

PbC Information Provision

Engaging Primary Care Through an Understanding of Commissioning Data

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Intro

- Engaging Primary Care
- Budget setting
- Monitoring and Variance
- Benchmarking
- Training sessions
- Next Steps





2006-07 Background

- Active PBC project 18/12.
- 2005/6 24/27 practices taken indicative budget
- Historic financial pressure
 - Non-recurrent balance now in deficit
- Over performing 2ndry Care
- Concurrent (and unpopular) national agendas





Internal Engagement

- Full engagement of PbC leads from early on
- Owning the data
- Data not the answer
- Part of a holistic portfolio
- Long term strategy
- Lever for service change





The Achievement

- Understanding of commissioning agenda
- Confidence in the data
- Indicative monitoring
- Linking to the big agendas
- Data available to all
- Show potential beyond 'savings'
- Universal engagement





2005-06 Approach

- Provide indicative Budgets and monitoring
- Provide historic raw data
 - and some analysis
- Follow up with training sessions on data and its manipulation
- Training on PbR
- Build confidence in data





Requirements 2006/07

- 24. We expect PCTs to provide practices with activity and financial information for their own practice on:
 - elective activity inpatient and day case;
 - non elective admissions, including information on length of stay;
 - first outpatient appointments, and follow up appointments;
 - use of diagnostic tests and procedures;
 - consultant to consultant referrals;
 - prescribing;
 - community and mental health services;
 - primary care including essential and enhanced PMS and GMS services; and
 - accident and emergency attendances.
- 25. PCTs are also expected to provide benchmarked data to practices that enables them to compare themselves with other practices in the PCT area and with the national average. Practices can expect benchmarking data on the following areas:
 - referral rates;
 - admission rates;
 - first outpatient attendances; and
 - follow up rates.





Budget Methodology

- Based on DoH guidance: historical spend linked to LDP
- Pro rated 2006/07 SLAs to practice level
- Admitted Patient Care & Outpatients
 - Rest of SLAS shown for information purpose
- Agreed approach with LMC





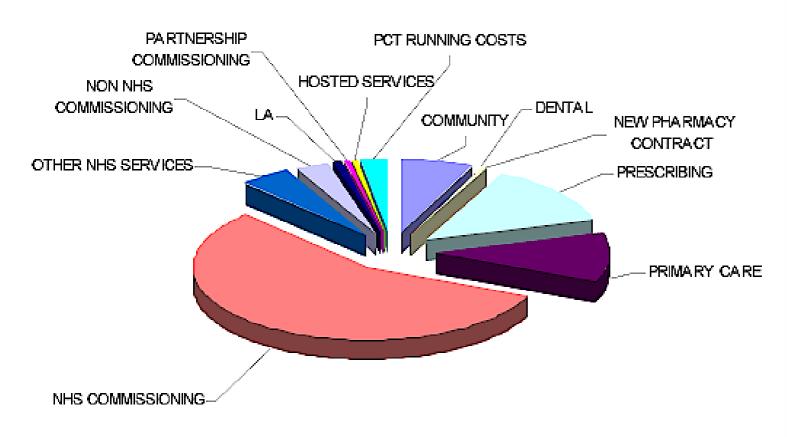
Linking to SLA

- 2003/04 activity does not reflect:
 - What would happen this year
 - What was actually spent in 2003/04
- 2005/06 SLAs reflect changes in:
 - Commissioning methods
 - Referral patterns
 - Coding
 - Clinical practice
 - Patient Pathways
 - Plus planned interventions for this year





PCT Total Spend

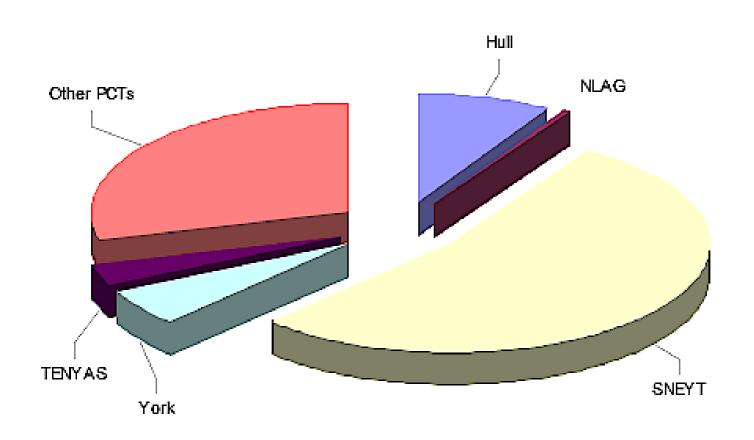








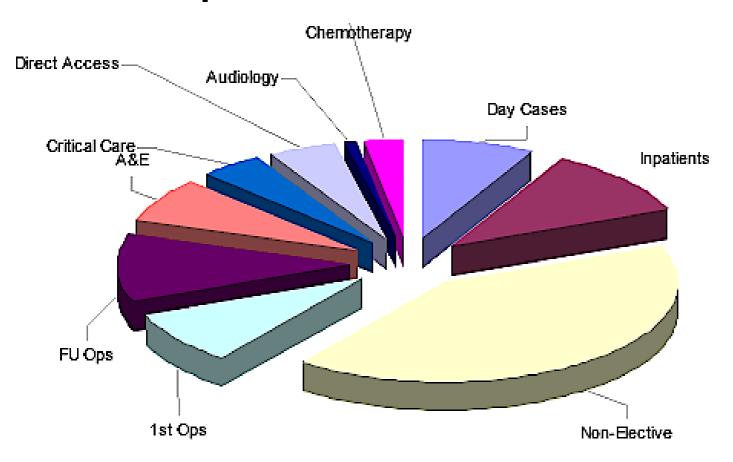
NHS Commissioning







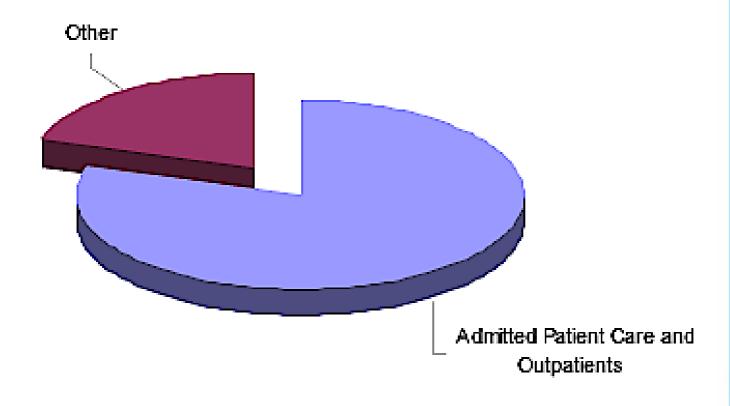
Spend at SNEYT







Spend at SENYT







Monitoring: Variance Reports

- Quarterly Variance Reports
- Monthly costed data available to practices via MIDAS
- Led to engagement
- Variance identified hotspots
 - Linked to other analysis
- Some savings will be available





Variance Reports

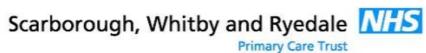
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Non-Elective	1098	939	-159	Non-Elective	9	11	2
Outpatients (1st)	262	258	-4	Outpatients (1st)	1	0	-1
Outpatients (Follow Ups)	336	332	-4	Outpatients (Follow Ups)	0	1	1
Outpatients Total	538	590	-8	Outpatients Total	1	1	0
Total Allocation	2318	2151	-167	Total Allocation	14	13	-1
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Inpatients	7	11	4	Inpatients	16	13	-3
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Non-Elective	3	14	11	Non-Elective	27	5	-23
Outpatients (1st)	1	3	2	Outpatients (1st)	4	3	-1
Outpatients (Follow Ups)	4	5	1	Outpatients (Follow Ups)	6	10	4
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Non-Elective	49	68	20	Non-Elective	35	19	-17
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Outpatients (Follow Ups)	20	8	-12	Outpatients (Follow Ups)	2	10	7
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		-		Inpatients	498	461	-37
				Elective Total	794	785	-9
		-		Non-Elective	1222	1056	-166
		-		Outpatients (1st)	284	272	-12
		-		Outpatients (Follow Ups)	368	365	-3
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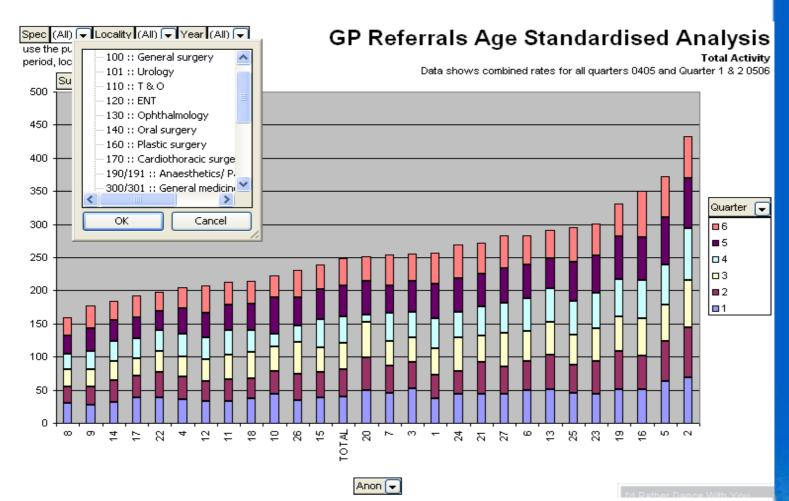
Further Analysis

- Raw Data
- 12 month frequent flyers
- Top HRGs by cost and volume
- Supporting info on PbR
- Age Standardised Benchmarking
 - Electives
 - Non-electives
 - GP Referrals





Further Analysis







2006-07 Info Provision

- Budget variance reports
- National benchmarked rates & local statistical process control
- Frequent Flyers
- Ability to monitor specific specialties, non-electives etc
- Reports on Financial Recovery Plans/ Cost Improvement Plans
- Comparison year-on-year on 1st OP following a GP referral
- PARR case finding tool (predictive risk of rehospitalization)
- Length of Stay
- Day of the week admits
- Emergency Bed Days
- Excess Bed Days
- 7 day readmissions/ 14 day readmissions/ 28 day readmissions
- Mortality
- Tertiary Referrals
- Outpatient DNAs
- More than one spell in a day
- more than one outpatient appointment in a day
- average spell cost
- etc







Training

- Training not just on data
- Needs assessment
 - Demand management methodologies, planning tools etc
- Training on data and analysis in tandem with PbC leads
 - meaningful examples relevant to practice/ locality
- Follow up





Problems Encountered

- Information overload
 - lines of communication
- Timeliness of data
 - flex & freeze dates
- Dryness of subject
- Building confidence
- Fair shares (within and without PCT)





Lessons Learnt

- Clear definitions
 - what will be provided when
- Engagement of PbC leads
 - support building confidence in data
- Provision of fast-track data a must
- Must maintain support (no assumptions)
- Visible presence in locality





Current Position

- Maintain support
 - Monthly newsletter
 - Full team support to practices
- Larger audience
 - Case finding etc
- Try to stay separate from political issues whilst maintaining focus
- Real time information





Next Steps

- New North Yorkshire PCT
- 4 Different Approaches (slowly merging)
- 4 Different DES
- Underlying issues with engagement
- Implementation of MIDAS





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Benchmarking

- Peer-to-peer comparisons
- Data available to all (now across N Yorks)
- Signposts not answers
- Local vs national
- MIDAS Statistical Process Control





Payment by Results

- National tariff
- Cost per case
 - Elective & Non-Elective cost per HRG
 - Outpatients cost per 1st & FU per specialty
- HRG v3.5
- Spells
- STANDARDISATION Same currency at every provider





What is a HRG?

- Health Resource group
- Dominant treatment in a stay governs the cost
- HRG allocated using:
 - Specialty code of consultant
 - Primary Diagnosis (ICD-10)
 - All subsequent diagnoses
 - Operation Codes
 - Admit Method
 - Sex
 - Age





How is a HRG costed?

- Each HRG has a cost at tariff
 - Different for elective and non-elective
- Excess Bed day charge
 - Trim point
 - Cost per day
- Specialist Top Up
- Short stay adjustment
 - For some HRGs





Timescales

- 1/12 per month
- Flex date
 - 1½ months after quarter end
- Freeze data
 - 2½ months after quarter end
- Accurate data 2 ½ months after quarter end





Why MIDAS?

- Easy to Use
- Incredibly straightforward
- Clean
- Crisp
- Robust
- All data shown in charts as well
- Accessible on your computer via the internet





Why MIDAS?







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HG4

Drs AM L

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Elective

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Elective

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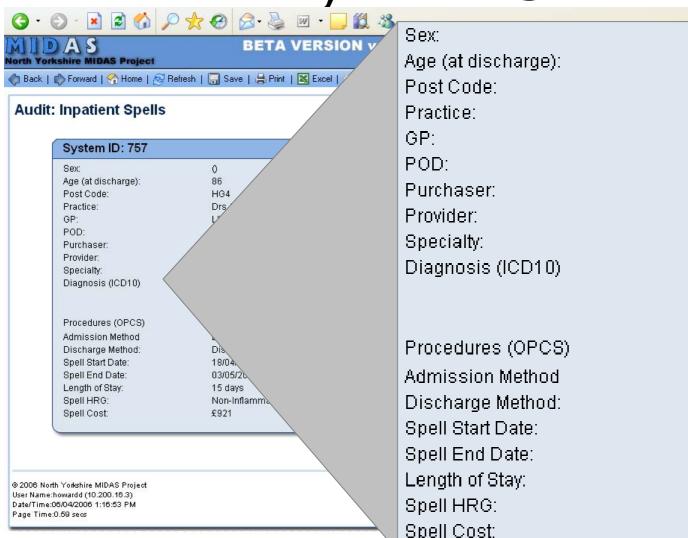
18/04/20 03/05/20

15 days

£921

Non-Infla

Why MIDAS?







Primary Care Trust