Blackburn with Darwen
Clinical Commissioning Group

Primary Care Co Commissioning Committee

Title of Paper	Enhanced Quality and Outcomes Enhanced Services Transformation Scheme		
Date of Meeting	**30th August 2017**	**Agenda Item**	14

CCG Corporate Objectives	
Through better commissioning, improve local health outcomes by addressing poor outcomes and inequalities	X
To work collaboratively to create safe, high quality health care services	X
To maintain financial balance and improve efficiency and productivity	X
To deliver a step change in the NHS preventing ill health and supporting people to live healthier lives	X
To maintain and improve performance against core standards and statutory requirements	X
To commission improved out of hospital care	X
CCG High Impact Changes	
Delivering high quality Primary Care at scale and improving access	X
Self-Care and Early Intervention	X
Enhanced and Integrated Primary Care and Better Care Fund	X
Access to Re-ablement and Intermediate Care	X
Improved hospital discharge and reduced length of stay	X
Community based ambulatory care for specific conditions	X
Access to high quality Urgent and Emergency Care	X
Scheduled Care	X
Quality	X

Clinical Lead:	A Black
Senior Lead Manager	S Wallace-Jones
Finance Manager	L Ring
Equality Impact and Risk Assessment completed:	Yes
Patient and Public Engagement completed:	No
Financial Implications	Yes
Risk Identified	Yes
Report authorised by Senior Manager:	

Blackburn with Darwen
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Decision Recommendations
Outlining overarching recommendations Agree the enhanced referral quality improvement component of the QOEST scheme as described in this paper

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Enhanced Quality and Outcomes Enhanced Services Transformation Scheme

1. Introduction

1.1 This paper provides the Executive with an outline of the proposal to enhance the primary care Quality and Outcomes Enhanced Services Transformation (QOEST) Scheme.

1.2 The enhanced QOEST Scheme is an innovative and ambitious scheme designed to support the 5 year forward view for the NHS promoting new ways of working and improving access to services within primary care, in particular with regards to improving the quality of secondary care referrals.

1.3 The paper outlines how changes will be delivered and supported to meet increasing secondary care demand and enable more patients to be provided with out of hospital care. This will be achieved through redressing the imbalance between the number of new secondary care appointments with the opportunity to transfer decision making and activity to primary care.

1.4 The scheme aims to achieve improved outcomes for service users and enhance experience through the provision of more high quality care being delivered closer to home.

1.5 The proposal includes an associated project plan, and timescales for review and approval.

2. Background

2.1 The NHS is experiencing significant pressure and unprecedented levels of demand. Nationally, around 1.5m patients are referred for elective Consultant led treatment each month. The average annual growth in GP referrals between 2009/10 and 2014/15 was 3.9%. Growth in 2015/16 compared to 2014/15 was 5.4%, (NHS England, Demand Management Good Practice Guide 2016).

2.2 NHS England Demand Management Good Practice Guide 2016 outlines a number of initiatives and schemes to manage demand on a sustainable basis as follows:

- Peer review of referrals
- Choice
- Alternatives to outpatient appointments
- Shared decision making
- Advice and guidance
- Direct access to diagnostics
- Management and monitoring of outpatient follow-up appointments
- Consultant-to-consultant referral protocols

2.3 There is an average annual growth of GP outpatient referrals to secondary care in Blackburn with Darwen of 3% and 4% in East Lancashire. ELHT and Non-GP referrals (including Consultants and Nurse Specialists) grew by 1.5%. For the same period nationally, other referrals, which include Consultant to Consultant referrals grew by 6.7%

2.4 The NHS 5 Year Forward View sets out a clear direction and requirement for future sustainability plans including the provision of new models of care and greater investment in primary care.

2.5 GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services, NHS 5 Year Forward View, page 4, October 2014. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

2.6 As the population is living longer with increasing complex medical needs demand is only predicted to increase.

2.7 In 2016/17 there were a total of 30400 actual GP referred first outpatient activities at a cost of £4,868,696.

2.8 There is evidence to support the fact that new models of care and new ways of working are able to contribute to an improvement in out-of-hospital services enabling more care to be delivered closer to home through for example, a range of alternative community services, thereby reducing the need for new and follow up hospital appointments.

2.9 In consideration of the rising demand and associated costs of secondary care referrals a central referral and demand management approach supported by the Commissioning Support Unit (CSU) had been recently proposed and explored. The proposal had been to introduce a model where the CSU would act as a conduit for all primary to secondary care referrals supported by clinical triage. The conclusions relating to this proposal are highlighted below:

- The administrative costs associated with the proposed model would be unlikely to deliver value for money and return on investment.
- There is little existing research relating to the impact of referral management centres, (King's Fund, Referral Management, Lessons for Success, 2010).
- There is the potential to misdirect or reject appropriate referrals with associated consequences and risk.
- There is a limited range of local alternative community services or capacity into which to deflect patients.
- There is the potential for disengagement with local GPs as a result of the proposed model.

3. Current position

3.1 Blackburn with Darwen has already implemented a range of local initiatives and tools to support primary care in improving the quality and timeliness of referrals. These initiatives and tools (Appendix 1) are aligned with the NHS England suggested actions and initiatives and based on the driver diagram (Appendix 2).

3.2 Pennine Lancashire has an established 'Procedures of Limited Clinical Value Policy'. This Policy includes procedures which national experts have suggested only have limited or temporary benefit. This means each procedure needs to be considered on a case by case basis and meet strict criteria before funding can be agreed by the NHS. Compliance with this

Policy ensures that NHS funding is made available on an equitable patient basis for procedures which are evidence based to be clinically effective.

3.3 Blackburn with Darwen Clinical Commissioning Group (CCG) has contracted with general practices to develop quality improvement plans via its Quality and Outcomes Enhanced Services Transformation (QOEST) scheme. The QOEST scheme includes sections 'Referrals and Referrals of Limited Clinical Value' and Collaborative Working (Appendix 3) with associated outcome measures. The aim of these sections within QOEST is to incentivize GPs to improve the quality of referrals and support compliance with the Procedures of Limited Clinical Value Policy. The payment for this scheme is 28p per registered patient which has a total annual value of £48,540

4. Proposal

4.1 The proposal is to enhance the following QOEST Scheme Quality Plans detailed in Appendix 3 and referred to in section 3.3:

-Referrals and Referrals of limited clinical value and

-Collaborative Working

with alignment to the overarching NHS 5 Year Forward View and Blackburn with Darwen CCG strategic plan of transforming outpatient and primary care services designed to:

- Provide high quality patient centred care closer to home
- Enable more people to receive the right care, from the right person, at the right time, in the right place
- Improve access
- Reduce secondary care demand
- Support a shift of investment from acute to primary and community services

4.2 The enhancement of the QOEST Scheme will provide additional support to general practices to redress the imbalance of the rising number of new secondary care appointments. The scheme will offer the opportunity to provide enhanced quality management and improve the quality of referrals for more patients in the community supported by a shift of additional resources from acute to primary care.

4.3 Improved quality of referrals, supported by utilising a range of tools for example evidence based peer review, shared decision making and improved care within the community, to ensure referrals are only made when in the best interests of patients and as a result of shared decision making, may result in reduced referrals to secondary care.

4.4 Primary care will be supported to improve the quality of referrals through the following initiatives:

- GPs will be provided with general practice and neighbourhood data in order that local benchmarking can be undertaken and referral trends can be reviewed and compared with peers.

- Collaborative arrangements will be established amongst GP colleagues, GPwSIs and Consultants to support improvements in the quality of referrals through positive dialogue and peer review.
- GP practices will have access to a range of resources and tools to support an improvement in the quality of referrals.
- Transfer of funding from acute to primary care services to support primary care sustainability plans.

4.5 It is important that patients receive timely referral and equitable access to secondary care services in order to prevent any deterioration in conditions that require Consultant review. The implementation of this scheme is designed to support equitable high quality referrals being made at the most appropriate point a patient's journey.

4.6 The proposal is for a notional budget to be set for each neighbourhood. This budget will be initially based on the 2016/17 outturn of all actual GP referred first outpatient activity as detailed in section 5.

4.7 GP practices will be supported and provided with national and best practice referral benchmarks in order to better understand their referral behaviour and to show areas for potential improvement.

4.8 This scheme will enable further investment in primary care by reinvesting a proportion of any savings realised from reduced GP referred first outpatient activity into neighbourhoods and primary care networks at the end of each financial year.

5. Finance

5.1 The 2016/17 outturn activity and cost for GP referred first outpatient attendances and discharges at first appointment for Blackburn with Darwen are as follows:

Actual GP Referred First Outpatient Activity 2016/17	Actual Cost £	Actual Discharges at First Appointment	Cost of First Appointments Discharged at First Attendance £
30400	**4,868,696**	**8126**	**1,376,970**

5.2 The population sizes for each of the neighbourhoods are as follows:

Neighbourhood	Population Size
Darwen	33,716
East	48,505
North	45,429
West	45,056
Total	**172,706**

5.3 It is suggested that annually there is the potential to transfer a number of activities from the acute to primary care services. This assumption is based on the fact that there are a significant number of patients discharged at first attendance from the acute trust.

5.4 It is anticipated that developments related to new models of care and the provision of alternative community services will provide alternative pathways for patients providing care closer to home.

5.5 In order to support the development of future sustainable primary care services the proposal is to enhance the QOEST incentive payment over and above the 28p per registered patient and reinvest 50% of funding released from improvements in the quality of referrals and that results in a reduction of first appointment activity in the acute trust based on the end of year outturn report.

5.6 As an example the table below details what an overall 5% reduction based on the data in 5.1 would realise:

Actual GP Referred First Outpatient Activity 2016/17	5% Activity Reduction	Total Cost 2016/17	5% Cost Reduction
30400	**1521**	**4,868,696**	**243,435**

5.7 The table below details the 5% target reduction for each neighbourhood and the proposed 50% proportionate reinvestment for each neighbourhood

Neighbourhood	Reduction of 5% based on 2016/17	Reinvestment per neighbourhood based on 50%
Darwen	323	26,095
East	405	32,648
North	386	30,578
West	405	32,327
Non specific	2	
Total	**1521**	**121,717**

5.8 The total cost for the scheme would be £121,717 based on 2016/17 full year effect. Savings for the CCG would be £121,717 based on a 5% reduction from the 2016/17 baseline. This does not take into account additional savings that would result from associated follow up appointments and be available to the CCG as QIPP savings. There would be an overall cap applied to the savings for reinvestment to be agreed between the Federation and the CCG.

6. Reporting and monitoring

6.1 Monitoring and progress of changes in referral activity will be reviewed quarterly on a neighbourhood basis with support from the CCG. This quarterly review will include individual GP practice level detail. The aim of this approach is to foster collaborative working amongst peer practices and the provision of inter-practice support to positively change behaviour.

6.2 The quality and performance metrics will be included within QOEST and refer to the development of internal professional standards to improve the quality of referrals, these will be agreed between the CCG and the Federation and will be designed to enhance those already within QOEST including:

- Peer review of referrals both in and inter-practice
- Reviewing all referrals from trainees, locums and nurse practitioners (until sufficiently experienced)
- Increasing referrals for Consultant/Specialist Advice and evidence of reflection and learning from that advice
- Optimum use of accredited alternative referral options
- Use of guidelines e.g. Procedures of Limited Clinical Value

- Use of referral proformas where indicated
- Use of shared decision making and patient decision aids
- Attendance a relevant educational events provided by the CCG
- Patient satisfaction

6.3 Data from the e-Referral service and Aristotle will be used to review changes in referral behaviour. This information will be used to determine any reinvestment over and above the 28p per registered payment.

6.4 Any reinvestment into primary care will need to be made out of actual savings based on the proposed notional 2016/17 baseline budget. Patient and staff experience survey methods will be utilised to inform what is working well and what requires changing to ensure the scheme is subject to continuous quality improvement.

7. Risks

7.1 A number of risks to the scheme have been identified and are detailed in Appendix 5

7.2 These relate to:

- Communication and engagement
- Data
- Clinical effectiveness
- Primary care support
- Finance
- Patient experience

8. Timescales

End of July 2017	• Agree the Referral Quality Improvement Scheme with CCG Executive, Federation and LMC • Agree clinical leadership for the scheme • Agree the project plan (Appendix 6) • Agree metrics (Appendix 4)
August 2017	• Agree data and scheme performance monitoring process and lead • Promote the scheme via neighbourhood groups/individual practices and Federation • Develop and distribute support toolkits for GP practices • Continue to develop primary care support tools for example consultant level advice and guidance
Sept – Dec 2017	• Implement the scheme • Plan and attend neighbourhood meetings to support and review performance • Review scheme in December and develop plans to build on current scheme for 2018/19

9. Communication and engagement

- The main stakeholders in relation to the proposal are:
- Potential secondary care service users
- Service user families and carers
- Staff employed within primary care
- Partner organisations, LPC Federation, ELHT, BMI
- Local interest groups
- Regulatory bodies i.e. Care Quality Commission

9.1 A full communications and engagement plan will be developed lead by the Scheduled Care Team in conjunction with the CSU Communication and Engagement team, LPC Federation and LMC.

10. Equality Impact Assessment

10.1 Under national equalities legislation, the CCG must have due regard to:

- Eliminating unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act.
- Advancing equality of opportunity between people who share a protected characteristic and people who do not share it.
- Fostering good relations between people who share a protected characteristic and people who do not share it.

10.2 It is therefore important to consider how the proposal contained within this report may positively or negatively affect this work. To support analysis, an Equality Impact Assessment (EIA) has been completed for the proposal outlined in this report, (Appendix 7).

The anticipated impacts of the proposal outlined in this report can be categorised into three main areas:

- Impact on future potential users of secondary care services
- Impact on staff working within primary care
- Impact on partner organisations

10.3 In terms of the scheme, it is anticipated that overall the proposal will have a positive impact on the quality of primary care service available and be a positive move towards improving the quality of referrals within a whole-systems strategy of managing demand.

11. Conclusion

11.1 The CCG has reviewed best practice guidance and approaches to demand management. The CCG has scoped and is presenting the CCG Executive Board with an alternative scheme to a centrally managed Referral Management Service as this is unlikely to provide value for money and has little evidence base as detailed in section 2.

11.2 The alternative proposal is for the implementation of an enhanced QOEST

Scheme, as detailed in section 4, which incorporates the overarching aims and demand management themes within an already established local primary care contract. Through the increased promotion of peer education, peer review, supportive patient and GP tools alongside robust monitoring of outcomes it is anticipated that this will enhance and support quality improvements within primary care.

Recommendation

Agree the enhanced referral quality improvement component of the QOEST scheme as described in this paper

Anne Greenwood
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Schedule Care
August 2017