

Realising the benefits of RightCare

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NHS England - South (South East)

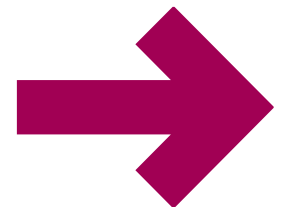


What do we want to achieve?

Aim To improve the value of healthcare in the South East

Objectives

- To support and encourage clinical engagement in RightCare
- To ensure a shared understanding of the potential and limitations of RightCare methodology
- To maximise and disseminate learning from Wave 1 CCGs
- To provide support and guidance to Wave 1 and Wave 2 CCGs



Programme for today

1010	The future of the NHS is Value Based Healthcare – Sir Muir Gray			
1100	Value based healthcare in the South East: achieving clinical ownership and leadership – Hugh McIntyre and Larisa Han, South East Clinical Senate			
1130	Questions and discussion			
1140	Coffee break in the Orangery			
1200	Addressing the needs of complex patients Rhian Monteith Morning Room	Understanding and demonstrating variation through use of national data tool Claire Bradshaw Garden Room	Lessons learnt from Wave One CCGs' experiences of RightCare - NW Surrey CCG and Canterbury & Coastal CCG Antonia I Room	How to use RightCare data to support the STP and improve provider value - Bruce Pollington and Steve Sparks Antonia II Room
1300	Lunch and networking in the Orangery			
1350	Key points from workshops			
1400	Lessons from Wave 1 and plans for Wave 2 – Steve Sparks and Bruce Pollington			
1445	How NHS England can support the process – Ivor Duffy			
1500	Final questions			

Why RightCare? Why now?

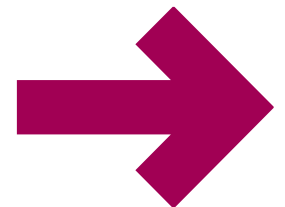
- OECD report – quality of care variable in the UK
- We lag behind other developed countries e.g. cancer care
- Carter review
- Shift of focus to prevention in 5YFV





Key issues

- Clinical leadership and engagement
- Relationship with QIPP
- Relationship with GIRFT
- Keep a wide focus



**And now let me
introduce
Sir Muir Gray**



We have had 2 healthcare revolutions, with amazing impact

The First was the public health revolution



The Second has been the technological revolution supported by 50 years of increased investment & 20 years of evidence based medicine, quality and safety improvement e.g.

- Antibiotics
- MRI & CT
- Coronary artery bypass graft surgery
- Hip & knee replacement
- Chemotherapy
- Radiotherapy
- Randomised controlled trials
- Systematic reviews

after 50 years of progress all societies still face three massive problems.

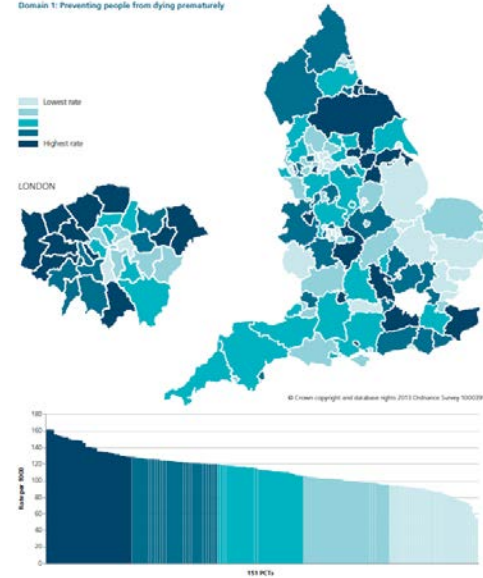
The first is unwarranted variation in healthcare i.e. "Variation in utilization of health care services that cannot be explained by variation in patient need or patient preferences."

Jack Wennberg

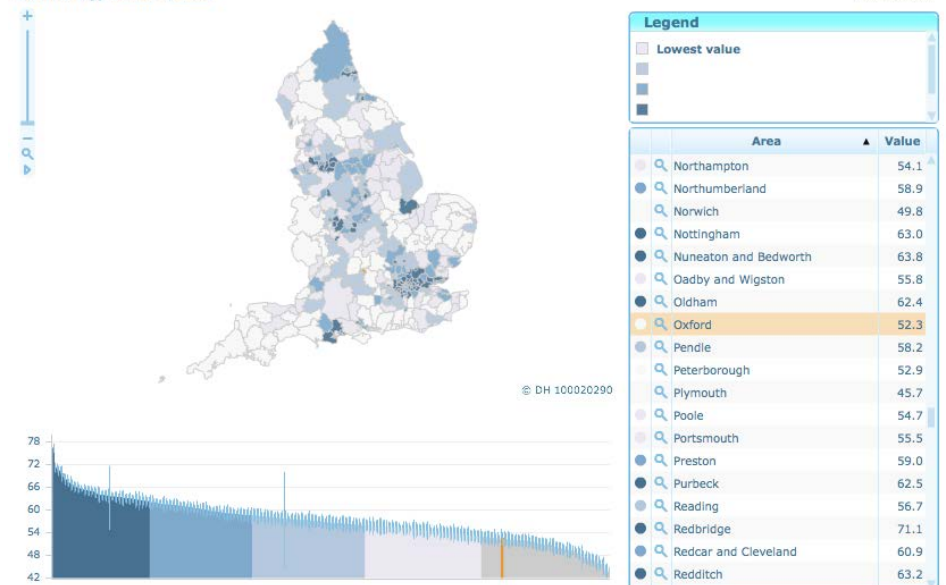
Variation reveals the other two problems

Map 3: Rate of non-obstetric ultrasound activity per weighted population by PCT 2012/13

Domain 1: Preventing people from dying prematurely



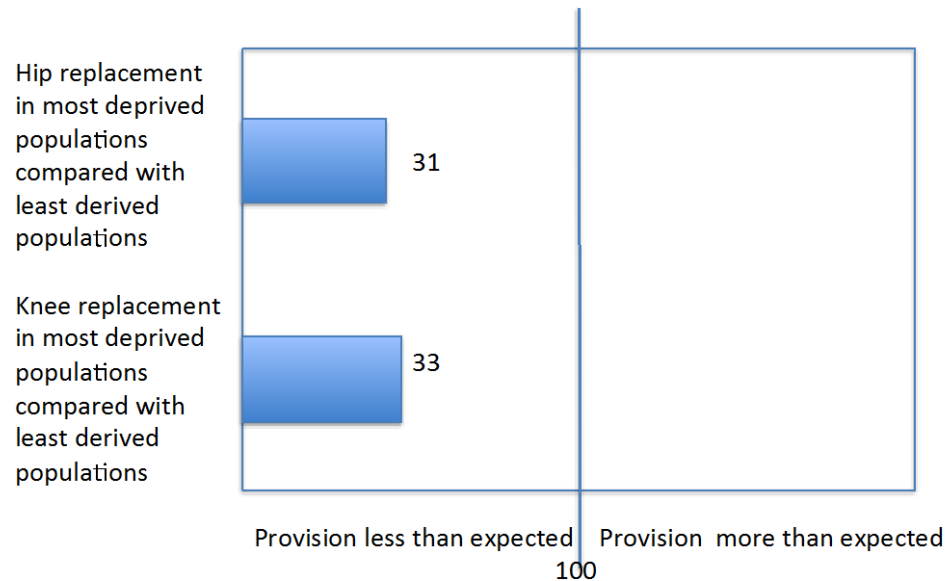
Percentage of all deaths in an area that occur in hospital, by local authority, 2006–2008



sepho
South East Public
Health Observatory

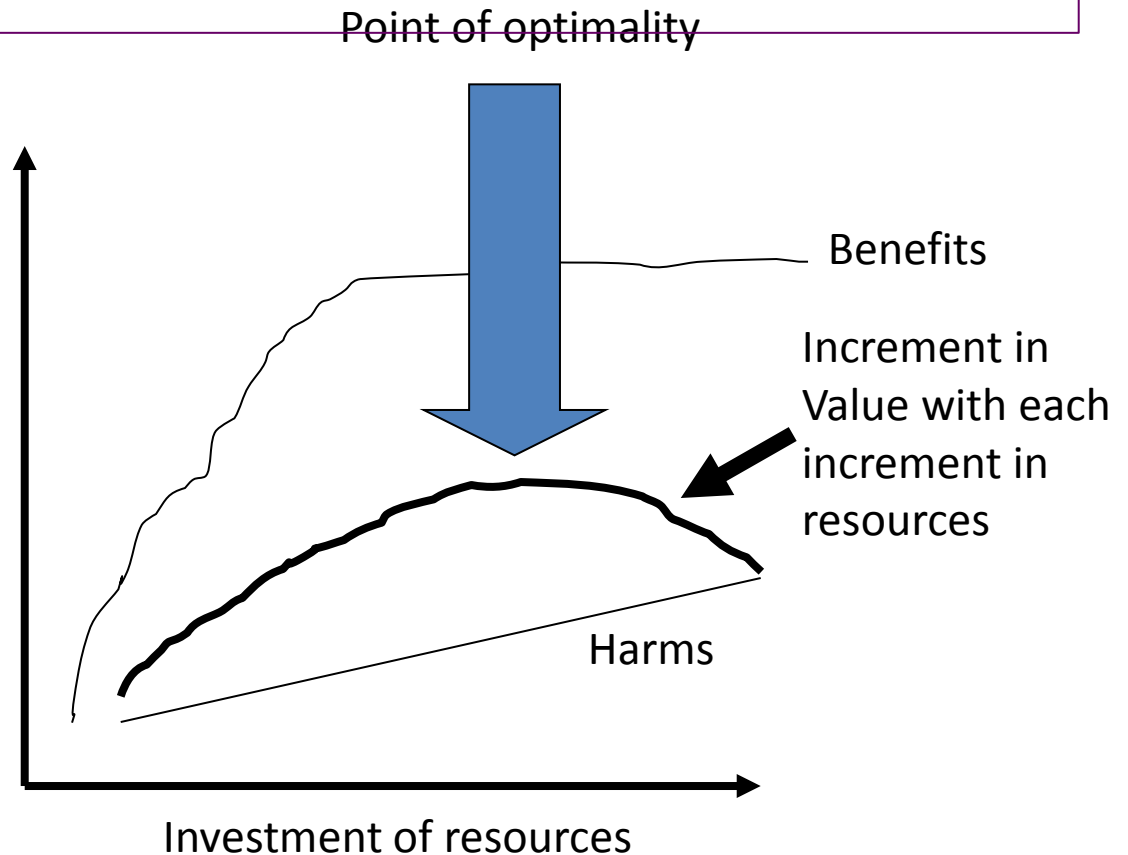
The first is Underuse of high value interventions which results in

1. Preventable disability and death e.g. if we managed atrial fibrillation optimally there would be 5,000 fewer strokes and 10% reduction in vascular dementia, and
2. inequity



The second is **OVERUSE** of lower or zero value interventions which results in

1. waste of resources
2. harm



Republished editorial from The BMJ

Republished editorial from *The BMJ*

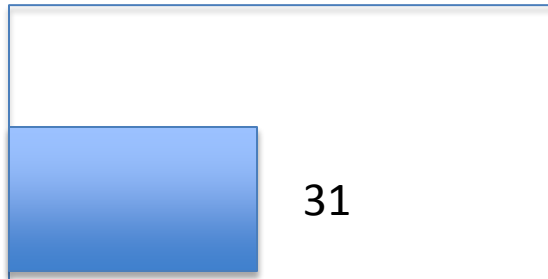
Arthroscopic surgery for degenerative knee: Overused, ineffective, and potentially harmful

Andy Carr

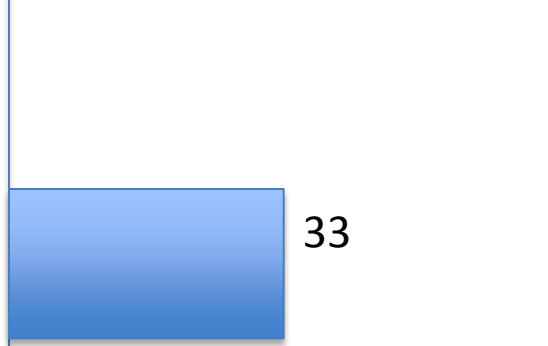
The most frequent indication for knee arthroscopy is degenerative joint disease poorly described and given at a suboptimal dose.

variety of factors that alter beliefs and expectations.¹² Importantly, Thorlund and colleagues also review the harms associated with arthroscopic knee surgery. They were unable to identify harm from randomised trials alone because the trials were too small, so they did a wider review including observational studies. These studies were heterogeneous and inconsistent, but the risks associated with non-surgical treatment including exercises are clearly

Hip replacement in most deprived populations compared with least derived populations



Knee replacement in most deprived populations compared with least derived populations

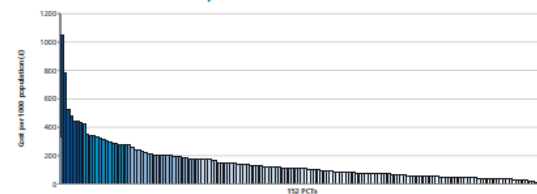
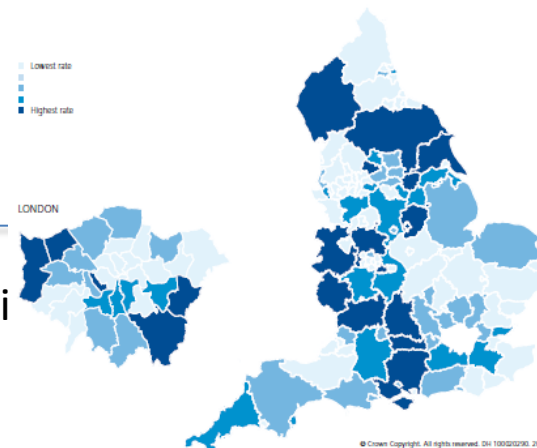


Provision less than expected

100

Provi

**THERE IS ALSO TRIPLE WHAMMY HEALTHCARE !
OVERUSE +
UNDERUSE +
UNWARRANTED VARIATION**



NHS or nHS?

- *Is the service for people with seizures & epilepsy in Sussex better than the service in Surrey?*
- *Who is responsible for the headache service for people in Croydon?*
- *How many liver disease services are there in the South East and how many should there be?*
- *Which service for frail elderly people in Surrey provides the best value?*
- *Which service for children with mental health problems improved most in the last year?*
- *Who is responsible for the service for women with pelvic pain in Kent?*

In the next decade need and demand will increase by at least 20 % so what can we do?

Well, we need to continue to

1. Prevent disease, disability, dementia and frailty to reduce need
2. Improve outcome by provide only effective, evidence based interventions
3. Improve outcome by increasing quality and safety of process
4. Increase productivity by reducing cost

These measures reduce need and improve efficiency

BUT we also need to increase value

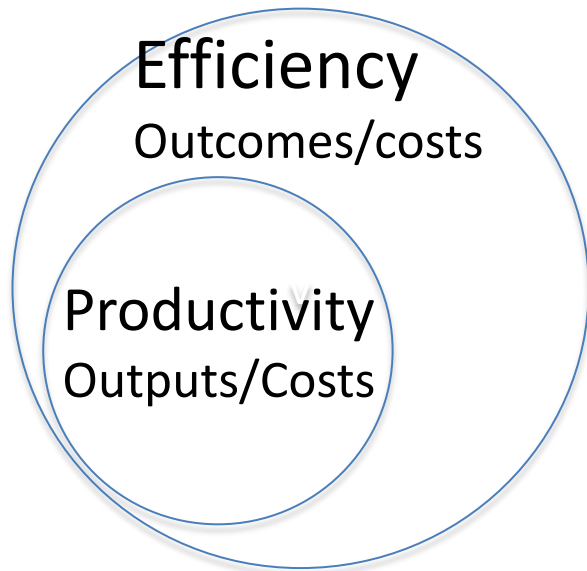
The Aim is **triple value**

- Allocative value , determined by how well the assets are distributed to different sub groups in the population
 - Between programme
 - Between system
 - Within system
- Technical or utilisation value determined by how well resources are used for outcomes for all the people in need in the population
- Personalised value, determined by how well the outcome relates to the values of each individual

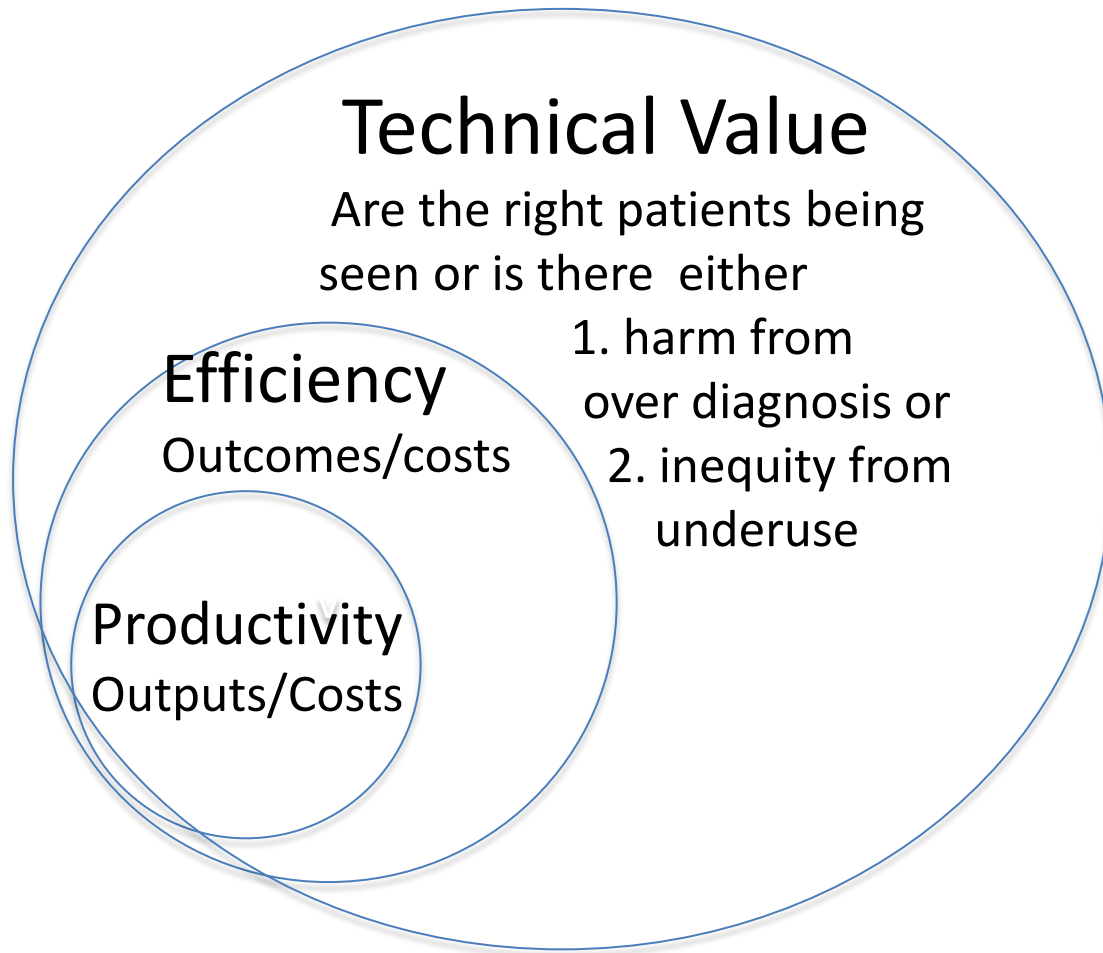
waste is anything that does not add value and as the Academy's re[port emphasises we need to develop a 'culture of stewardship' to ensure the NHS will be with us in 2025 and 2035

Productivity
Outputs/Costs

FOR EXAMPLE, AVERAGE
DURATION OF STAY FOR
KNEE REPLACEMENT



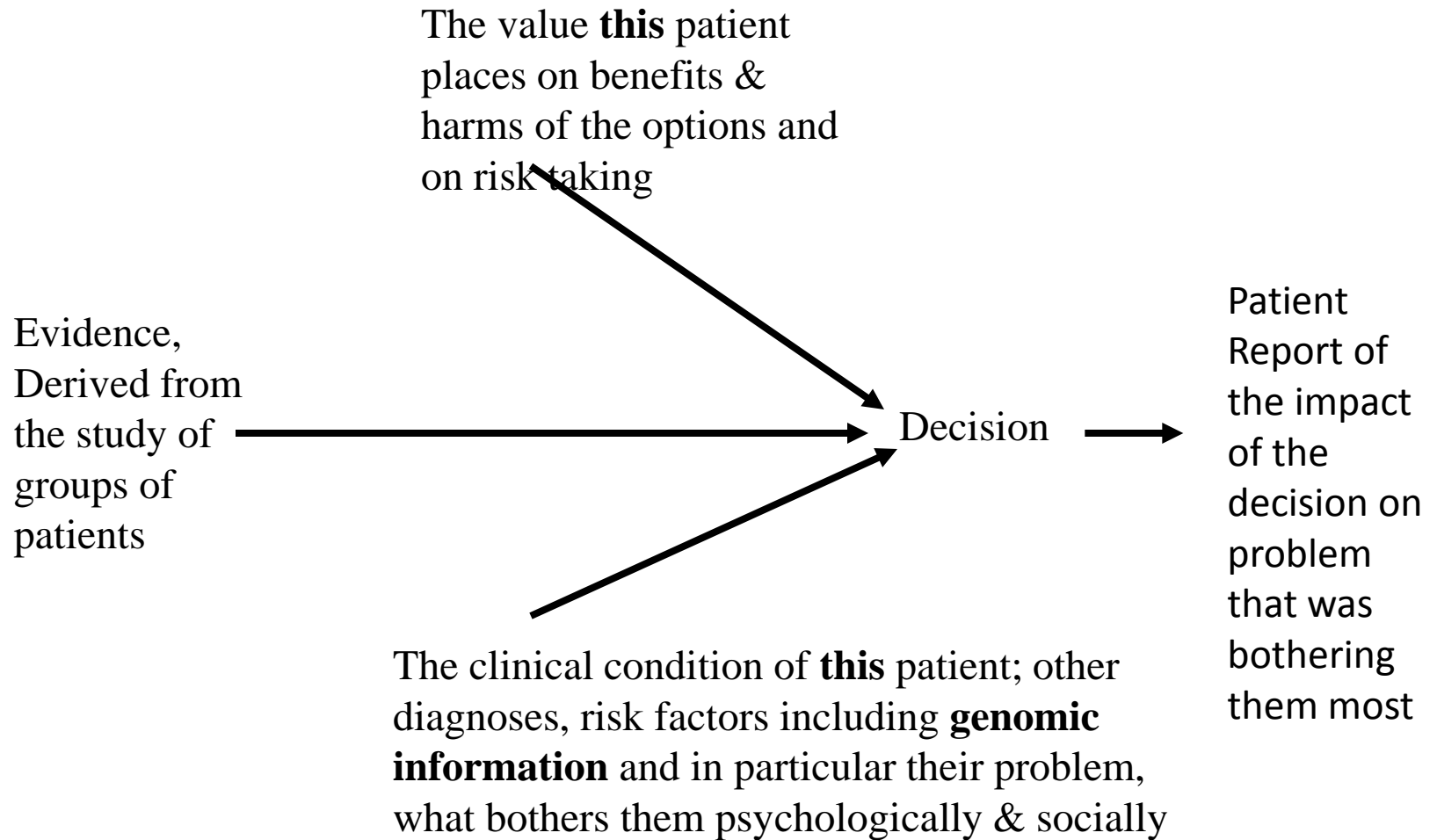
FOR EXAMPLE,
% OF PATIENTS WHO HAVE A KNEE
REPLACEMENT AND REPORT THAT
THE OUTCOME IS GOOD OR VERY
GOOD



THE Better Value Healthcare METHOD OF INCREASING VALUE FOR POPULATIONS **AND** INDIVIDUALS IS BY

- Ensuring that every individual receives high personal value by providing people with full information about the risks and benefits of the intervention being offered
- Shifting resource from budgets where there is evidence of overuse or lower value to budgets for populations in which there is evidence of underuse and inequity
- Develop population based systems that
 - Address the needs of all the people in need, with the specialist service seeing those who would benefit most
 - Implement high value innovation funded by reduced spending on lower value intervention
 - Increase rates of higher value intervention funded by reduced spending on lower value intervention e.g. shift resources from treatment to prevention

1.Ensuring that every individual receives high personal value by providing people with full information about the risks and benefits of the intervention being offered and relating that to the problem that bothers them most and their values and preferences



And if genomic information is included the term used is usually precision medicine rather than personalised medicine

We are now in the third healthcare revolution

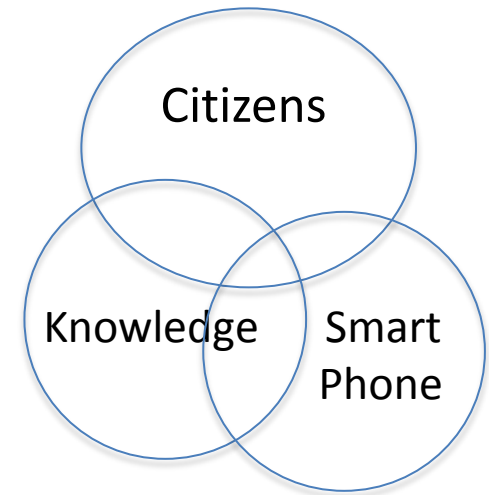
The First



The Second

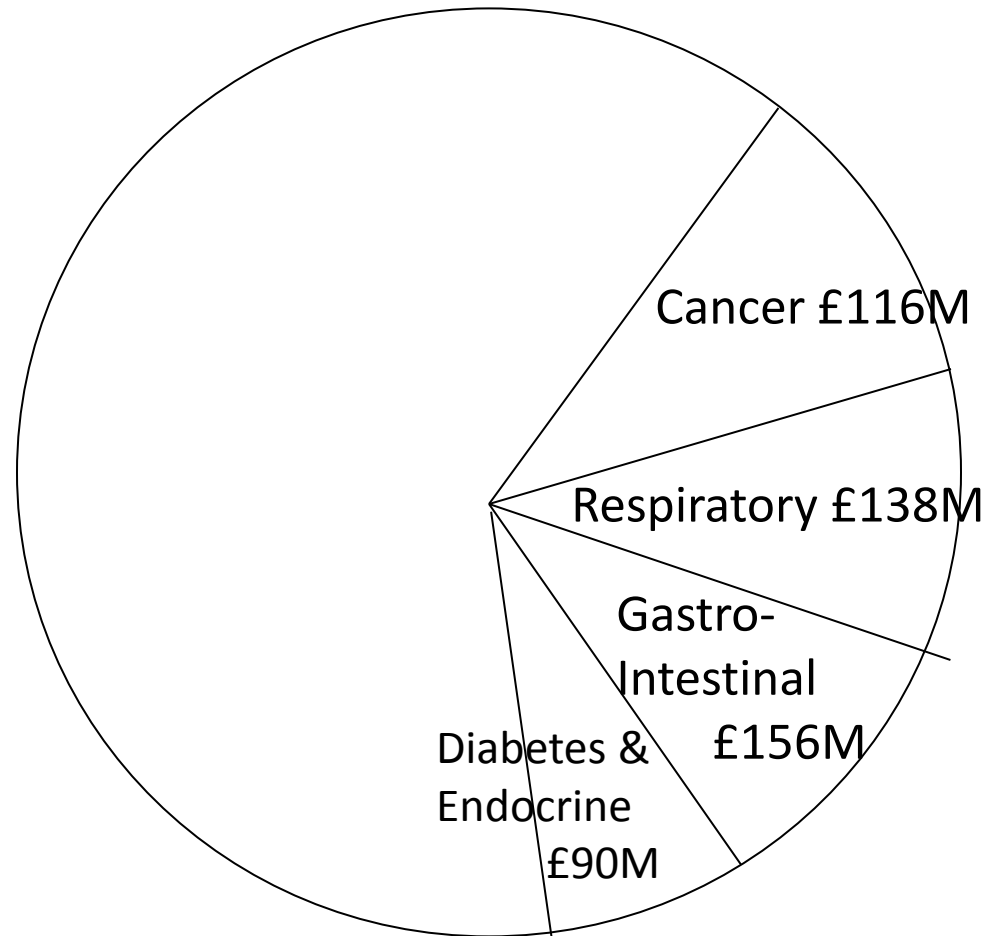
- Antibiotics
- MRI
- CT
- Ultrasound
- Stents
- Hip and knee replacement
- Chemotherapy
- Radiotherapy
- RCTs
- Systematic reviews

The Third



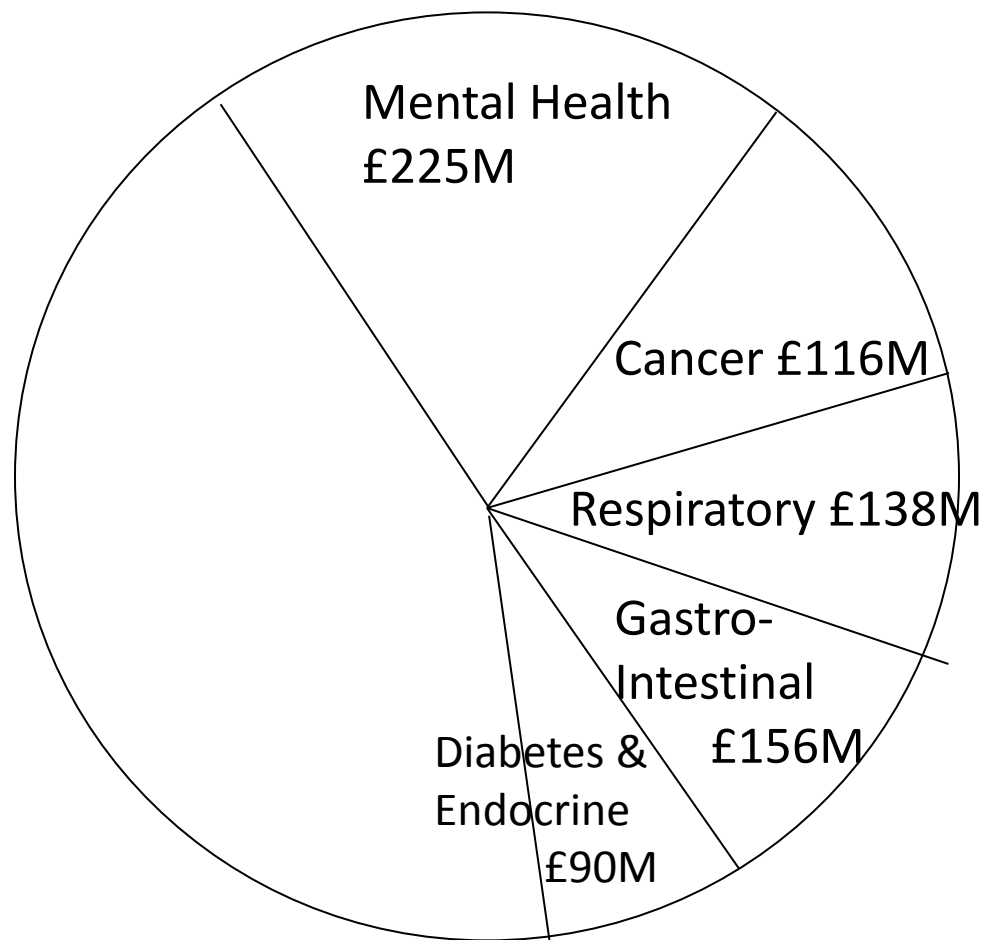
2. Shifting resource from budgets where there is evidence from unwarranted variation of overuse or lower value to budgets for populations in which there is evidence of underuse and inequity

”



ANNUAL SPEND PER MILLION

”

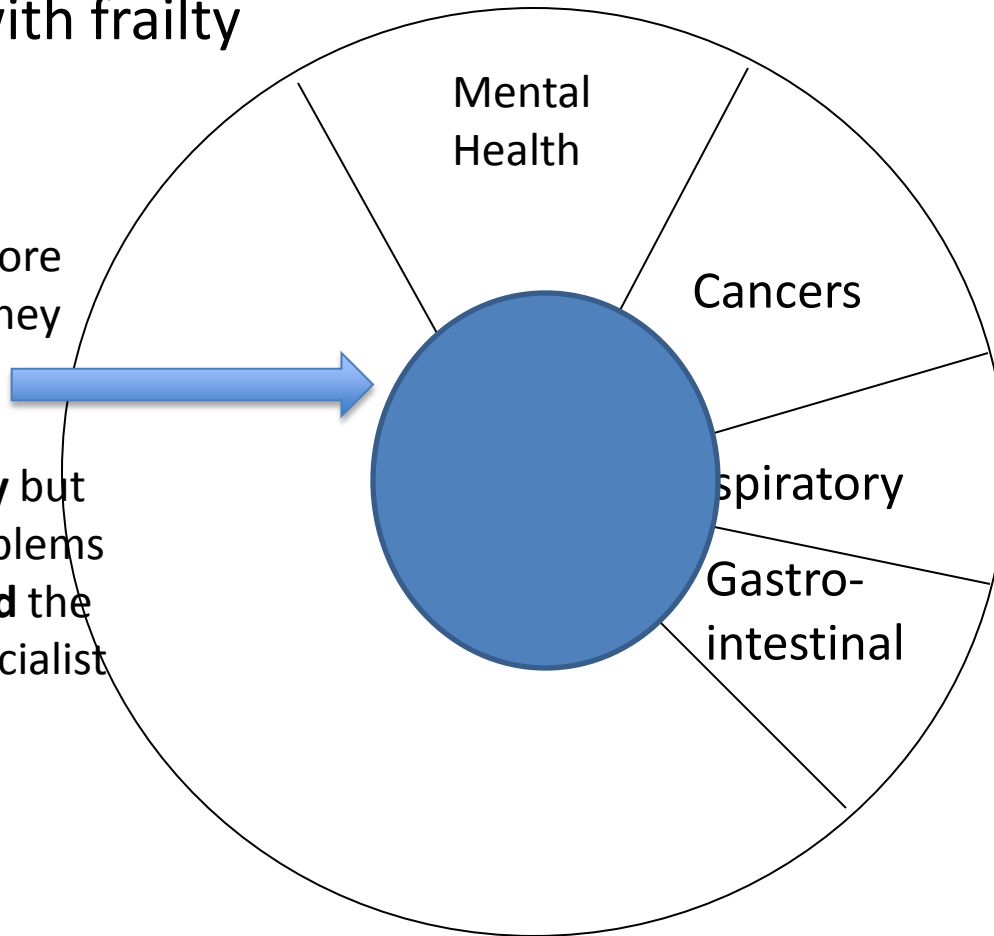


ANNUAL SPEND PER MILLION

www.NHS England.programmebudgeting

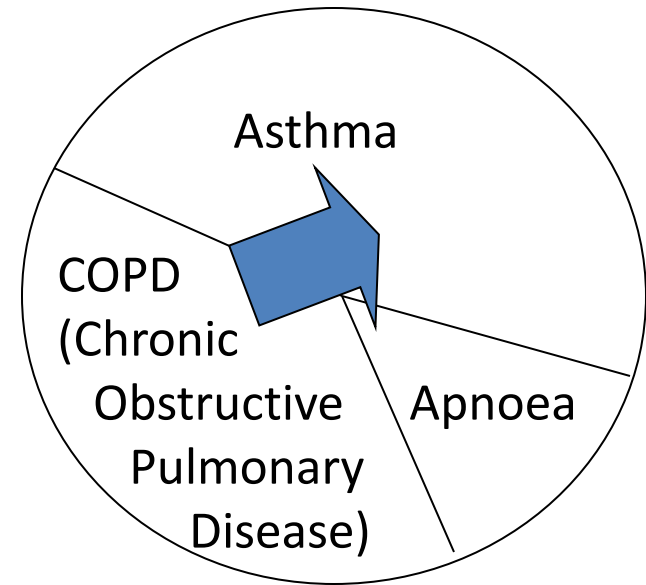
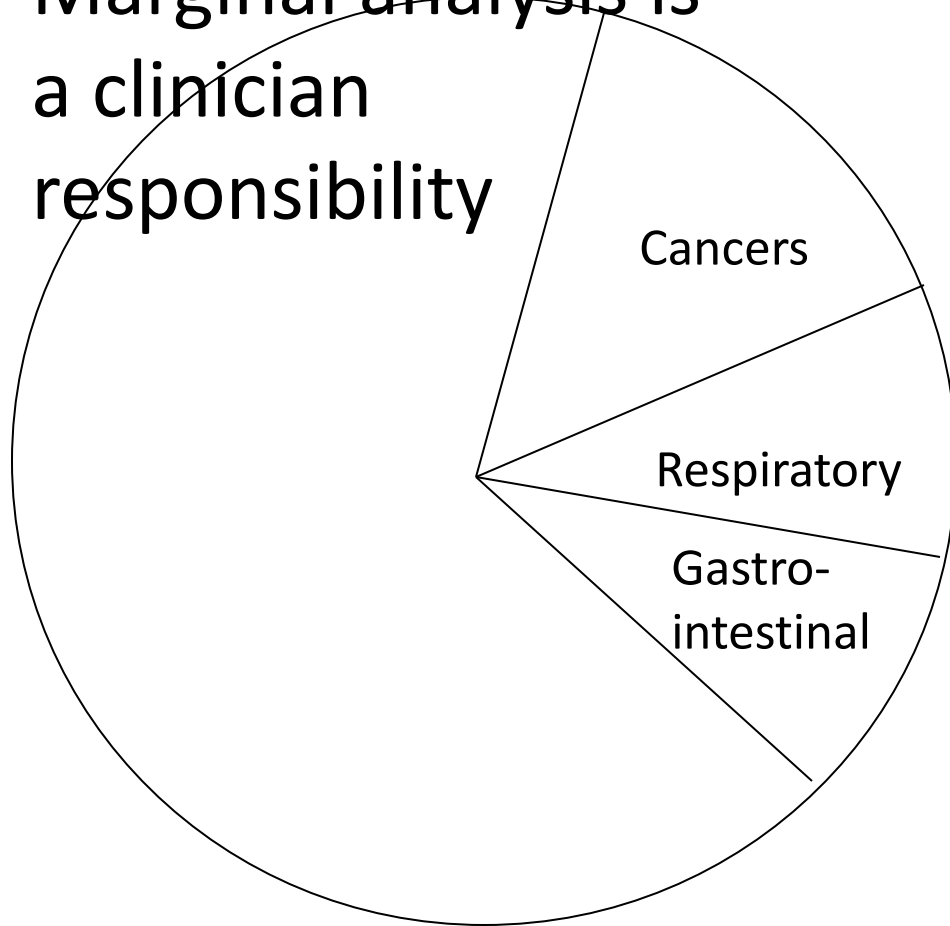
2. We are working to develop programme budgets determined by characteristic such being elderly with frailty

Many people have more than one problem ; they have complex needs. GP's are skilled in managing **complexity** but when one of the problems becomes **complicated** the Generalist needs Specialist help



VARIABLE	RATIO OF THE LOWEST TO THE HIGHEST RATE AFTER THE 5 HIGHEST AND THE 5 LOWEST HAD BEEN EXCLUDED
EVAR PROCEDURES FOR AAA/100,000	4.3
DEXA SCANS /1000	6
FREE THYROXINE T ₄ TESTS/1000 ORDERED BY GP	16
PSA TESTS /1000	4.7
% OF DEATHS IN HOSPITAL	1.73
CRUCIATE LIGAMENT RECONSTRUCTION	50
FOLATE TESTING	14
RHEUMATOID FACTOR TESTING	107

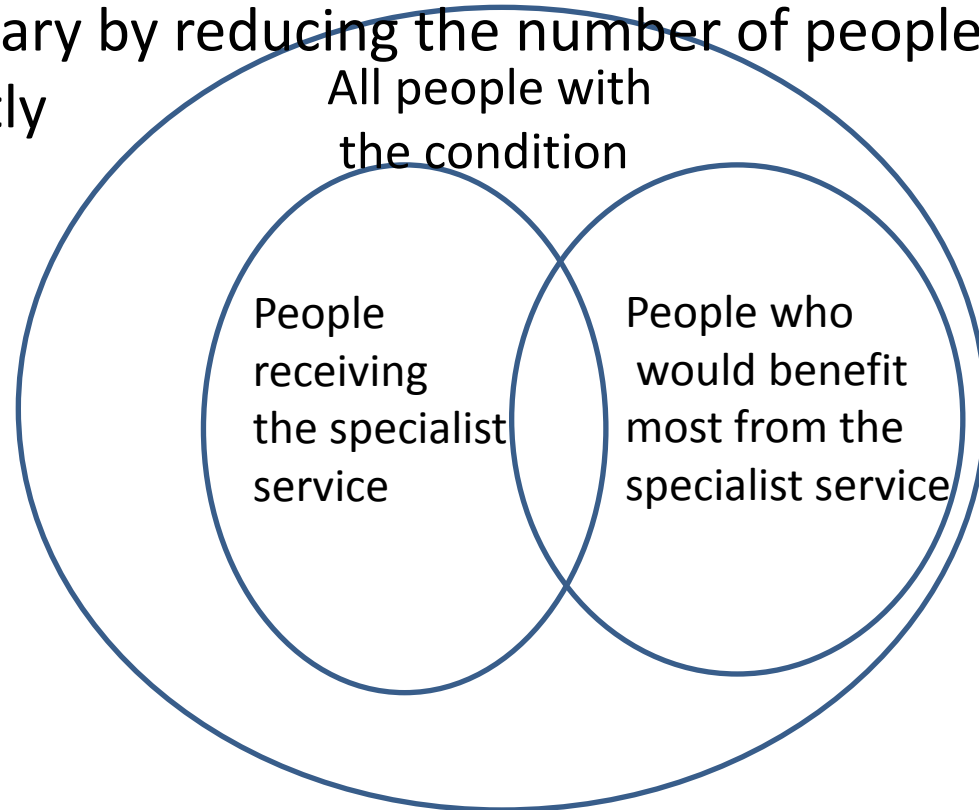
Within Programme,
Between System
Marginal analysis is
a clinician
responsibility



Population healthcare systems focus primarily on populations defined by a common need which may be a symptom such as breathlessness, a condition such as arthritis or a common characteristic such as frailty in old age, not on institutions , or specialties or technologies.

Its aim is to maximise value for those populations and the individuals within them

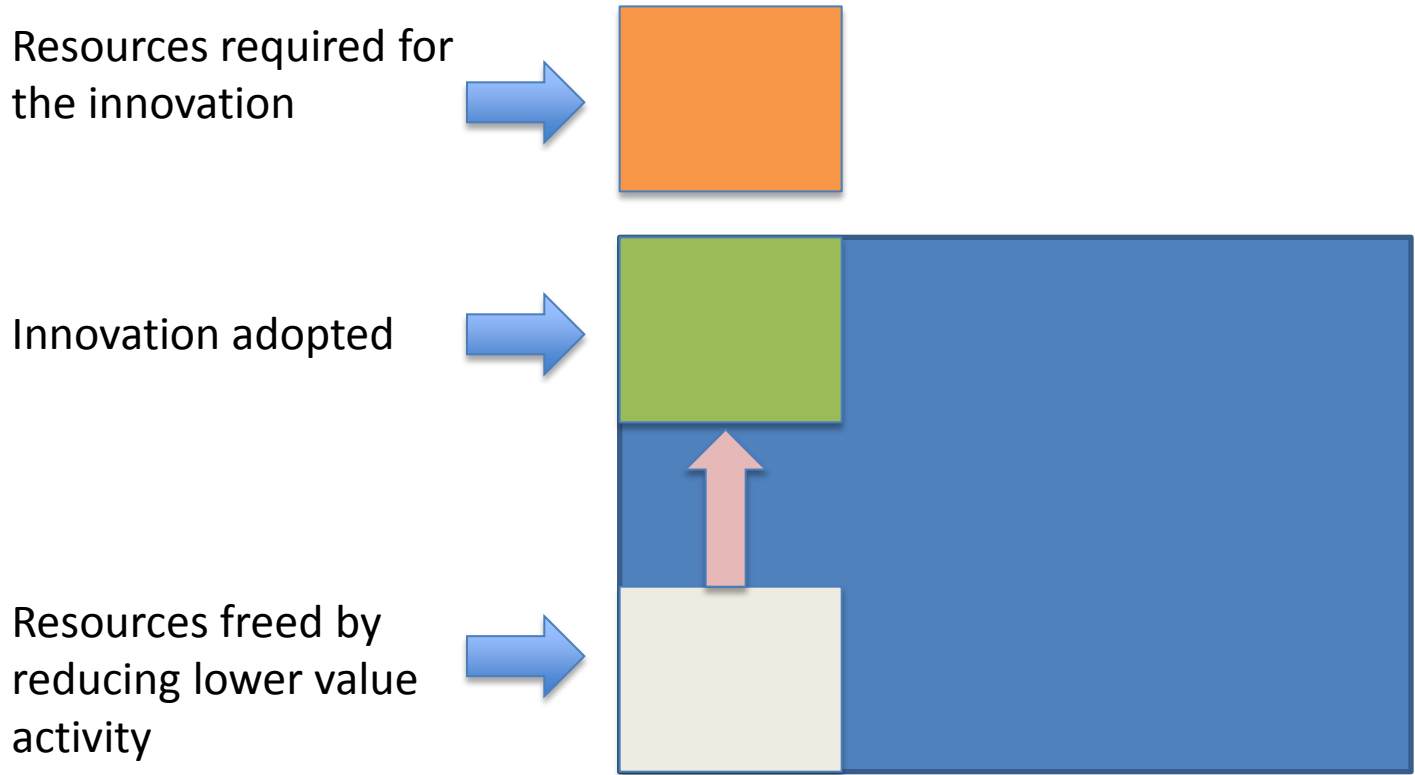
3. Develop population based systems that meet the needs of all the people affected by ensuring that those people in the population who will derive most from a service are in receipt of that service if necessary by reducing the number of people seen by that service directly



This requires clinicians including specialists to become population focused as well as delivering high quality care to referred patients and the surgical services initiative which is part of the Efficiency programme will develop this approach

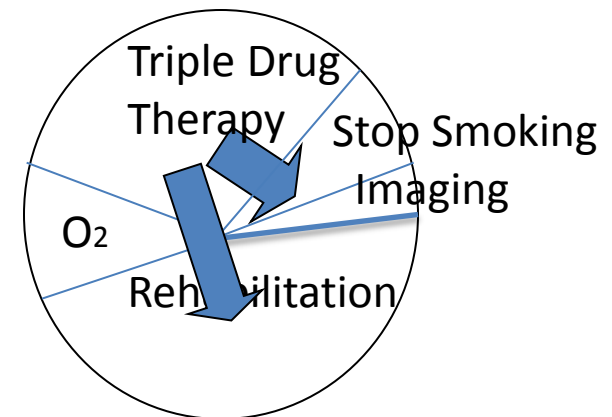
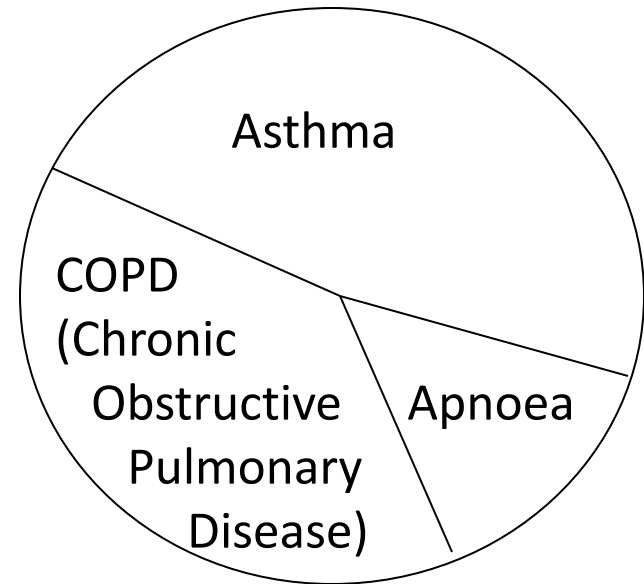
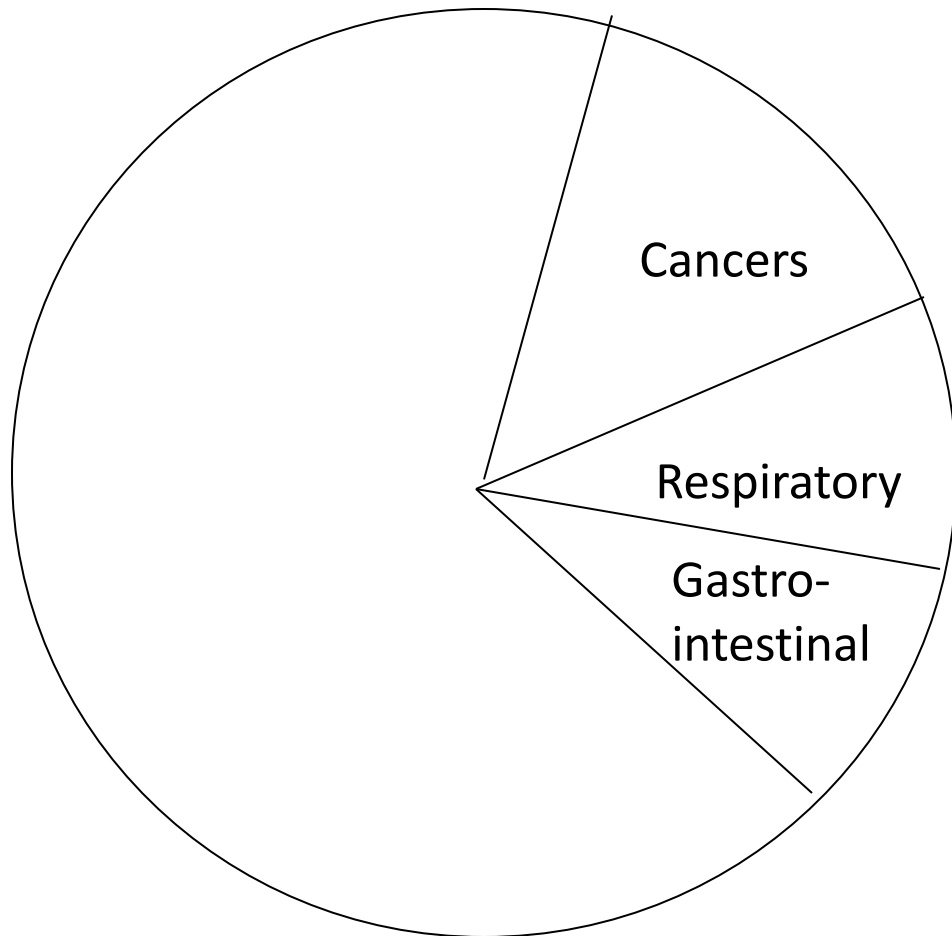


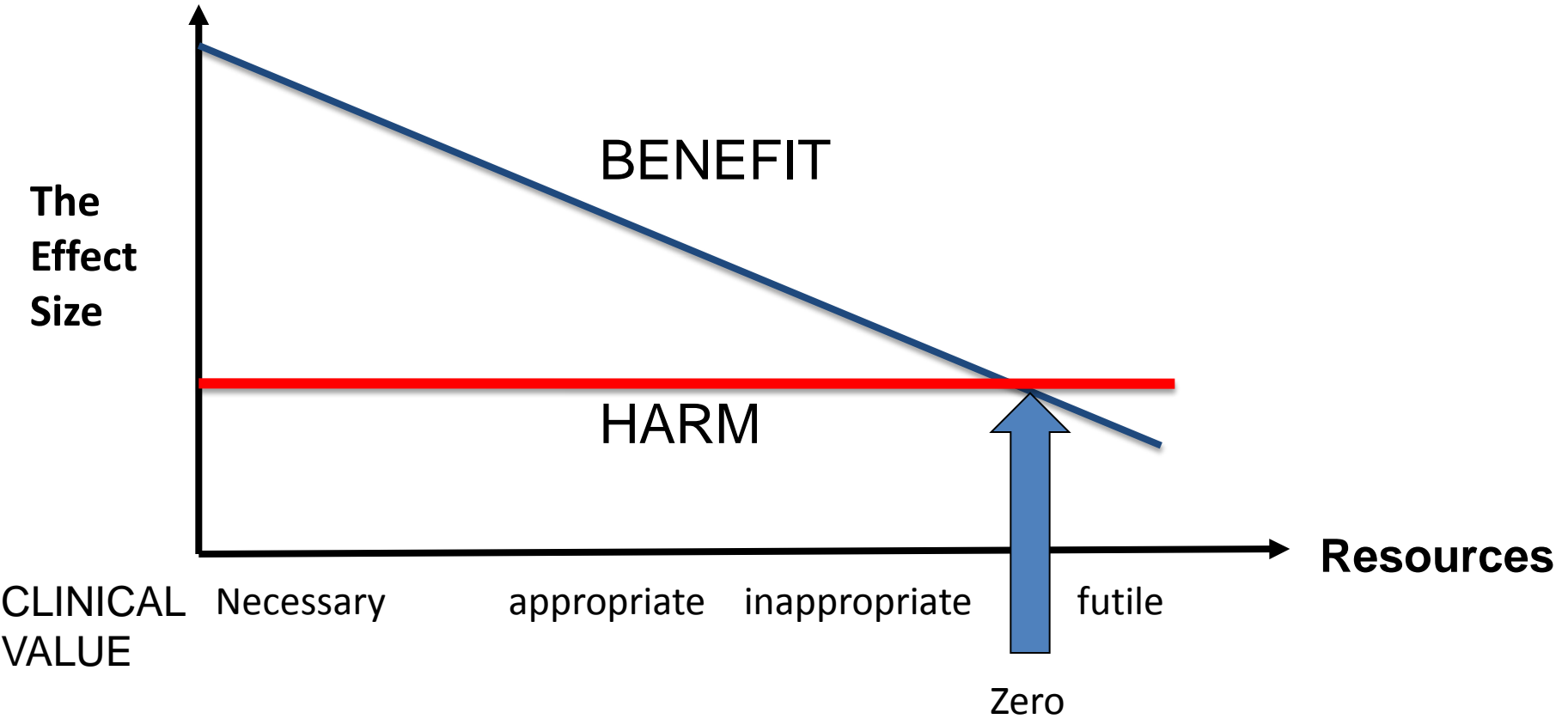
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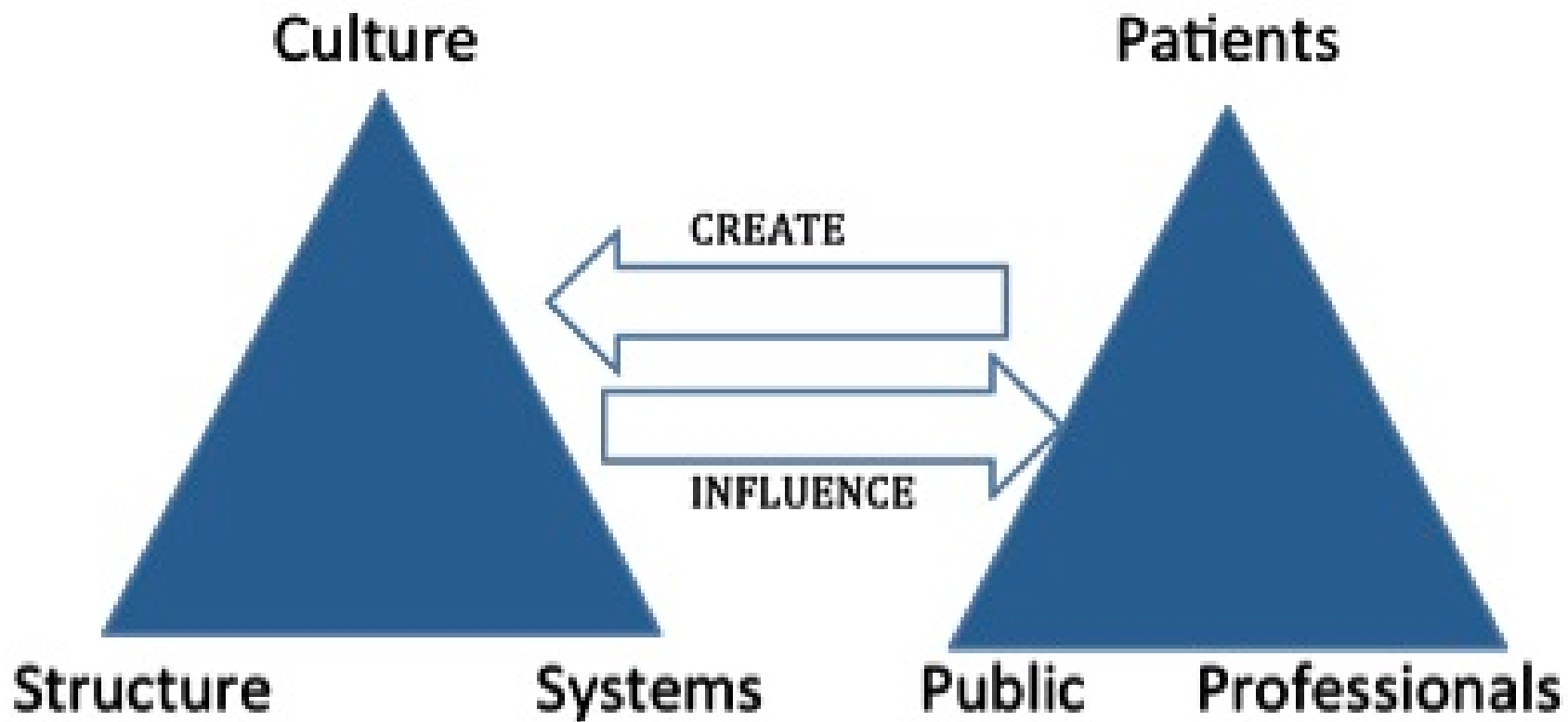


Population based systems that implement high value innovation funded by reduced spending on lower value intervention in the same programme budget

Population based systems that optimise resource use for each population







The Healthcare Archipelago

GENERAL
PRACTICE

MENTAL
HEALTH

PRIVATE
PHYSIOTHERAPY
OSTEOPATHY
CHIROPRACTIC

HOSPITAL
SERVICES

The Commissioning Archipelago

GP/
Pharmacists/
optometrists

152
Local
Authorities

211 CCGs

Public
Health

Specialist
commissioning

SELF CARE

INFORMAL CARE

GENERALIST

SPECIALIST

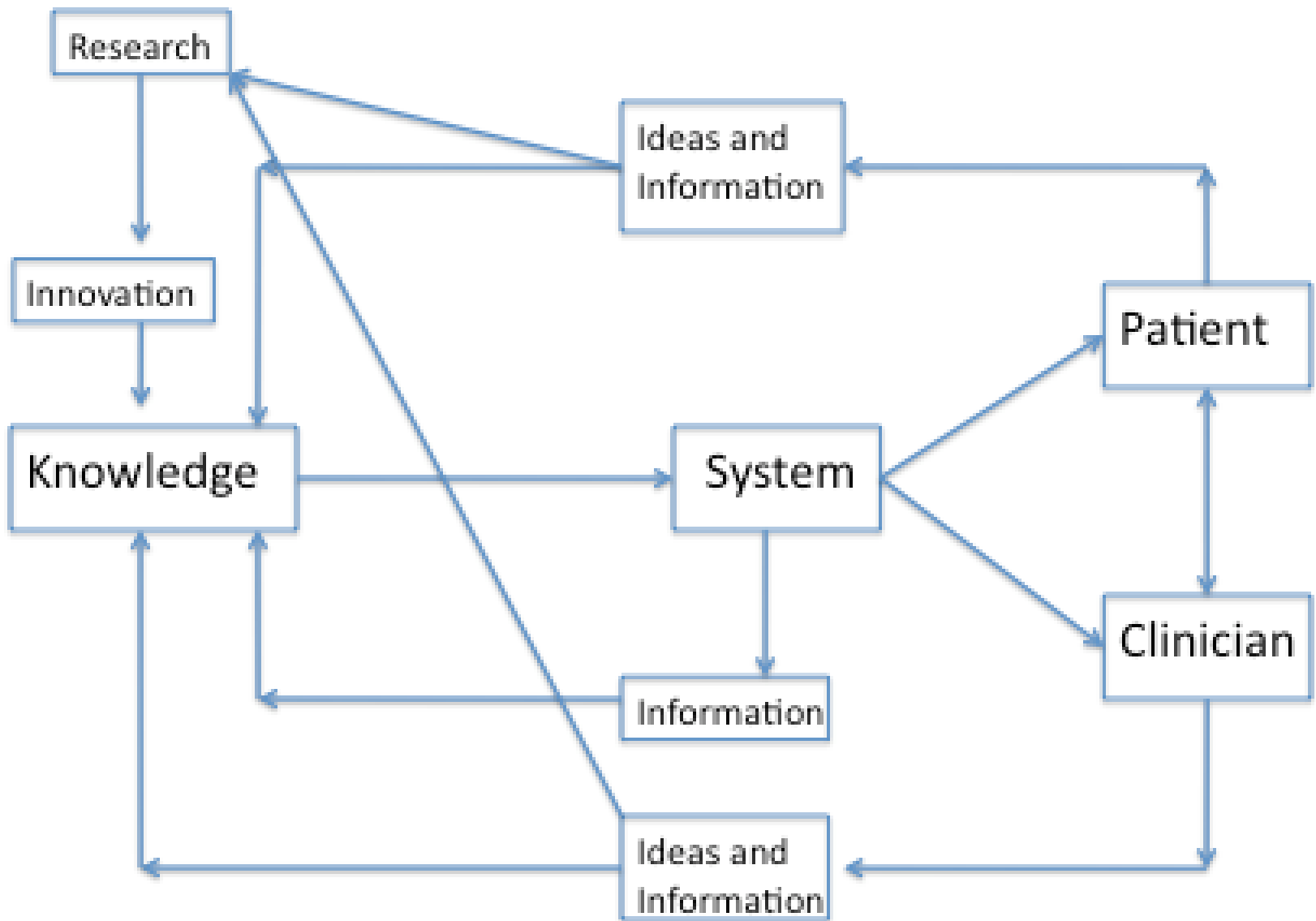
SELF CARE

INFORMAL CARE

GENERALIST

SPECIALIST

SUPER
SPECIALIST



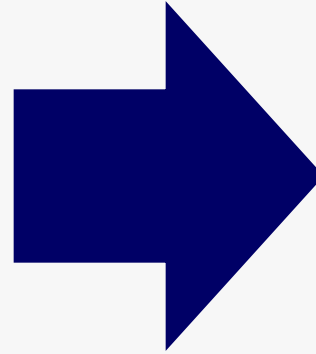
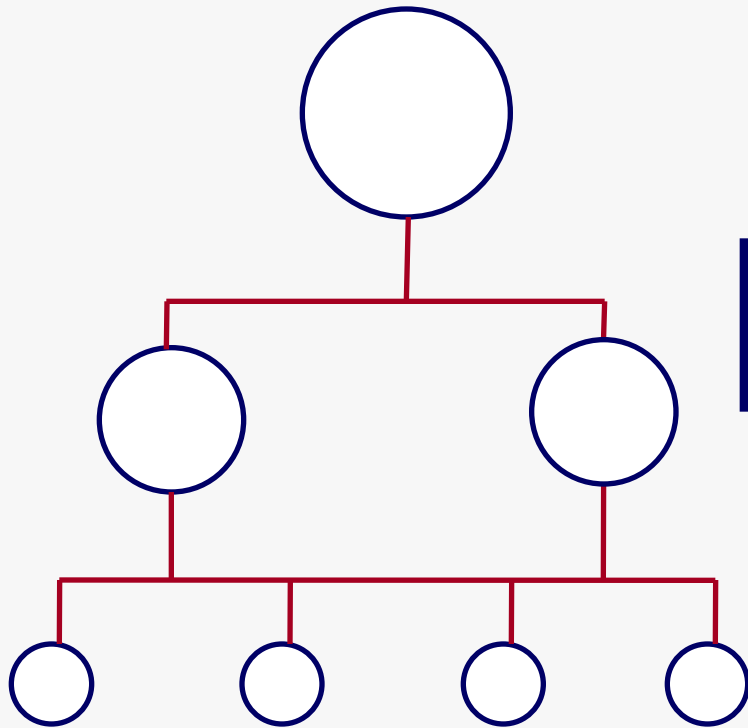
CHOOSING CRITERIA & SETTING STANDARDS

Newborn Screening for Sickle Cell Disorders Programme Standards

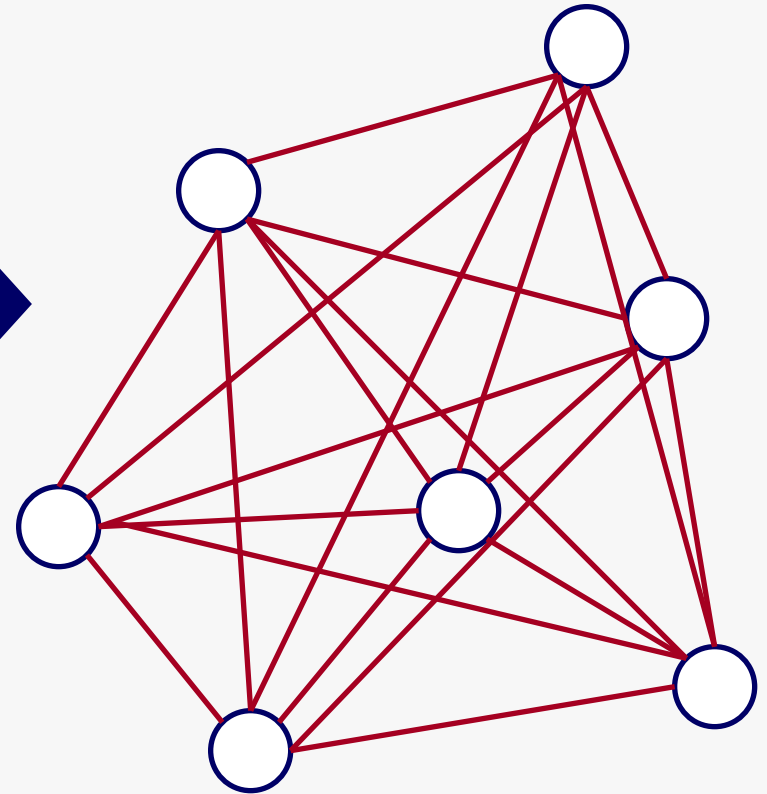
NEWBORN PROGRAMME OBJECTIVES:	CRITERIA	STANDARDS	
		Minimum (Core)	Achievable (Developmental)
Programme Outcome			
Best possible survival for infants detected with a sickle cell disorder by the screening programme	Mortality rates expressed in person years	Mortality rate from sickle cell disease and it's complications in children under five of less than four per 1000 person years of life (two deaths per 100 affected children)	Mortality rate in children under five of less than two per 1000 person years of life (one death per 100 affected children)
Programme Outcome			
Accurate detection of all infants born with major clinically significant haemoglobin disorders*	Sensitivity of the screening process (offer, test and repeat test)	99% detection for Hb-SS 98% detection for Hb-SC 95% detection for other variants	99.5% for Hb-SS 99% for Hb-SC 97% for other variants

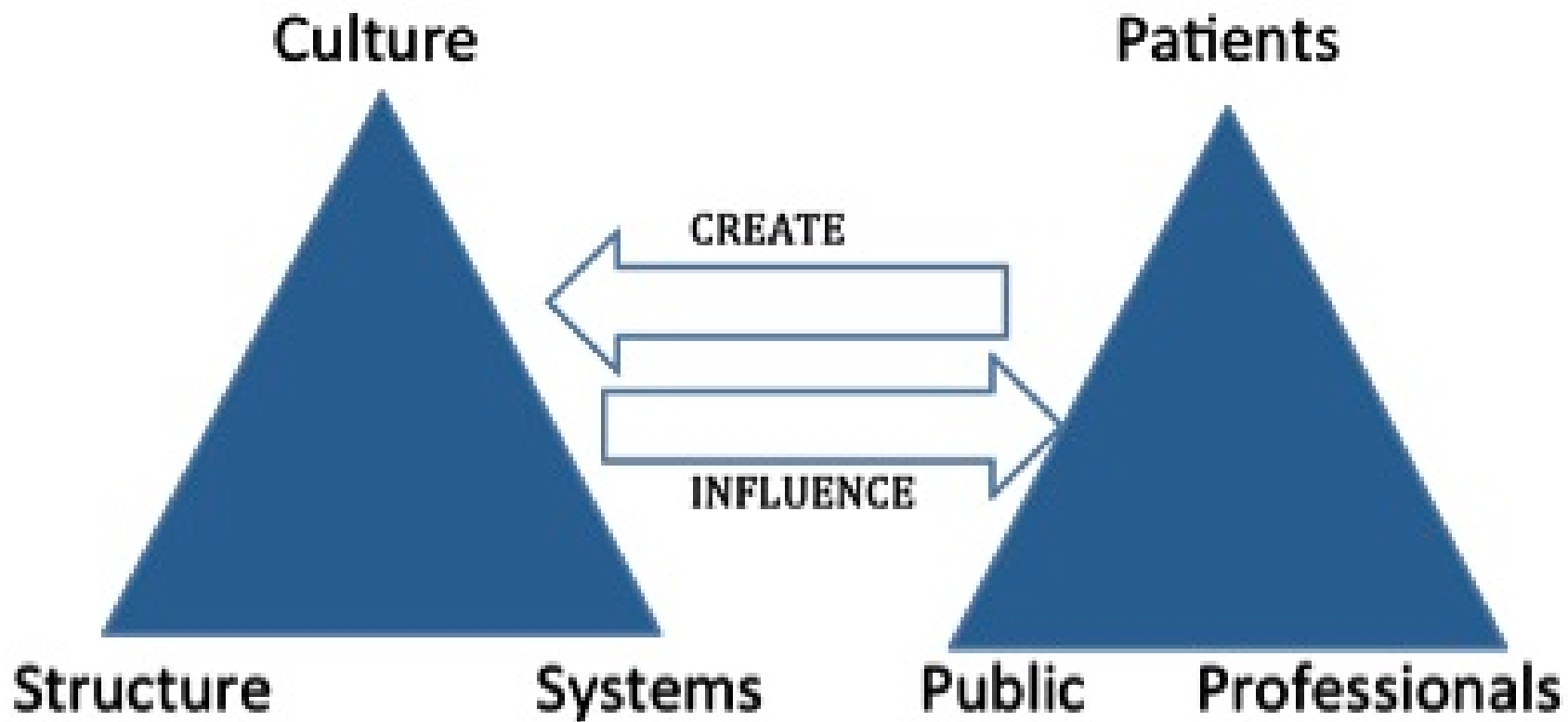
This is an example of a national service set up as a system

Hierarchy



Network







Work like an ant colony; Neither markets nor bureaucracies can solve the challenges of complexity

WE NEED A NEW CULTURE

Ban old language

PrimarySecondaryAcuteCommunityManagerOutpatientHubandSpoke

Introduce new language

A **SYSTEM** is a set of activities with a common set of objectives and outcomes; and an annual report. Systems can focus on symptoms, conditions or subgroups of the population (delivered as a service the configuration of which may vary from one population to another)

A **NETWORK** is a set of individuals and organisations that deliver the system's objectives (a team is a set of individuals or departments within one organisation)

A **PATHWAY** is the route patients usually follow through the network

A **PROGRAMME** is a set of systems with a common knowledge base and a common budget

We need a new set of skills and tools

what is the relationship between value and efficiency?

What is the relationship between value and quality ?

what is meant by the optimal use of resources?

How would you assess the culture of an organisation?

What is a system and what is a network?

What is the relationship between a system and a service?

Value based healthcare in the South East:

Achieving clinical ownership and leadership.

Larisa Han and Hugh McIntyre.
7th February 2017

A case study: Bob

82 year old patient whose wife died 18 months ago.

Bob is frail for his age, lives alone though a son stays often. The relationship between Bob and his son, can be 'difficult', impacting on the doctor/patient relationship.

There are possible signs of early dementia. Also has Type 2 diabetes, previous CVA and AF plus a pacemaker.

Bob presents with:

- Increasing frailty and poor mobility, walking with 2 sticks. Seen by ortho who has told him he has a bad hip.
- Poor anaesthetic risk, high risk of dying on table , seen by anaesthetist
- Gets minimal pain just poor mobility.
- Has had Physio and OT.
- Now fallen a few times.



A case study: Bob

- GP has had a discussion with Bob about:
 - The hip replacement and whether it will benefit him.
 - The high risk of the operation and the likely reduced mobility after, and stressed that mobility is unlikely to improve.
- The hospital doctor has told Bob that he can have the surgery despite the risks.
- Both Bob and his son want full resus even though there is a low chance of a good outcome.



A case study: Bob

- How do we have this discussion with our patients about poor outcome procedures?
- How do we, as GPs and Hospital Drs develop the same approach to a pathway?
- We need to have a shared approach but also a shared language and understanding of what value is.



Value definition

$$\text{Value} = \frac{\text{Health outcomes}}{\text{Costs of delivering the outcomes}}$$

Outcomes are the full set of patient health outcomes over the cycle of care

Costs are the total costs of resources used to care for a patient's condition over the care cycle



Starting the Conversation

- What does value based health care mean in practice?
- How can we bring this into commissioning, budgets, hospitals and primary care?
- How does it affect an individual consultation and the needs of the patient?

We need to have *a structure to value* that everyone understands and use it to *develop a series of rules for commissioning pathways.*



Who is the audience?

- The “clinician” (exemplified by the doctor) for:
 - They are the vehicle of care at the 1-1 interface with the citizen.
 - They are central to the development of pathways.
 - They have a duty of “reasonableness” (GMC and NHS Constitution).
- The patient also needs to have a shared understanding of value.



STPs and Value

- STPs are the potential start for how interaction of budgets and wider population costs can be addressed to sustain services. We can start the transformation by talking about value:
 - It is not about rationing; it is about finding the value of every part of the NHS: keeping and building on value and reducing anything not of value.
 - We need to build pathways that are based on value that go beyond primary/secondary care boundaries
 - Need to reduce variation by reducing poor outcomes



Primary Care

- GPs have tended to do this anyway both one to one and at scale.
- For example, gatekeeper role- advising patients if referral is necessary whilst also being aware of the constraints on services
- In some cases- of rationing of services (eg physio- we used to run out of our allocation each year around month 9).
- It really undermines the whole pathway when patients hear contradictions from different doctors



Value as an idea locally

- STP language remains ambivalent – quality / outcome discussed but the reality of traction with cost seems separate – albeit to some more than others.
- Drive to see all sectors engaged in planning for local *populations*.
- Wider engagement of clinicians in STP discussions developing *pathways* of care.
- A shared understanding of value so that a clinical decision is not interpreted as a personal judgement.



Value

- “We need to have a ***structure to value*** that everyone understands and use it to ***develop a series of rules for commissioning pathways.***”
- Value as the “glue” to give clinicians a common meaning and approach to pathways



Reconciling meaning and approach

One pathway – one value

- Can a definition of value at a population level reasonably be the same as that at the 1-1 level?
- Is there a difference between primary and secondary care?
 - GP practice already embraces this duality of purpose, often facilitated by targets and guidance.
- There is a need for a unitary definition that affords:
 - Clarity, simplicity and thus utility for all stakeholders (and is already practiced in primary care).

Value = best outcome for the patient at best cost.

- Thus we reach the principle that *all* clinicians engage in developing one agreed pathway to one agreed value definition.



The clinicians role

Through pathways value based healthcare centres on:

- The professionalism of individual clinicians and their responsibility for decisions *across the full range of care*.
- Finding the best for the person though a focus on: minimising harm, reducing overuse, increasing prevention, and maximising outcome.
- Shared decision making - *between clinicians as well*. Many patients (and doctors) may lack either the information or permission to have this discussion.

We need to start. It is a conversation as much between clinicians as well as between doctors and patients.



The conversation

One language

If “one pathway - one value” is “given” then a common “language” is permitted that allows agreement across the healthcare system.

This starts to address questions such as:

- Who is being offered hip/knee replacements? Are these the right people who will benefit most from them?
- Are the right people being offered chemotherapy? Or is it not going to add any quality (or even added time) for the patient?
- Is the renal patient being offered a drug with an uncertain evidence base - just because the clinician and patient feels something else must be done?



A contract?

One payment

An agreed one pathway - one value approach allows a structured rationalisation between the population and the personal.

But there remains the issue of “misaligned” incentives both in primary and secondary care.

- For example a LES or the current ability for secondary care to generate income by activity...
- If payment is to the pathway (or population) this issue disappears for there is only one incentive and that aligns all to best delivery of the pathway.

One pathway, one value, one language, one payment.



What might happen next?

A wider conversation

For clinicians:

- To have the conversation with their patients:
 - Clarifying the outcomes.
 - Starting with illustrative examples around high variation and low value intervention.

They will need wider organisational leadership and help to embed.

For provider organisations:

- To talk with individual clinicians to enable discussions with patients regarding value of treatments against costs.
- To tease out value conflicts within a 1:1 transaction as opposed to a population level.
- To *emphasise quality and deliver value.*



What might happen next?

A wider conversation

For commissioning organisations:

- Engage all clinicians in pathway development .
- Embed population (not silo) value as a shared language .
- Understand outcomes.

For partner organisations, PH, AHSN, Health Education:

- Bring training to clinicians and commissioners.
- Public health need to initiate this value based discussion with patients.

One pathway, one value, one language, one payment. A joined up integrated approach to care of our patients and population.



The role of the Clinical Senate?

- Facilitating the wider conversation:
 - Engaging and enthusing clinicians with the concept of value in healthcare, and their role in describing and delivering it.
 - Developing the language that reconciles value and pathways and that clinicians can use together.
 - Agreeing important patient outcomes, not process measures, when assessing how to improve value.
 - Describe features of patient-specific outcomes.
 - Provide concrete grounded practical examples that are expressed in the conceptual framework of value.

