Right Care Workstream

Malcolm Qualie/Donna Hakes – Workstream Lead
Nigel Beasley/Stephen Clay– Clinical Lead

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Case for change

- NHS management has often focussed on organisations and structures. Clinicians have held the balance of power, creating clinical systems of an ever increasing sophistication.
- Historically, use of NHS resource has been driven by demand, expanding services or new technology, sometimes without considering a sound evidence base, ceasing other ways of working or the impact on the health system as a whole.
- Currently patients undergo treatment in the face of “avoidable ignorance” and consent to interventions which they might not undergo if they were provided with a fuller understanding of the risks, benefits and alternatives to fully exercise their values and preferences.

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Case for change cont'd

- It is also evident that the public and patients have not always been included in the debate about the development or design of services.
- The NHS is unlikely to hold sufficient resource to meet ever rising demand and thus we need to change the nature of the debate between the public and the NHS about how resources are utilised for their care - to do the right things, at the right time and place, safely and effectively in order to increase the sustainability of healthcare.
- Moreover, there is now a clear and immediate financial imperative to invest to save to meet the budgetary constraints from 2011/12 which means that action must be taken now to maximise value quickly while engaging more effectively about future provision.

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Variation & Opportunity

- National Right Care Programme has identified procedures of lower value (PLCV) from PCT initiatives. The national team has also produced The Atlas of Variation. http://www.rightcare.nhs.uk/atlas/

- Locally, a PLCV policy has been widely circulated and discussed for proposed regional implementation.

- An analysis by EMPHO of identified procedures has identified wide variation of access and a total financial spend of £173m within the East Midlands.

- In addition, the EMQO has identified wide variation in access to standard procedures across the region, e.g. Laparoscopic Cholecystectomy.

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BADS – General Surgery Table (RY Q1 1011)

NHS

General Adult	CRHFT		DHFT		KGHFT		NGH		NUH		SFHFT		UHL		ULHT		Recommended Rate
	Vol	% DC	Vol	% DC	Vol	% DC	Vol	% DC	Vol	% DC	Vol	% DC	Vol	% DC	Vol	% DC	
Diagnostic laparoscopy	113	62%	231	40%	83	58%	135	56%	257	6%	160	69%	414	49%	290	63%	85.0%
Excision biopsy of lymph node for diagnosis (cervical, inguinal, axillary)	73	48%	123	29%	81	58%	106	38%	230	50%	51	41%	307	47%	145	48%	40.0%
Excision of lesion of parathyroids	32	0%	23	0%	6	0%	26	23%	75	0%	12	0%	42	0%	18	0%	30.0%
Excision/destruction of lesion of anus	74	91%	131	84%	43	79%	93	86%	74	36%	77	88%	125	81%	120	78%	65.0%
Laparoscopic cholecystectomy	336	47%	560	18%	326	6%	322	44%	591	16%	437	11%	849	16%	648	7%	60.0%
Pilonidal sinus surgery - laying open or suture/skin graft	64	33%	157	34%	65	40%	69	29%	128	24%	85	31%	178	27%	106	19%	45.0%
Primary repair of inguinal hernia	311	64%	669	67%	258	55%	379	71%	469	48%	390	54%	793	40%	646	54%	95.0%
Repair of umbilical hernia	72	64%	193	58%	88	51%	100	53%	177	34%	95	57%	200	37%	197	52%	85.0%

General Paed	CRHFT		DHFT		KGHFT		NGH		NUH		SFHFT		UHL		ULHT		Recommended Rate
	Vol	% DC	Vol	% DC	Vol	% DC	Vol	% DC	Vol	% DC	Vol	% DC	Vol	% DC	Vol	% DC	
Herniotomy / ligation of patent processus vaginalis	15	100%	71	92%	18	94%	43	91%	114	95%	17	94%	160	87%	35	94%	95.0%
Orchidopexy	14	86%	48	73%	12	83%	41	73%	74	84%	18	67%	133	71%	34	88%	90.0%
Repair of umbilical hernia	3	100%	27	85%	9	89%	16	94%	36	97%	2	50%	30	93%	7	86%	95.0%

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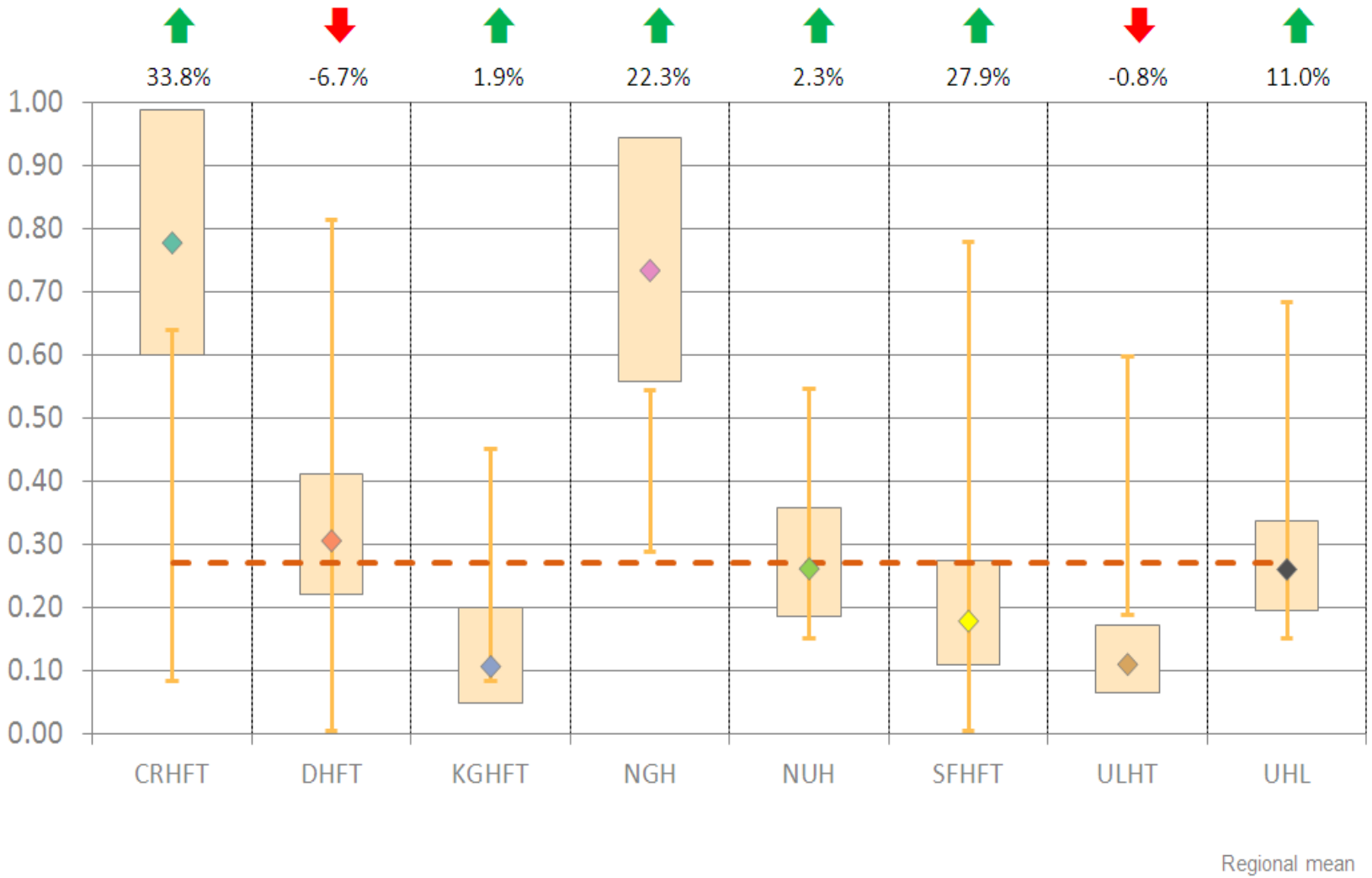
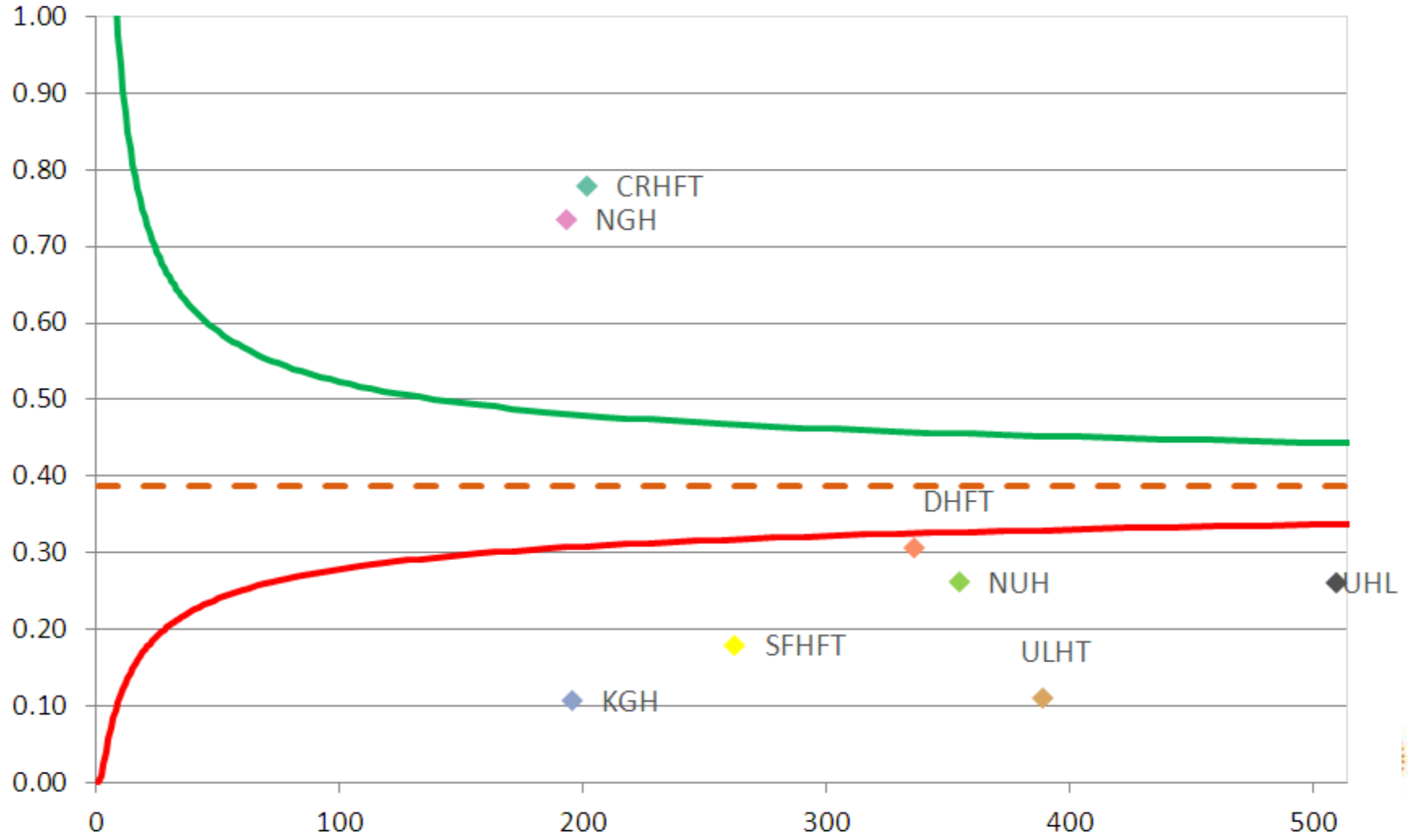
BADS – Zoom in on Laparoscopic cholecystectomy Day Case Rate actual to expected (BADS day case + out patient thresholds) RYO1011



Source: HES

BADS – Zoom in on Laparoscopic cholecystectomy Day Case Rate actual to expected (BADS day case + out patient thresholds) RYQ1011



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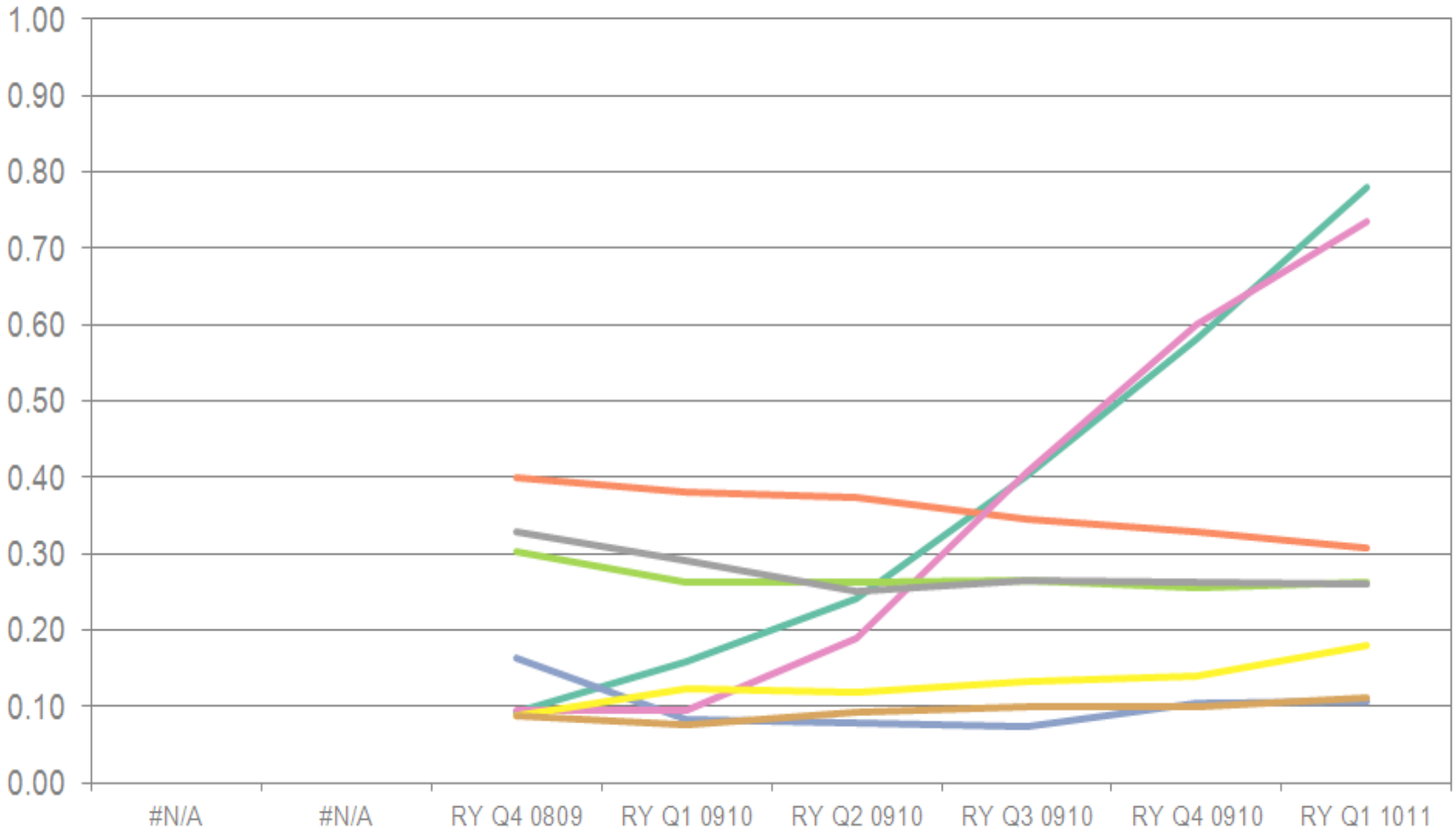
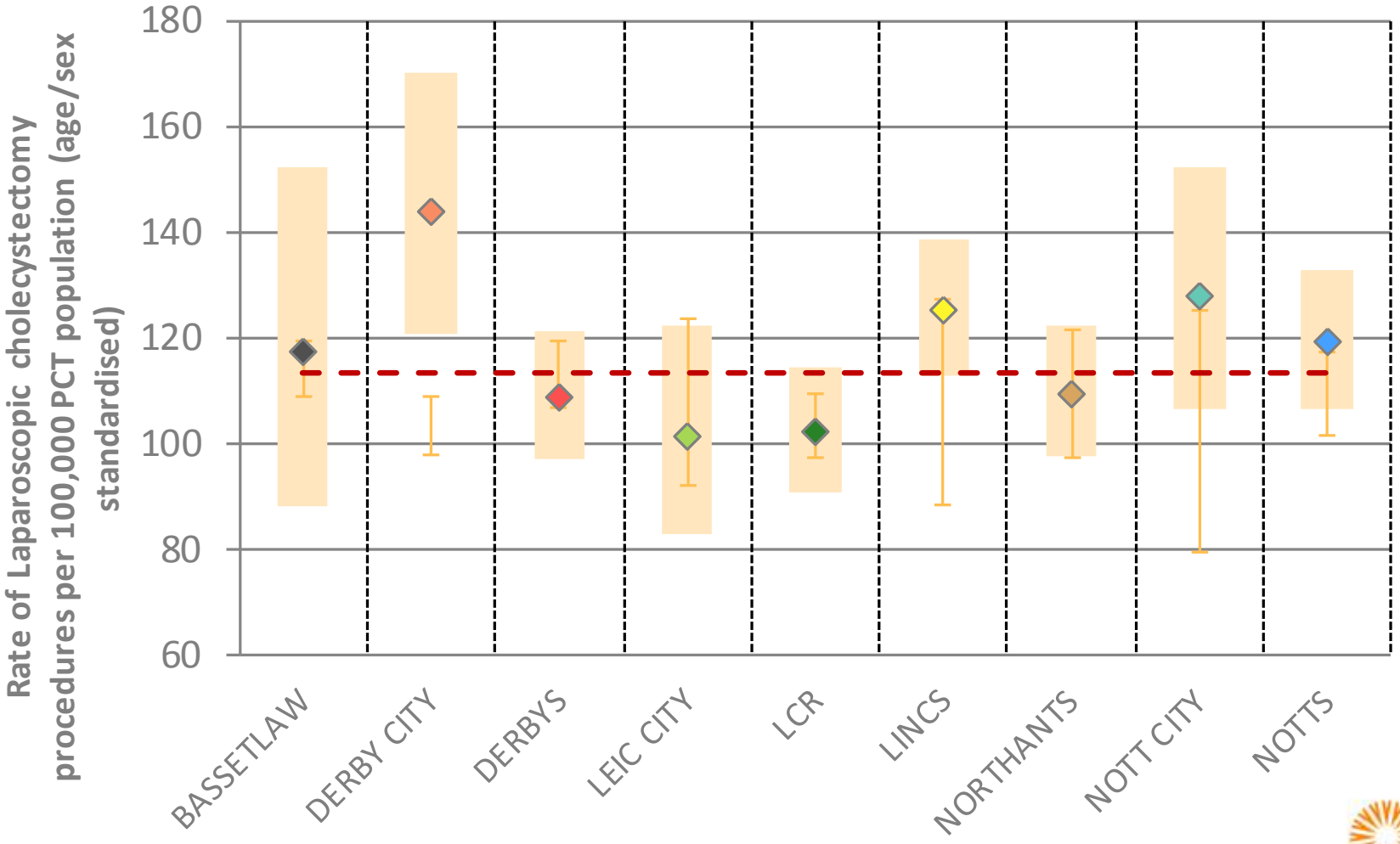


Source: HES

BADS – Zoom in on Laparoscopic Cholecystectomy Rate per 100,000 population (BW)



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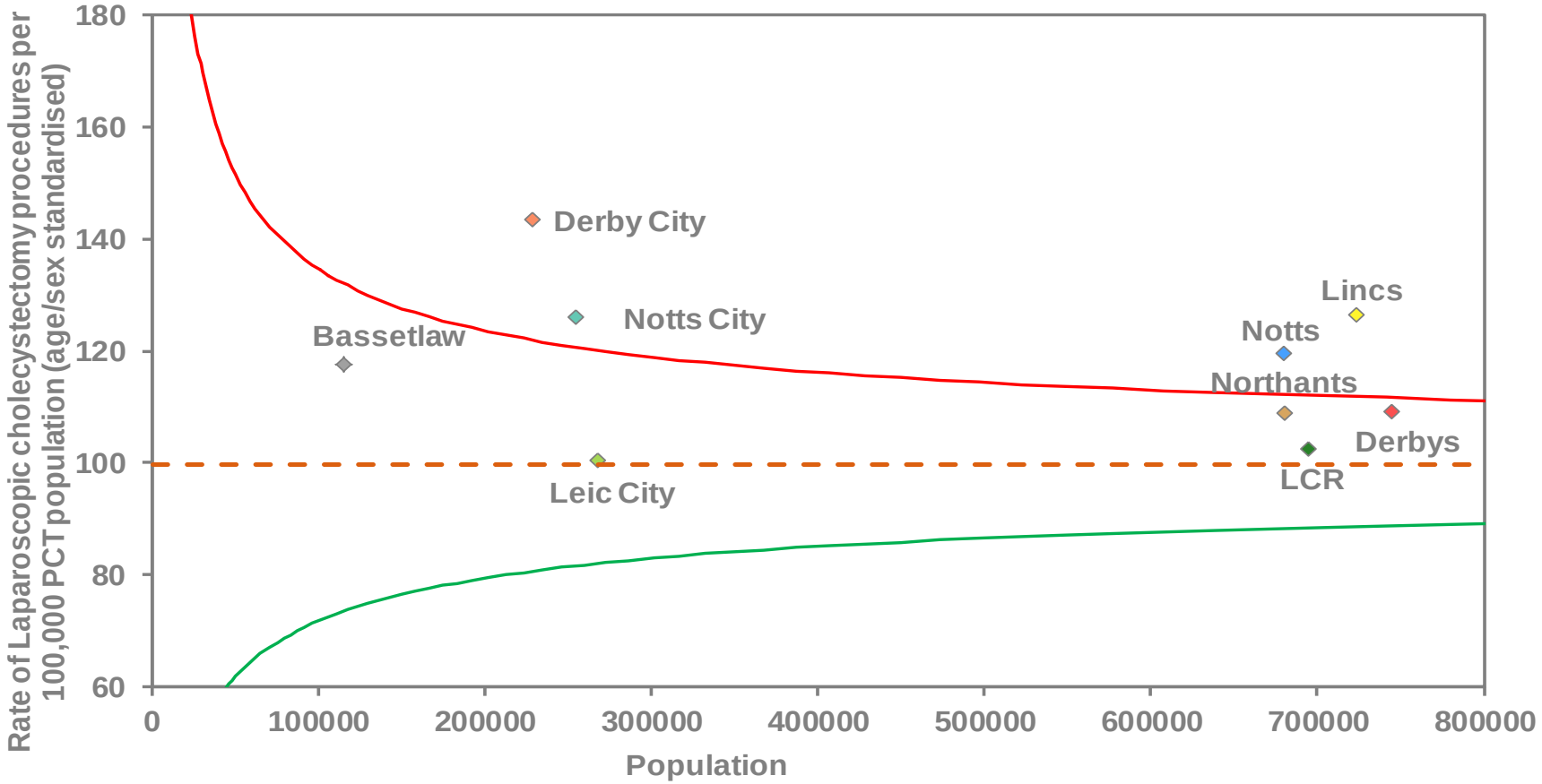
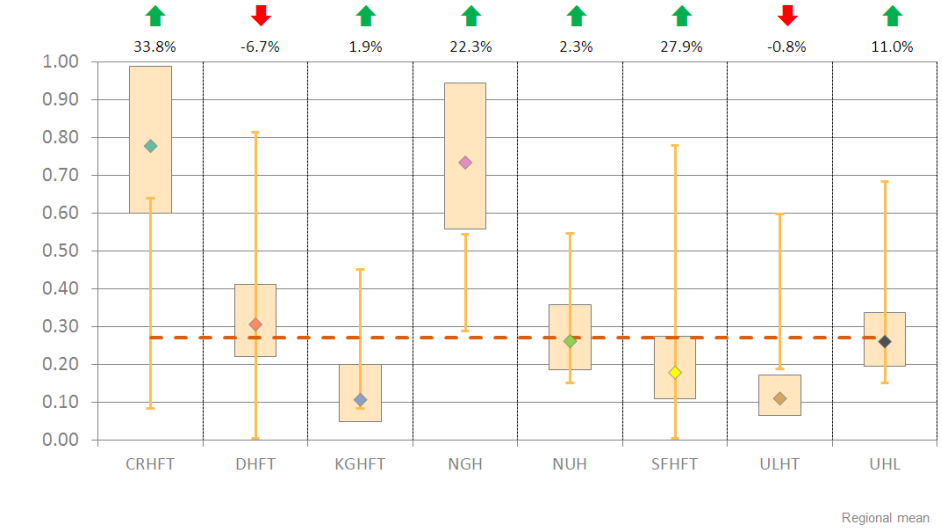
BADS – Zoom in on Laparoscopic cholecystectomy
Rate per 100,000 population (FP)

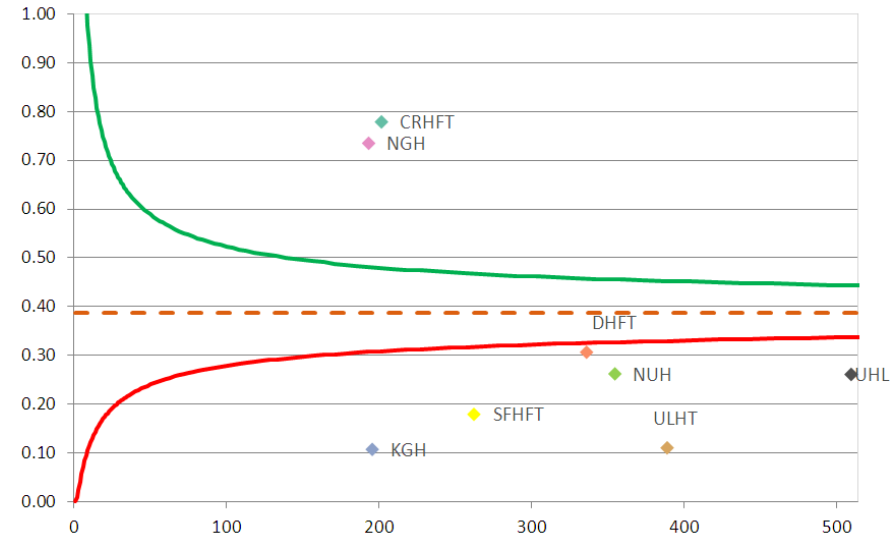


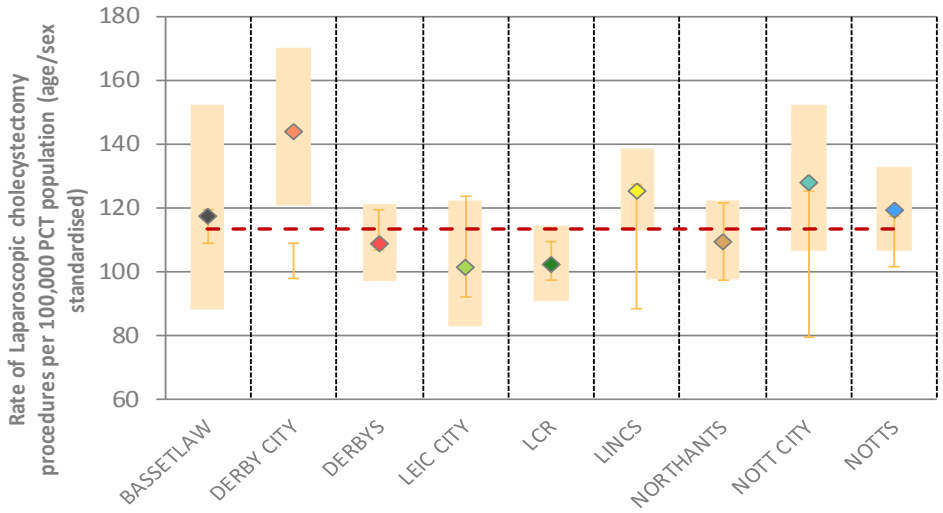
Source: HES APC 0910 / 1011

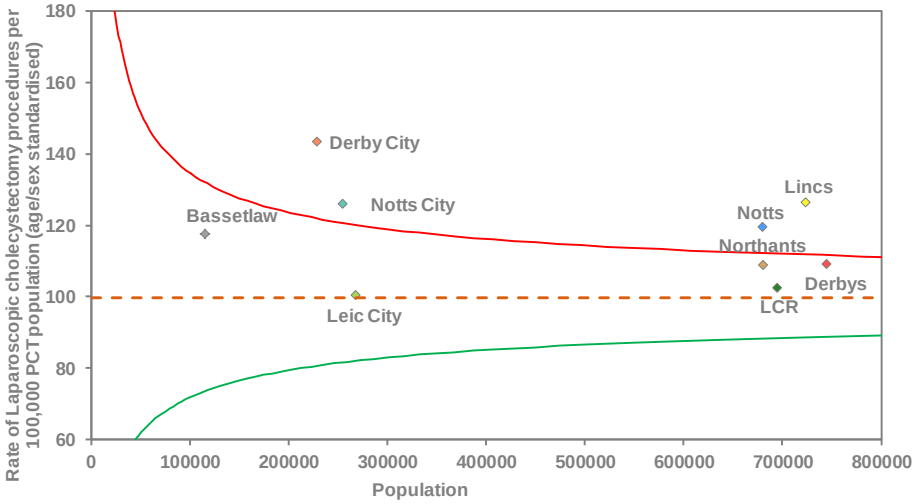
Note: Population is adjusted due to Standardisation Calculations

Variation & Opportunity









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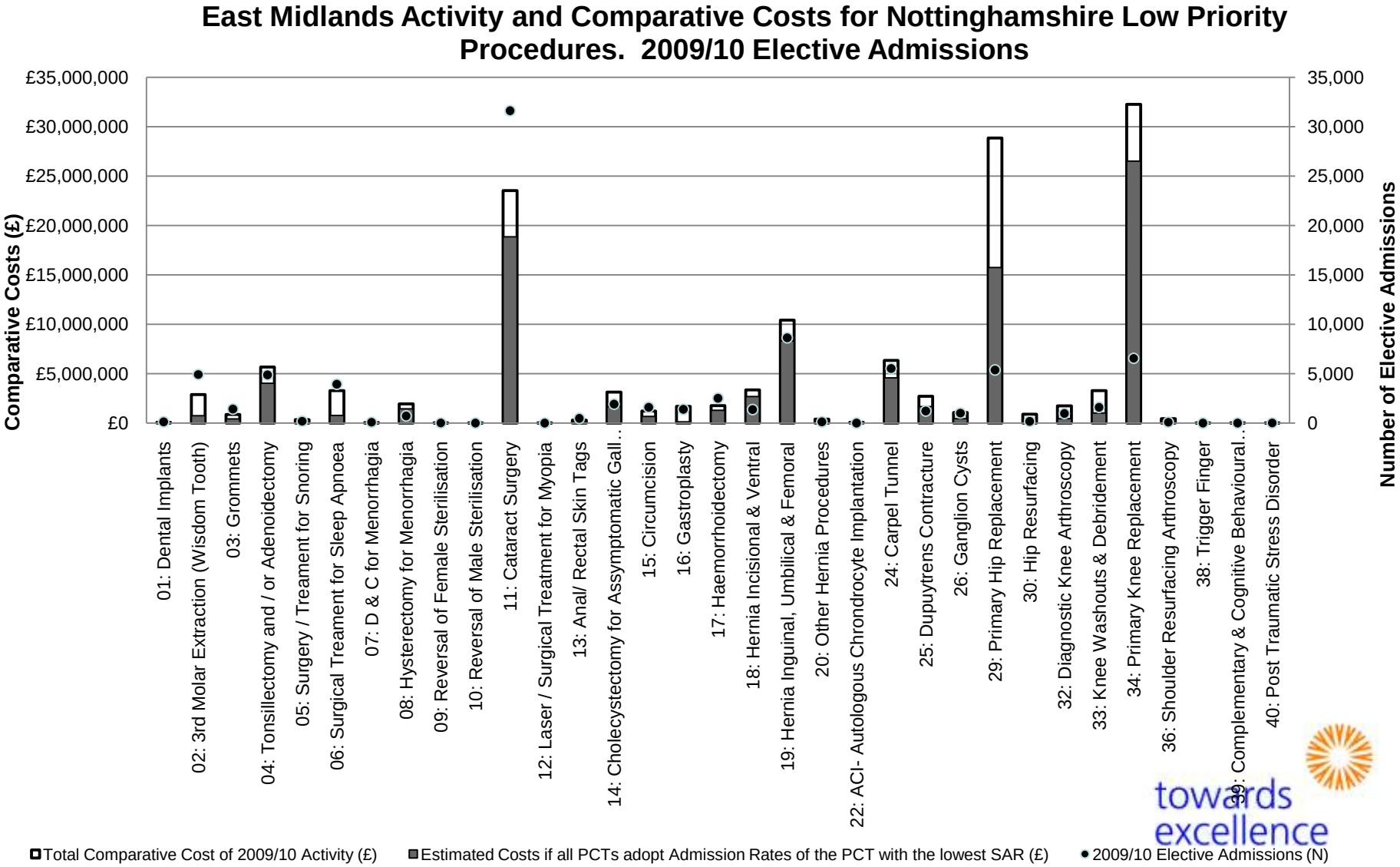
Variation & Opportunity



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Primary Hip Replacement

.	Statistic					
Registered PCT	*Standardised Admission Ratio (SAR). Value of '100' shows activity in line with that of the East Midlands*	2009/10 Elective Admissions (N)	Total Comparative Cost of 2009/10 Activity (£)	Financial Impact of PCT Adopting East Midlands Activity Levels (£)	Financial Impact of PCT Adopting the Admission Rates of the EM PCT with Lowest SAR (£)	Average Cost per Elective Admission (£)
Nottingham City PCT	*90*	245	£1,312,000	£139,233	-£519,445	£5,355
Bassetlaw PCT	*115*	163	£872,727	-£112,437	-£460,457	£5,354
Derbyshire County PCT	*117*	1080	£5,799,357	-£832,315	-£3,087,621	£5,370
Derby City PCT	*97*	304	£1,621,200	£53,329	-£703,942	£5,333
NHS Nottinghamshire County	*112*	936	£4,989,851	-£554,428	-£2,569,560	£5,331
Lincolnshire PCT	*108*	1116	£5,997,613	-£451,433	-£2,977,310	£5,374
Leicestershire County and Rutland PCT	*75*	614	£3,304,543	£1,124,836	-£888,029	£5,382
Leicester City PCT	*55*	157	£858,783	£716,564	£0	£5,470
Northamptonshire PCT	*102*	768	£4,110,240	-£64,223	-£1,910,619	£5,352
East Midlands		5383	£28,866,314	£19,126		

Products achieved

The NHS East Midlands QIPP Right Care workstream has:

Product	Status	Attachment
Procedures of Limited Clinical Value Policy	Contract negotiation	
Atlas of Variation	Published	http://www.rightcare.nhs.uk/atlas/
EMPHO analysis - Funnel plots	Completed	
PCT HIPs	Published to PCTs	
EMQO analysis	Ongoing	
EMPHO analysis – PLCV variation and spend	Ongoing	
Regional Clinical Engagement Workshop	Held 11th January 2011	
MSK analysis (Bazian)	Commenced January 2011	

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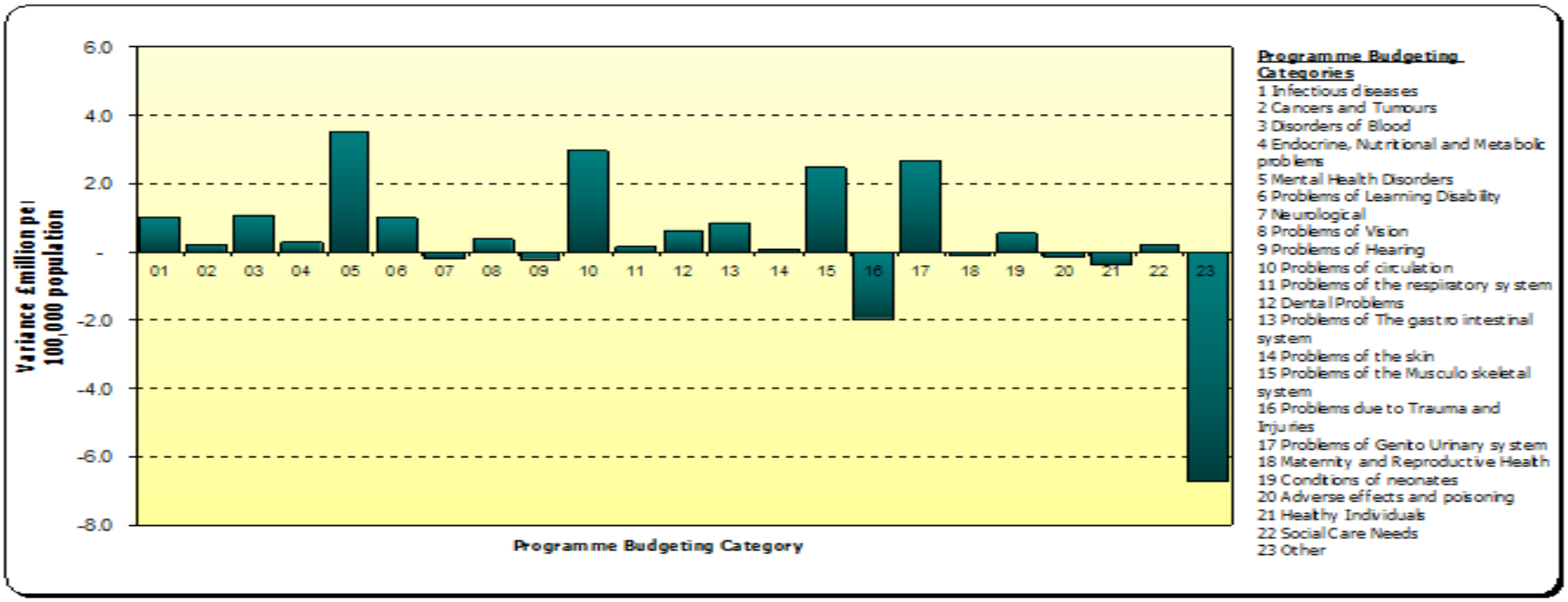
Case study / good examples

In West Cheshire, the PCT has been taking a radical approach to redesign of services using analysis of spend and outcomes as outlined in the Right Care Health Investment Packs (HIPs). With an approach that adopted "reform is the day job", Cheshire have made maximising outcome for health spend central to their strategy. Working with GP and Acute clinical champions in key project roles they have already delivered £11m in savings and aim to achieve £15m by the end of the financial year.

The West Cheshire programme focuses on “allocative efficiency”: that is, using resources to produce the right quantity of each service. Using programme budgeting tools, they compared their expenditure with that of similar organisations (other prospering smaller towns).

A higher spend on GU services, for example, with poorer outcomes relative to other PCTs has led to a service review and decisions to remodel urology services to develop “one stop” community clinics for haematuria, ultrasound, urinary flow diagnostic service - projected full year savings of £347,505.



Case study/ good examples

Geoff Watson is the Clinical Director for Planned Care in South Central SHA. He used his involvement in the Clinical Leaders Network (CLN) to develop a fully Integrated Clinical Assessment and Treatment Service (ICATS) specification for MSK services across the SHA. Early versions of the scheme in other parts of the UK are helping health communities improve the standard of care while reducing unnecessary delays. Integrating care in this way aims to improve the patient experience and the clinical quality of services for MSK patients.

Musculo-skeletal problems represent one of the biggest cost areas in the NHS (for example, statistics show 30% of GP consultations are with patients with MSK problems) and there is high level dissatisfaction with current systems of investigation, intervention and long term management. A number of different models of interface services have been established in the NHS to address problems of provision in MSK. To build on this through a new approach in South Central a whole pathway (from problem to conclusion) has been created, involving all stake holders in the design and implementation.

The SHA are keen to ensure that the benefits of the new pathway are measured and monitored beyond the present audit of length of stay data and early outcomes (for example, hospital acquired infection rates, wound breakdown rates, delayed discharges etc). There is a plan to use PROMS data to confirm the benefits to patients.

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Securing the benefits

Securing the benefits

	Provider	Commissioner
Service intelligence	Accurate information on activity and variation in practice .Benchmarking information against other regional and national organisations. Focus on appropriateness of clinical service.	Accurate information on activity, cost and variation in practice. Benchmarking information against other regional and national organisations. Focus on appropriateness of clinical service and ability to plan and allocate finite healthcare resources.
Regional Planning Labs	Working collaboratively to review the service intelligence relating to variation in practice and determine a good practice approach.	Working collaboratively to review the service intelligence relating to variation in practice and determine a good practice approach .
Pathway redesign	Reduction in unwarranted variations in practice and expenditure whilst increasing quality, outcome, value and equity.	Reduction in unwarranted variations in practice and expenditure whilst increasing quality, outcome, value and equity.
Higher value activities	Addressing appropriateness of services. Reduction in lower value activities to produce savings which could be used invest in higher value activities.	Addressing appropriateness of services. Reduction in lower value activities will produce savings which could be used to commission higher value activities.
Map of Medicine	Incorporates local and national information sources in one repository. Tool for clinical updating / revalidation. Highlights quality and productivity opportunities for clinicians at pathway level. Promotes consistency of care. Communication tool across health and social care	Help commissioners and providers develop local services. MoM pathways accredited by NICE so will support the new NHS Outcomes Framework. NICE quality indicators will be reflected in commissioning contracts and financial incentives. Communication tool across health and social care . Promotes consistency of care.

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Securing the benefits

Dimension	Benefit Statements	Outcome
		Metric
Quality	1. Reduction in side effects and interactions following low clinical value procedures	1. Total number of consultant transfers 2. Number of re-dos 3. Number of transfusions 4. Number of cases of DVT 5. Number of infections 6. Number of deaths
Activity	1. Decreased rate or ceasing of referrals for procedures of low clinical value where the clinical threshold has changed 2. Reduction in low clinical value procedures 3. Reduction in bed days associated with low clinical value procedures 4. Reduction in excess bed days (EBDs) 5. a)Reduction in procedures of high value where access is higher than average in order to redress inequity of access ; b) increase access to procedures of high clinical value	1. Number of referrals from primary care for low clinical value procedures 2. Number of low clinical value procedure episodes of care 3. Number of bed days following low value procedures 4. Number of excess bed days 5. Number of patients who access high value treatment
Finance	1. Reduction in spend on procedures of low clinical value	1. Total cost of decommissioned procedures
Workforce	1. Increase in clinician availability for higher priority treatment activity	1. Number of specified interventions undertaken

Key contacts

Main Regional Contacts

Regional Workstream	Name	Contact	Contact	Role	Location
Exec Sponsor:	Catherine Griffiths	Catherine.griffiths@lcrpct.nhs.uk		Chief Executive	NHS Leicestershire County and Rutland/NHS Leicester City
Management Lead:					
Clinical Lead:	Nigel Beasley	Nigel.beasley@nuh.nhs.uk		Deputy Medical Director/ENT Consultant	Nottingham University Hospitals NHS Trust
Clinical Lead	Stephen Clay	SJC.Clay@GP-Y00252.nhs.uk		General Practitioner	
Workstream Lead:	Donna Hakes	Donna.hakes@emscg.nhs.uk		Associate Director	East Midlands Specialised Commissioning Group
	Malcolm Qualie	Malcolm.qualie@emscg.nhs.uk		Head of Health Policy	East Midlands Specialised Commissioning Group

Derbyshire	Name	Contact
PCT 1		-
PCT 2		-
Provider 1		-
Provider 2		

Northamptonshire	Name	Contact
PCT 1		-
PCT 2		
Provider 1		-
Provider 2		-
		-

Leicestershire	Name	Contact
PCT 1		
PCT 2		
Provider 1		-
Provider 2		-
		-

Nottinghamshire	Name	Contact
PCT 1		-
PCT 2		
Provider 1		-
Provider 2		-
		-

Lincolnshire	Name	Contact
PCT 1		-
PCT 2		
Provider 1		-
Provider 2		

Other	Name	Contact

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Challenges

1. Engagement:
   - GP/PCT commissioner
   - Provider engagement
   - Patient/Public
   - Media (management)
2. Sharing best practice
3. Maintaining momentum in a period of transition
4. Releasing the money
5. Resources

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