RightCare CASEBOOK

Identifying "Value Opportunities" in West Cheshire

Service Reviews and Business Process Engineering

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Summary

West Cheshire PCT and CCG have used Right Care principles to identify "where to look" for service improvements that can generate savings for re-investment and service quality and outcomes improvements. They have combined the use of spend and outcome tools, analysis of variation and Programme Budgeting with Service Reviews and Business Process Engineering techniques to take reform, innovation and efficiency proposals through to successful delivery, generating £7m across three service areas in one wave of service reviews, as part of a successful £15m QIPP programme. The approach has been replicated in other CCGs in the region and has contributed to successful CCG Authorisation panel reviews.

The Setting

West Cheshire Clinical Commissioning Group (CCG) is a Wave One CCG applicant, covering the City of Chester, Ellesmere Port and the surrounding area. The CCG has inherited a programme of continuous improvement from previous work done by the predecessor body, Western Cheshire PCT.

The Situation or Problem

Western Cheshire PCT was formed with a deficit of £42m, considered to be one of the largest proportionate deficits in any English health economy. The turnaround process the PCT had been through to eradicate this deficit had been particularly painful, due to the size of the problem.

A positive outcome of that experience was the PCT teams were galvanised to adopt an approach based on continuous improvement to transform the whole system into a financially sustainable health economy rather than respond piece-meal to problems as they surface. In other words, rather than reform being considered as 'part of the day job', it became 'The Day Job'. This enabled all involved, whatever their pay level or role, to prioritise the areas of their job that were part of the reform pathway to improve local commissioning for their population.

What action was taken?

In 2010/11, the management team, fully supported by clinical commissioners, agreed to focus the majority of the efforts of the PCT/ CCG on reform, and Service Reviews in particular. Service Reviews are a highly effective process in driving and delivering the early phases of transformation because they look at 'sweeping' change across whole areas of the system, as opposed to individual episodes of care or activity. This means by service area, or programmes as per Programme Budgeting. The reviews adopted a simplified three stage process:
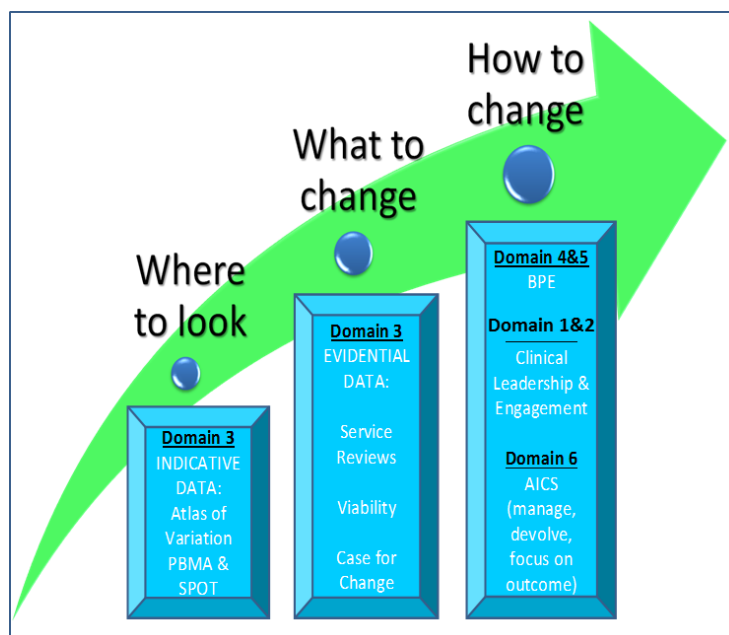
Founding principles for the Service Reviews were:

- To adopt the Right Care approach in focussing on value - spend for what outcome - and to look at whole spend on whole populations (Programme Budgeting) and to address un-warranted/un-explained variation as opportunities to innovate and improve the value and quality of healthcare.
- Ensure clinical ownership and leadership. This was achieved by handing the reins of decision-making to the Practice Based Commissioning infrastructure, with the PCT management team positioning themselves as the clinicians' support function. Clinical ownership of the reform and transformation adds to the robustness and credibility. Where a health economy can say "the clinicians have decided to make this clinical reform", that reform is far more likely to happen.
- To use Business Process Engineering (BPE) techniques to ensure that change happens and happens at pace

Where to Look

The Right Care approach is to focus on clinical programmes to identify value opportunities, as opposed to focussing on organisational or management structures and boundaries.

This is achieved using **Programme Budgeting Marginal Analysis** and **Spend and Outcome data** to highlight the areas in which the health economy has the most opportunities to improve. That is, those clinical programmes where the health economy is an outlier and therefore will be most likely to yield the most improvements to clinical pathways and policies.

This review of **indicative data** highlighted the top priorities (opportunities) for transformation. For this CCG they were Genito-Urinary Medicine, Musculo-Skeletal services and Problems of Circulation. Across just these three programmes, the economy was spending £9m above what they would have been if levels were at the average for their demographic peers, even after accounting for population size. Health outcomes were below average.

In the first cycle of service reviews, Right Care's Atlases of Variation had not yet been published. However, since the first edition, published in November 2010, and in all of the health economies that have since adopted the BPE approach to QIPP and reform, the Atlas series is also used at this stage in the service review to triangulate with Programme Budgeting.

West Cheshire CCG – Service Reviews

☐ Programme budget outliers –

- Genito urinary system (£24.3m)- £2.7m more than demographic peer PCTs

- Musculo skeletal system (£26.5m)- £2.5m more than demographic peer PCTs

- Circulatory problems (£39.2m)- £3m more than demographic peer PCTs

Doing this both adds value and robustness to the decision of which service areas to focus on for transformational change and also provides 'starters for ten' as to actual reform projects to undertake within that programme.

What to change

Following identification and agreement of the priority programme areas to reform, a clinical engagement is undertaken to establish why the current pathway was not considered as optimal for patients and value. That is, what exactly was 'wrong' and needed improving in the pathway.

The end result of this stage is to produce a blueprint of the changes that need to be made in that service area and document:

- describe the current "as is" service;
- describe the optimal "to be" service, and;
- decide the changes needed to turn the current service into the optimal.
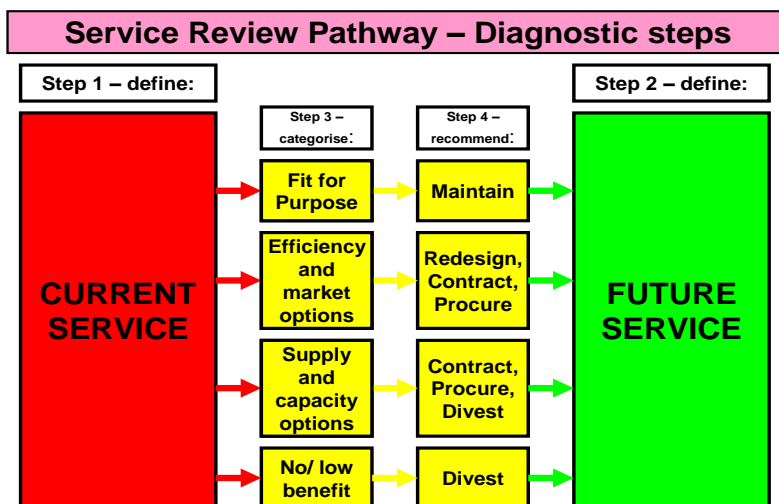
Clinical engagement at each level of reform ensures the detail of what is delivered is right for patients and can produce optimal outcomes and weaves credibility and clinical appropriateness throughout everything the process is used for.

Another way of portraying this is that a service review paints a detailed picture of the current situation and of the future optimal service. It then plays spot the difference between the two and each difference is a change that needs to be made, that is, a reform project that needs to be delivered.

How to Change

When a health economy has identified an area for reform, an initial view on the optimal delivery method needs to be determined. This invariably falls into one of three categories for a commissioner:

- Contract management

- Policy development or

- Service redesign.

Each proposed reform from the Service Review was broken down into these categories. A summary of each category is:

Contract Management

£1.5m (in terms of net impact) of the service review recommendations related to contract management.

These included good house-keeping initiatives, such as reducing outpatient follow-up ratios to peer averages, and then further where clinician's agree, reducing admission rates to at least the level of previous years,

particularly where the service review had demonstrated no demographic or clinical justification for recent growth.

Because many of the contract management recommendations were generic principles rather than specific to service areas, for example, having less units of activity per unit of care, the contracts team were able to spread the impact over all service areas where performance was less than optimal. This increased the net impact, in financial terms, to £3m full year effect.

In addition, the potential to lever efficiency, reform and improvement by using this approach inspired the contracts team to identify further proposals and efficiencies to be delivered via efficient contract management. Over the course of the year, the net impact QIPP saving from contract management increased significantly again. In other words, contract management is a very effective means of increasing productivity and levering technical efficiencies within providers.

Clinical Policies

There are many types of clinical policies available to the commissioner to help achieve both technical and allocative efficiencies, including policies that cover admissions, prescribing, referrals and policies on when individual packages of care are appropriate.

The planned care parts of the service reviews were able to take the change recommendations from the diagnostic phase, convert these in to new or amended clinical policies that then became contractual requirements of providers, and delivered reform within the system with a net financial impact of £2m. The same policies also ensured more appropriate and higher quality healthcare and outcomes. For example:

> A&E attends and admission reductions;
> Elective and non-elective activity reductions;
> Outpatient first and follow-up reductions;
> Improvements in quality and outcomes.

Service Redesign

Achieving allocative efficiency and improving quality and outcomes may require change across whole pathways. This takes longer than using contracts mechanisms or implementing new clinical policies. Service re-design will usually require more extensive supporting work including options appraisals and full impact assessments. As the whole pathway is involved there may also be a need for consultations and as a shift in practices is always involved, partner engagement is essential.

To support the "Business Case" for change, West Cheshire added **evidential data** to the indicative data garnered from the service review stage.

Examples of the evidence added to the initial recommendation include:

> Public Health evidence of impact of proposed change;
> Public Health assessment if the need for change and the anticipated health gain from it;
> Quality impact to be expected from change;
> Medical appropriateness and clinical governance;
> Expected improvement in outcomes from change;
> Full net financial impact from projected changes (savings less cost);
> Affordability;
> Viability (that is, a demonstration that the proposed change can be made);
> System-wide impact (for example, a change may lead to an increase in primary care activity and a reduction in secondary care);
> Risk factors and mitigation plans, and;
> Impact on system sustainability.

Service re-design invariably takes longer to achieve. It is here, above all other areas, where BPE supports a step change in delivery of QIPP. BPE techniques drive the changes through until change in frontline services has actually occurred, something the NHS has historically struggled to deliver on a large scale.

Discussion

The approach to the QIPP challenge described above has produced both cash releasing savings for re-investment and quality improvements to healthcare. The evidence of its successful adoption by other CCGs demonstrates that the process is reproducible and not simply dependant on key individuals or specific circumstances. There are however some key ingredients which need to be present for success, as discussed below.

A principle of the approach is that it is a process of continuous improvement. The early phases of the approach may deliver service improvements that move a health economy from an outlier position on spend and outcomes to above average or to the upper cohort. However, there is always the scope for further improvement and there is always the next set of service areas that hold opportunities to make transformational reform.

To demonstrate the impact of the principle of continuous improvement, in West Cheshire, the following has occurred:

> In 2009/10, BPE was adopted mid-year and supported the delivery of in-year strategic recovery;

> In 2010/11, BPE was embedded for the whole year and supported the delivery of a £15m QIPP and reform programme;

> In 2011/12, the CCG was able to identify and begin its entire QIPP and reform programme in advance of the year starting and delivered its £15m QIPP requirement before the end of the year

> In 2012/13, due to the successes of previous years, the original projections for the size of the QIPP requirement has reduced, allowing an increased focus on quality and outcomes over net savings.

That is, each year the position of the health economy improves over the previous year, both in terms of quality and outcomes and in terms of the financial position.

Quality and Innovation

BPE provides an approach that allows reform energy to deliver quality and outcomes improvements in addition to cash savings.

In West Cheshire CCG, Service Reviews have delivered (and continue to deliver) the following improvements:

> A&E attends and admission reductions;
> Elective and non-elective activity reductions;
> Outpatient first and follow-up reductions;
> Improvements in quality and outcomes.

Examples of some of the new enhanced and/ or increased services that have been implemented within the projects and programmes delivered include:

> Medicines administration training in care homes;
> Personalised care planning improvements;
> Community endoscopy and optometry pathways, and;
> Intermediate ophthalmology services.

Additional Benefits of the approach

In addition to the improvements gained from the service reviews carried out in the first cycle of BPE in West Cheshire, additional benefits from this process that have added further value to later cycles include:

> Galvanised whole of health system – including within the commissioner and led to an increase in engagement and involvement from provider organisations and from clinical commissioners;

> Freed up strategic management and clinical leaders to focus on strategy – that is, the second and mid-tiers of management have taken the lead role on the delivery components of service reviews and the wider QIPP programme, allowing the senior tier and Governing Body clinicians to focus on strategy and delivery of high level corporate objectives;

> Management function efficiency gains – by focussing more energy and effort on the reform agenda, BPE and service reviews have helped to 'shine a light' on activities that previously used up a lot of the time of the commissioner but have been shown not to be adding value, or not to the extent that they should be prioritised. This has allowed the organisation to 'find' more time to look for and deliver reform, without the need to invest in more staff.

Key Success Factors

For successful delivery, five key factors need to be in place.

> **Effective Clinical Leadership** of the reform agenda

> **Indicative data** – in where un-explained variation exists – focus here to drive improvements

> **Effective Clinical Engagement** to support individual reforms, supported by project managers and teams

> **Evidential data** – on what, how and why to change

> **Effective processes** to drive through change – Business Process Engineering and Project management

Right Care Resource Centre

Right Care has a new resource centre where CCGs can find supporting materials describing the Commissioning for Value approach:

- o Online learning videos
- o "how to" guides
- o Theme based Webinars
- o Casebooks showing learning from early adopters
- o Essential reading lists and glossary
- o Tried and tested process templates to support taking the approach forward
- o Access to a Practitioner Network

Other Casebooks in this series

Identifying "Value Opportunities" in local commissioning: Service Reviews and Business Process Engineering

Mathew Cripps, Right Care Associate and Transformation Lead (West Cheshire Clinical Commissioning Group)

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Alistair Blane, Right Care Associate, et al

Pennine MSK Partnership:
A case study of an Integrating Pathway Hub (IPH) "Prime Contractor"

Paul Corrigan and Dr Alan Nye

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