Patient's GP and/or Referrer.

"Discharge Summary"

Means a summary of information relevant to each Patient to be produced by the Provider, which shall be easily legible and shall without limitation contain:

1. the date of the Patient's admission by the Provider
2. the date of the Patient's discharge by the Provider
3. details of any Services provided to the Patient, including any operation(s) and diagnostic procedures performed and their outcomes
4. a summary of the key diagnosis made during the Patient's admission
5. details of any medication prescribed at the time of the Patient's discharge
6. any adverse reactions or allergies to medications or treatments observed in the Patient during admission
7. the name of the responsible Consultant at the time of the Patient's discharge
8. any immediate post-discharge requirement from the primary healthcare team
9. any planned follow-up arrangements

10. whether the Patient has any relevant infection, for example MRSA
11. the name and position of the person to whom questions about the contents of the Discharge Summary may be addressed, and complete and accurate contact details (including a telephone number) for that person and which shall where required be accompanied by a certification of sickness;

If LPBCC is to redesign pathways, and be able to challenge current practices, and potentially, move patients back in to Primary Care for ongoing management of their conditions, as part of this process, we need excellent turnaround of the clinical mail from the acute sector.

- In order to allow LPBCC to carry out the work detailed above we would welcome support from Lambeth PCT, acting on our behalf, to make it a pre-requisite with each hospital provider that we get 7 to 10 day turnaround of the clinical mail.

LPBCC defines good clinical mail as:

- Accurate discharge summary, within 7 days
- Clinic letters within 7 to 10 days, containing: diagnosis, treatment and procedures, ongoing medication and follow up
- A copy of information given to the patient
- Diagnostic investigation results, including radiology, within 7 to 10 days

An early indication, from Lambeth PCT, of their plans to support this request, along with details of when we can expect to see the 7 to 10 day turnaround in clinical mail being implemented would be much appreciated.

5.2 In-patients

Intermediate Care

The BSU will continue to work with key partners on the PCT led group in improving intermediate care delivery and will work to develop an evidence based business case over time.

6. Audit & Evaluation

Audit and evaluation comes down to an ability for LPBCC to demonstrate that what we have done, in redesigning and developing new services, has been effective in delivering, improved quality in the services we offer, improved outcomes being achieved by patients, and where we have indicated the new redesigned / new service will deliver efficiencies, that the improved budget efficiency has been achieved.

As part of this process, LPBCC will undertake audit and evaluation of all new services by benchmarking the data from 1st April 2008 to 31st March 2009; versus 1st April 2009 to 31st March 2010, in order to show the overall reduction in referrals and budget spend, to the outpatient specialties, and inpatient HRG spells identified above.

On an ongoing basis, using the data tools provided by Lambeth PCT, the Collaborative will benchmark each quarter against the same quarter from the previous financial year, and continue to benchmark one quarter against the previous quarter.

We will also benchmark annual, financial year, performance, year upon year, in order to demonstrate overall reduction in referrals / demand.

6.1 Additional Information

Typically many of the anticipated patient benefits / outcomes / efficiencies expected from this commissioning plan, will not start to materialise until after the completion of the programme.

It will therefore be necessary to conduct a monthly / quarterly review to check that the patient benefits / outcomes / efficiencies targets are being achieved.

These reviews may form part of a wider post implementation review of all new demand management pathways redesigned as part of this plan.

We suggest a review could cover the following topics; however, would agree all audit and evaluation process as part of the planning process with Lambeth PCT:

- An internal audit of compliance against anticipated patient benefits / outcomes / efficiencies targets within the each pathway.
- Analysis of the reasons for over or under achievement of patient benefits / outcomes / efficiencies.
- Identification of opportunities for further patient benefits / outcomes / efficiencies
- A review of each pathway at year end to ensure that all the activities related to patient benefits / outcomes / efficiencies were successfully completed
- Interim compliance audits may be appropriate for large programmes with multiple, significant patient benefits / outcomes / efficiency streams.

6.2 Outcomes Checklist

LPBCC will also use the following "Outcomes Checklist" as part of ongoing Audit and Evaluation of our demand management pathway redesigns; this will include monthly feedback reports.

- Which planned patient benefits / outcomes / efficiencies have been achieved?
- If they have been achieved, were the targets correct or should they be increased?
- Which planned patient benefits / outcomes / efficiencies have not been achieved, and why were they not achieved?
- Can remedial action be taken to achieve them or must they be foregone?
- Is there any pattern to the success / failure that can be used to inform other pathway redesign projects?
- Were the assumptions on which the realisation of patient benefits / outcomes / efficiencies was based correct?
    - If not, what effect did this have on the realisation of patient benefits / outcomes / efficiencies?
- Were there any unexpected patient benefits / outcomes / efficiencies that have resulted.
    - If so, how can they now be planned and maximised further?
- Were there any unexpected problems.
    - If there were, can they now be managed and minimised?
- Are there any further patient benefits / outcomes / efficiencies on offer which warrant further work, and possibly a re-draft of the any / all of the demand management pathway redesigns?
- Do new targets / baselines need to be set for the next review?

7. Commissioning Intentions

In delivering the new demand management proposals (section 4), LPBCC will undoubtedly come across pathways which then require further work if we are to progress to the vision of commissioning with an outcomes focus on the basis of need.

Those pathways will be where LPBCC then develops business cases for complete redesigns; these will be developed individually in partnership with Lambeth PCT as each opportunity presents.

At this stage; however, the pathways for intermediate care (reduced bed based intermediate care, non elective in-patient care and better end of life care), identified within this plan, will be developed, within the commissioning cycle 2009/10, for procurement with a start date of 1st April 2010.

8. Summary

In summary, the next 12 months is a key period for LPBCC, we must be **self financing at the end of this period**; in order to achieve this we therefore must deliver Freed up Resources across the indicative budget the Collaborative manages.

This PBC Plan should be seen as the end of the beginning for PBC in LPBCC; while we accept it is primarily a transactional proposal, if approved, LPBCC offer this plan as a vision for 2009/10 which moves us towards a transformational approach to Practice Based Commissioning and patient care in Primary Care.

The plan is consistent with current NHS policy:

1. Delivery of more services in the community, and specifically moving services out of hospital
2. Innovation in promoting new services for Practice Based Commissioning
3. The proposal is clinically appropriate, affordable, based upon the efficiency gains it will deliver for both Lambeth PCT and LPBCC, and cash releasing.
4. The proposal also supports the **National 18-week target**.

The work is totally partnership based and inclusive of all stakeholders, vitally including patients, to ensure programmes reflect local needs and doesn't become a top down, rather than the bottom up approach it is.

Working in partnership with Lambeth PCT, and correctly funded, we believe we can achieve the desired outcomes as part of our approach to an overarching strategy towards successful Practice Based Commissioning.