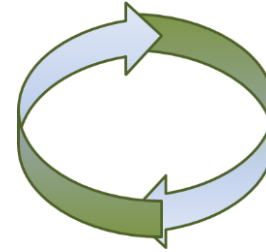




Understanding Variation – Increasing Value



□ This Session will Cover:

An Overview of the NHS in England

What is the Problem with Variation?

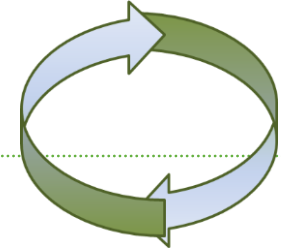
Why is it Important to respond?

The Genesis of the RightCare Programme

Good Data Delivers Change

Case Studies

An Overview of the NHS in England



Themes:

Reform(s)

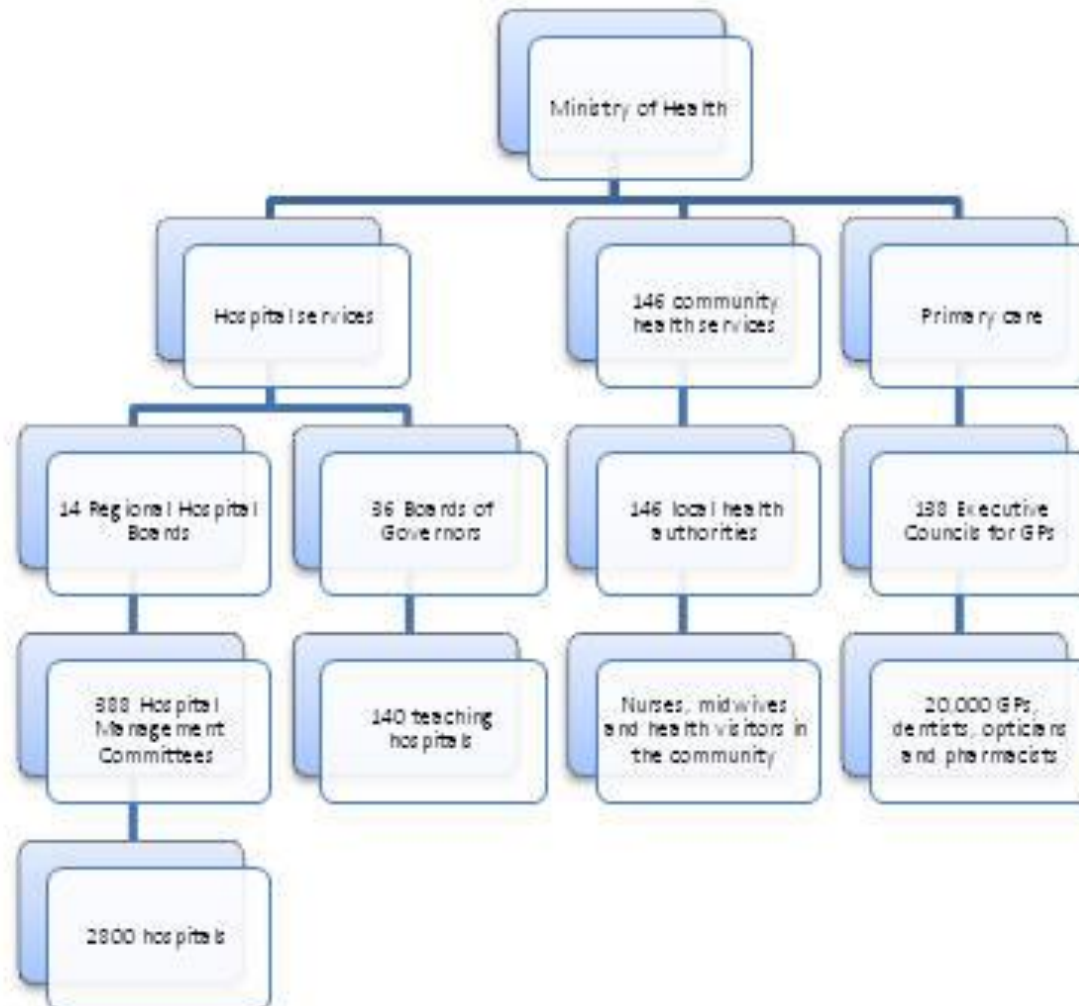
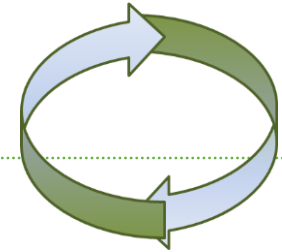
Market Principles

Evolving Structures & Static Organisations

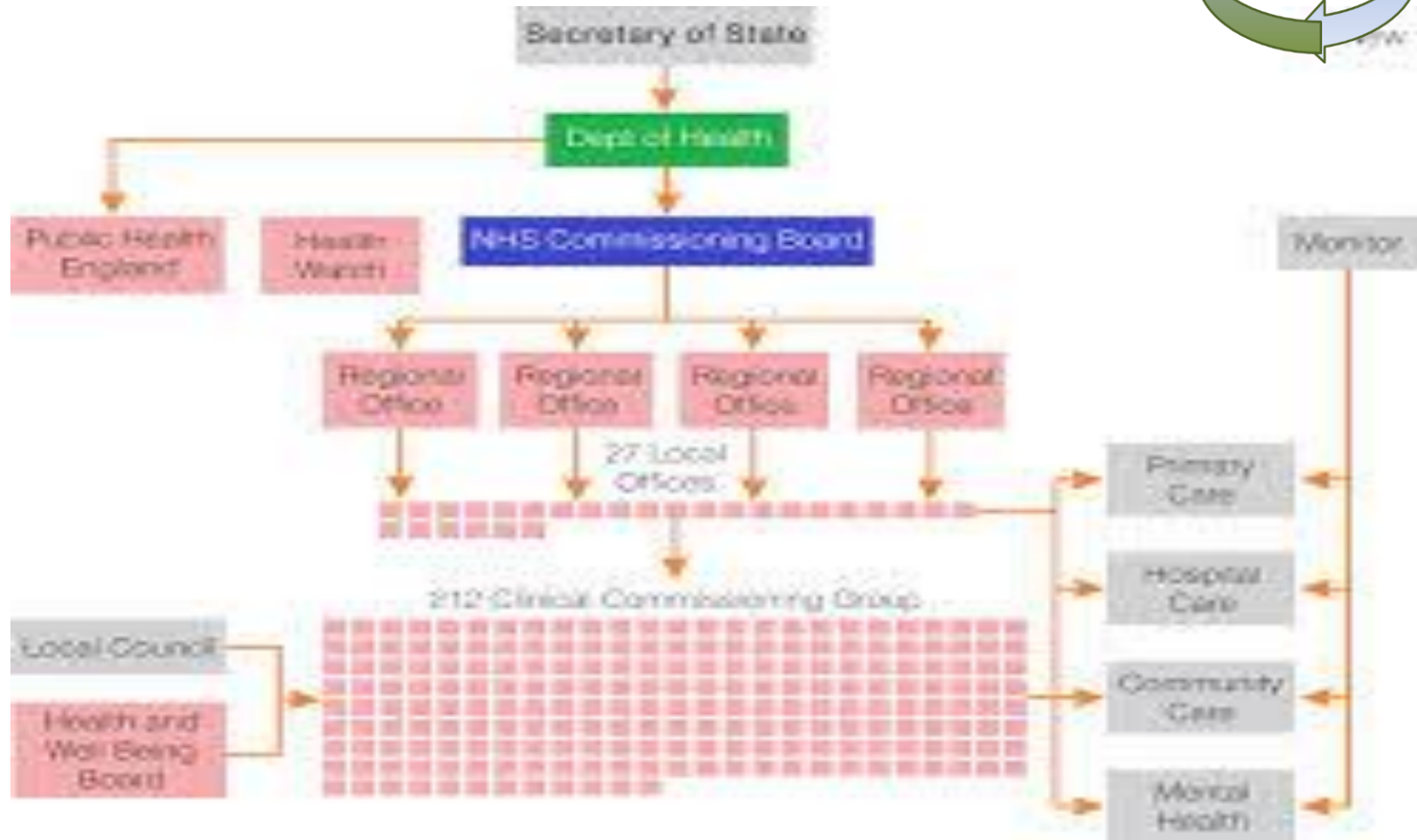
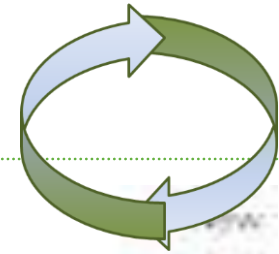
5 Key Challenges

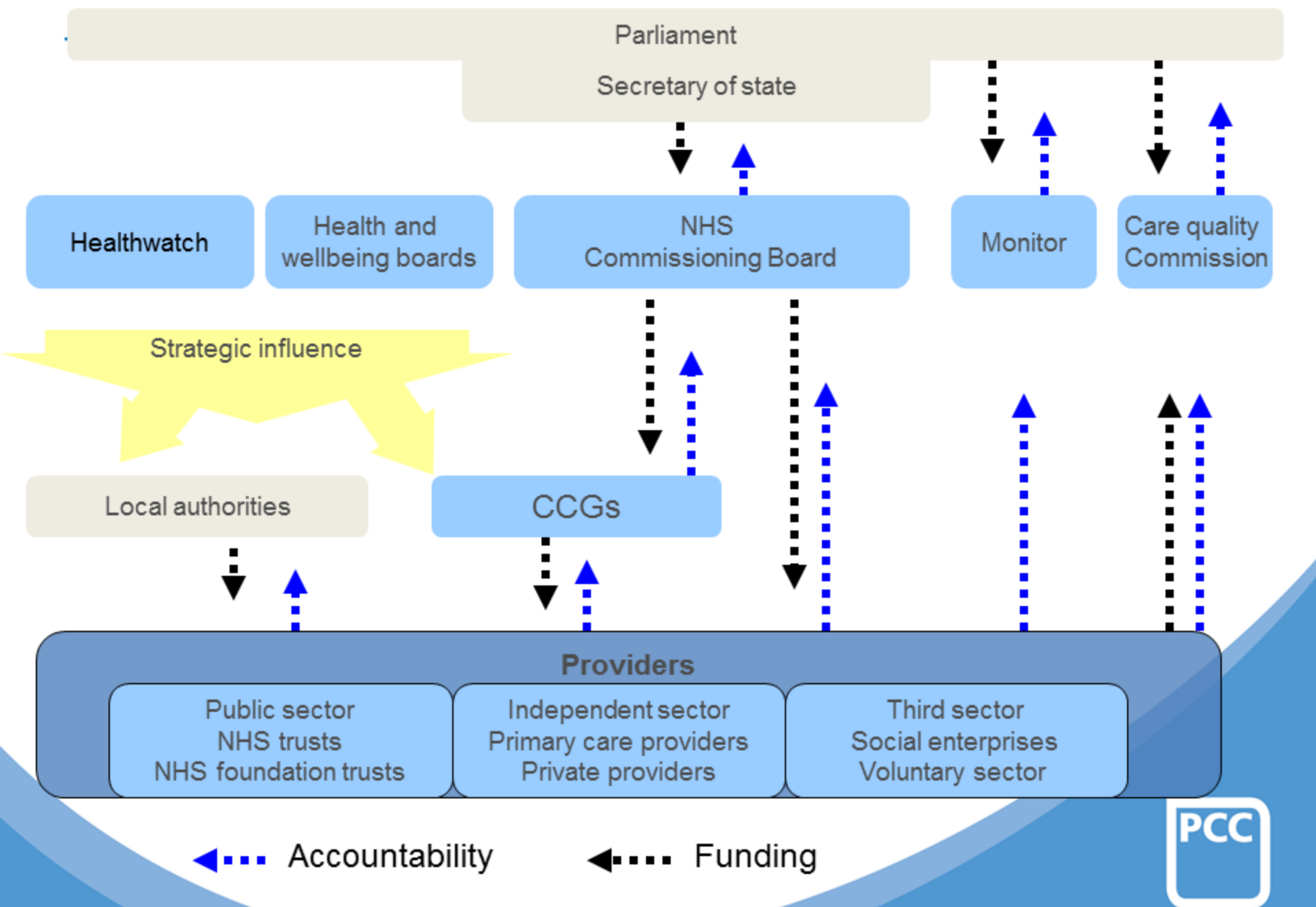
Never Forget your Patients & Population

Is it All about the Structure?

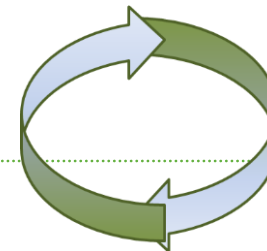


When I Last Looked.....



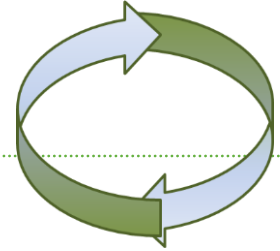


The NHS faces 5 key challenges:



- There is no new money – Tightening Budgets
- An aging population and rising demand for healthcare
- Widespread variation in healthcare in terms of quality, activity and outcomes
- A service that is “dis-integrated” with patients floating between an archipelago of care providers
- Inequity

What is the Problem with Variation?



The Curse of Variation

Who Decides the classification?

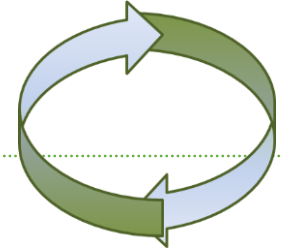
Is it really a Problem?

Is it just a Challenge for England?

Responding to the Data

Is variation only the curse of the NHS in England?

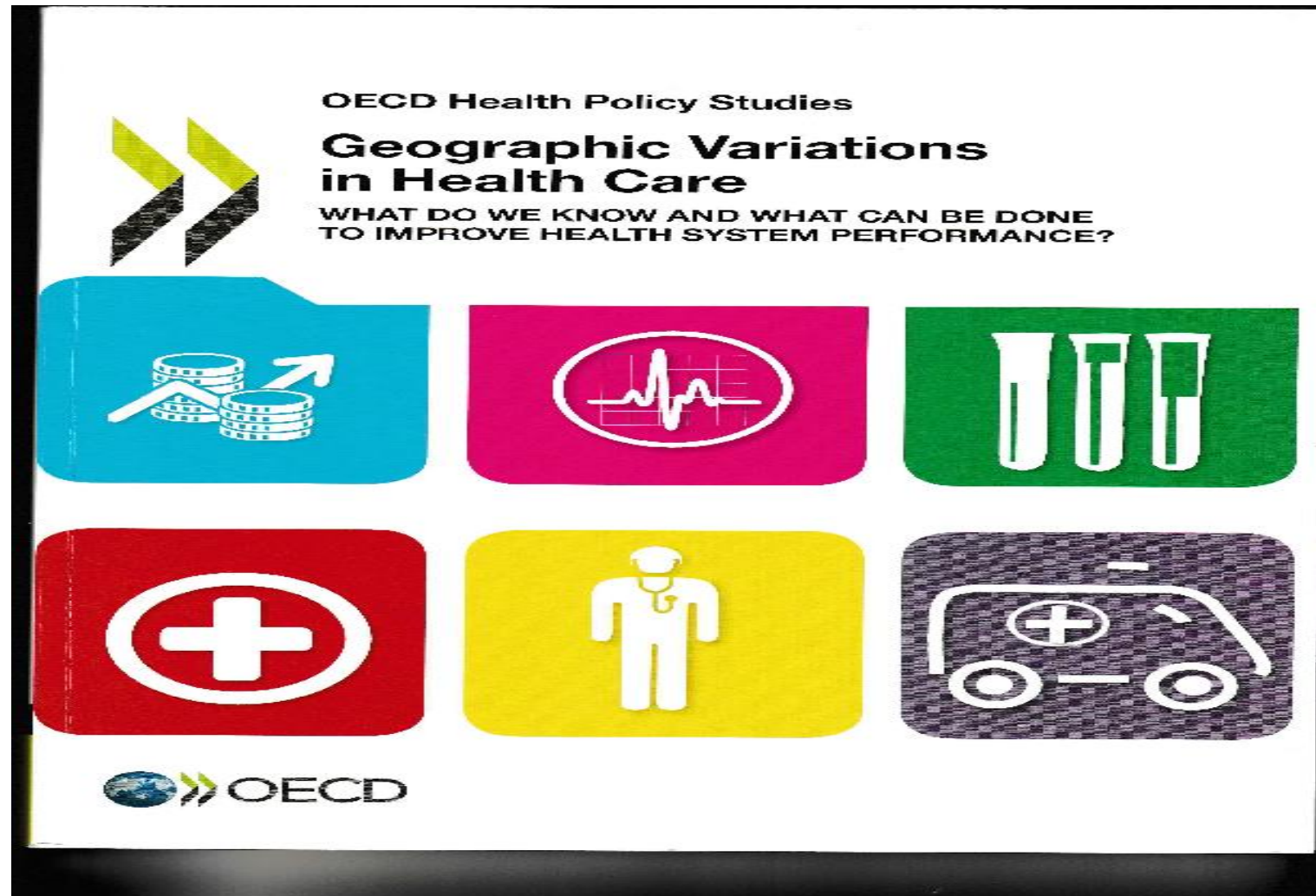


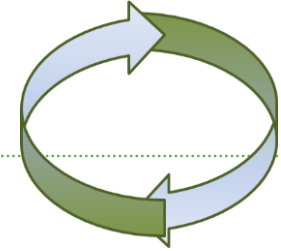


**We need to remember that not all variation is bad (Mulley 2009)
.....if it were all bad it would be easier to resolve.**

The view of variation as either being good or bad does not help.....we need to distinguish between that variation which is common cause or random and that which is unwarranted leading to a waste of resources, duplication of effort, poor quality and lower value health care.

Many countries are facing the same challenge, to identify and reduce unwarranted variation in their health care system.....

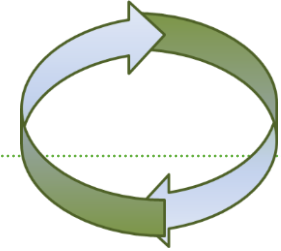




Variation is not a new phenomenon – it has been highlighted as an issue since the beginning of the NHS in 1948....

indeed it has been around since Glover's seminal paper in 1938.....

.....but it continues to puzzle policy makers, politicians, professional and our patients.



Q: Why is it important to explore variation?

A: So that we can do the right thing for the right patient at the right time

When organisations use the wrong data or don't explore variation or recognise the different types of variation the resulting decisions often tend to increase costs, reduce quality and efficiency – or value.

Now, you may be hearing...

“The data are wrong”

The data is “indicative”, they do not need to be 100% robust to indicate that improvement is needed in an area, especially where more than one indicator (triangulation) suggests the same.

“The data are old”

The data are the most recent available.

Have you done anything since to improve the pathway?

If not, the opportunity remains and, if others have improved.

“Some of the data are for PCTs”

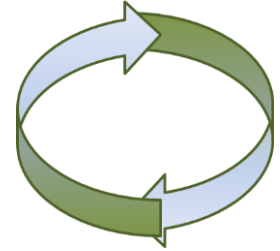
CCG data are used wherever they are available.

If you think that your CCG population is different – determine where you should be on the comparator before concluding that you need not act.

“We’ve already fixed that area”

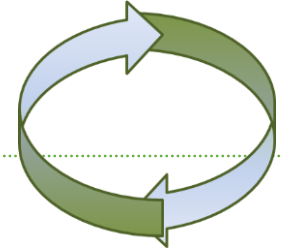
Great news!

Double-check that the reforms have worked and move on to the next priority area identified by the indicators.



The topic of variation and unwarranted variation requires better understanding and improved coordination through the application of technical, political and regulatory responses which are too important to leave to chance.

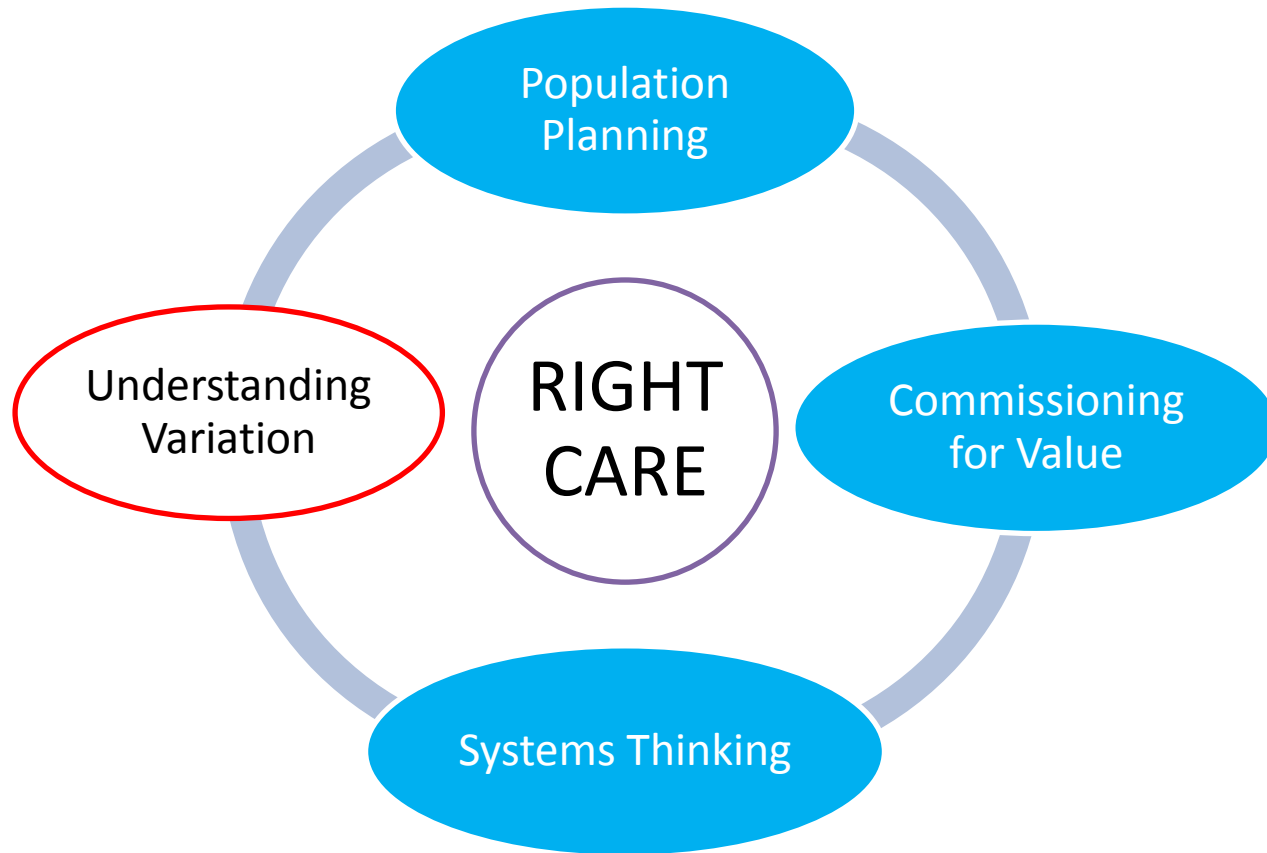
One such method of rising to that challenge is to explore and understand variation in health care and to reduce waste and duplication to increase value by eliminating unwarranted variation....only then can we begin to do the right thing for the right patient at the right time.....



An Introduction to the Right Care Initiative

- **Building the Programme team**
- **The Development of the Programme**
- **Lessons from the Atlas of Variation**
- **Atlas of Variation – Is it the only show in town?**

**NHS RIGHT CARE:
A Transformation Programme to Increase Value & Improve Outcomes**



The Four Domains of Right Care Programme

Right Care: The Road Map

Proof of Concept and Development

Awareness and Agenda Setting

Local and National uptake

Spread and adoption

Develop the approach

Developing Capacity

Population Healthcare

Un-warranted variation

Adapting to the System

2 National Atlases of Variation

6 Themed Atlases

Evolved and rolled across Y&H PHOs

Area Team CfV packs

Developing CSUs

Network/pathway based CfV packs

Variation Knowledge Service

New Atlas Programme

HIPs

Derbyshire Pilot CfV packs

211 CCG CfV packs

Learning resources

Peer-to-Peer networking

Academic Collaborative

Commissioning for Value Insights Academic underpinning

Increasing spread and adoption

Yr1

Yr2

Yr3

Yr4

Yr5

Design and
Deliver Care
through Systems
– not
organisations

Develop clinical
focus on
populations –
including
unidentified
patient need

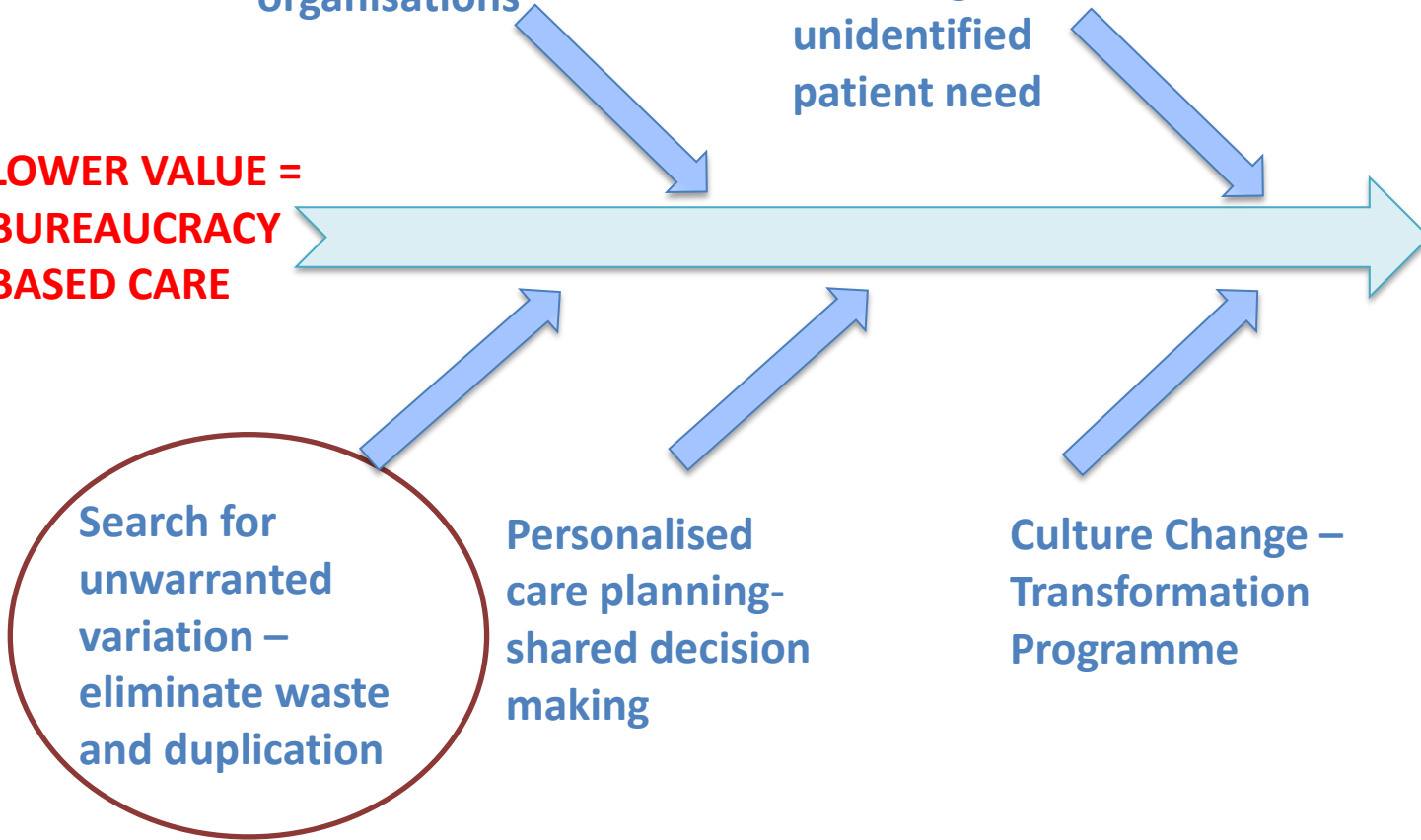
**LOWER VALUE =
BUREAUCRACY
BASED CARE**

**HIGHER VALUE
=
PERSONALISED
AND
POPULATION
BASED CARE**

Search for
unwarranted
variation –
eliminate waste
and duplication

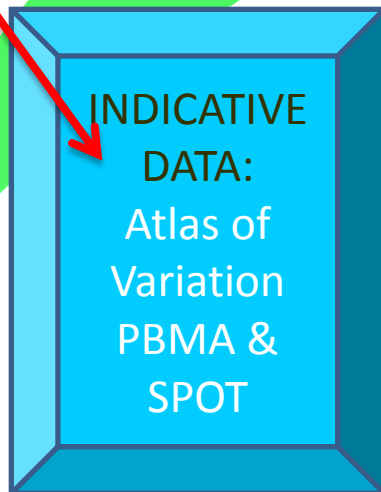
Personalised
care planning-
shared decision
making

Culture Change –
Transformation
Programme

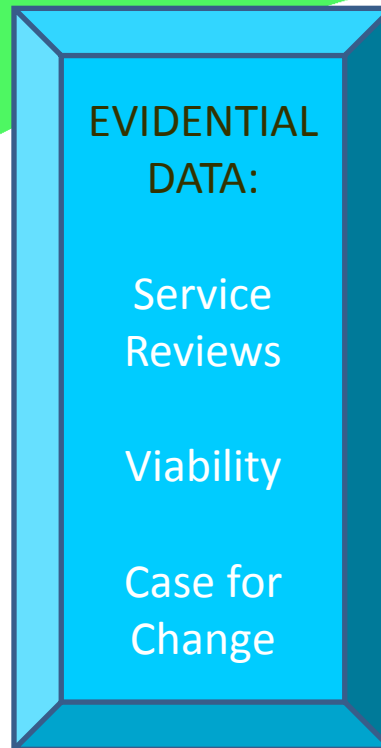


PRINCIPLES OF APPROACH

Where
to look



What to
change



How to
change



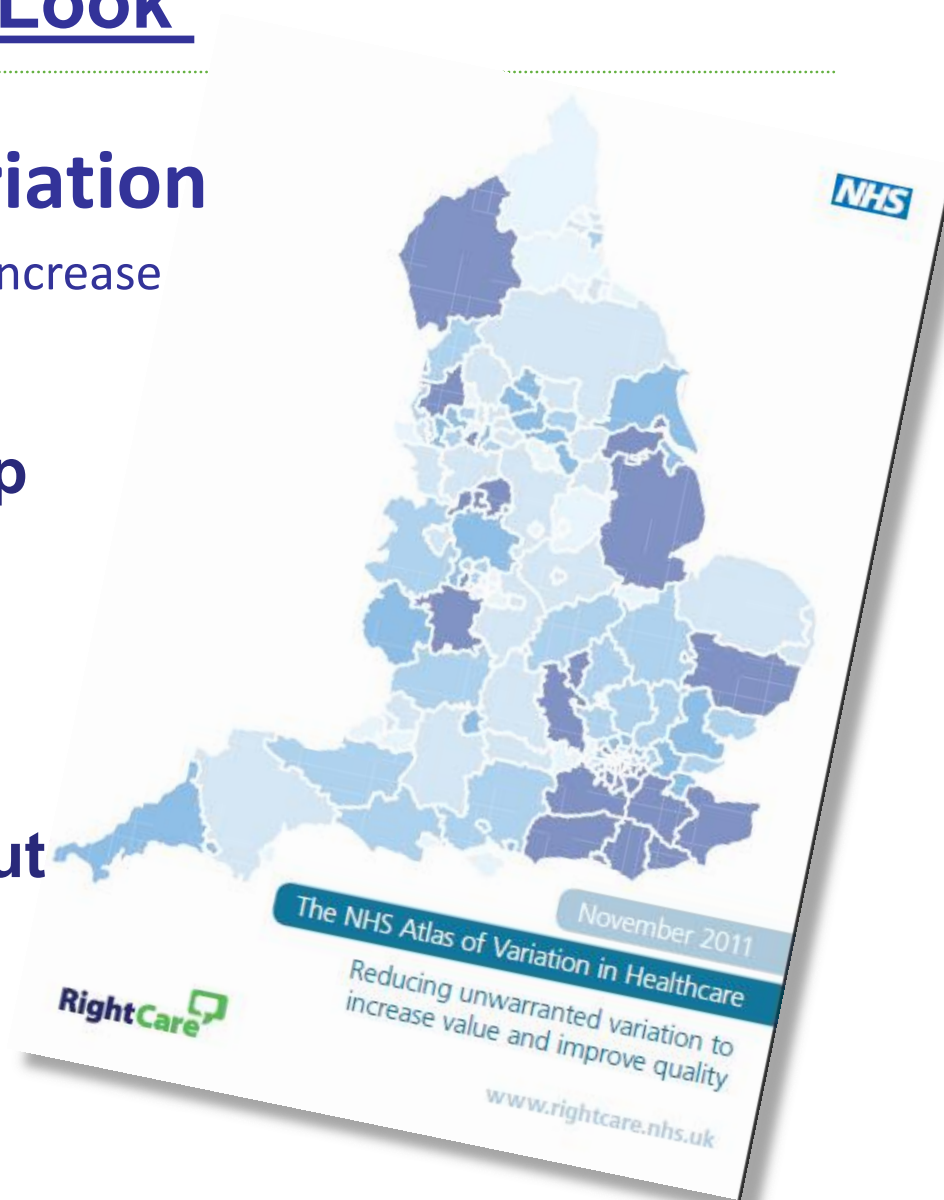
Phase One - Where to Look

The NHS Atlases of Variation

Reducing unwarranted variation to increase value and improve quality

Awareness is the first step towards value.

If the existence of clinical and financial variation is unknown, the debate about whether it is unwarranted cannot take place.

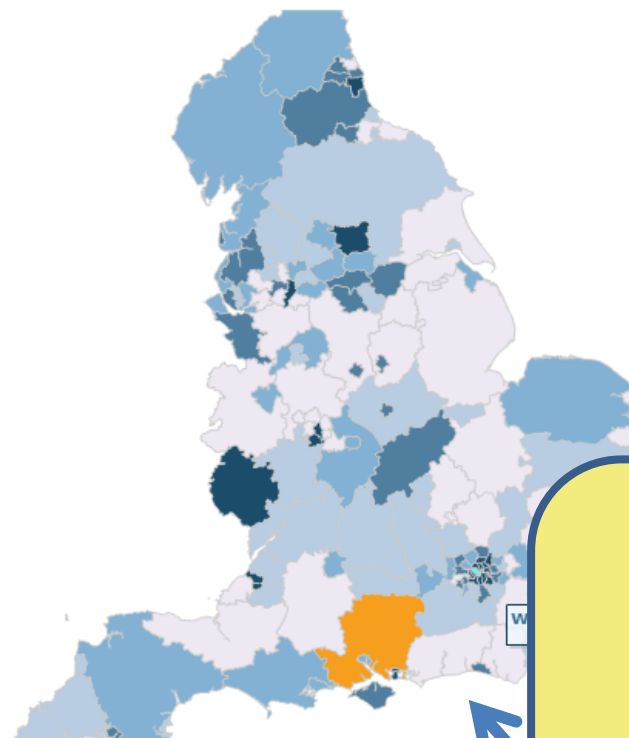


Mental Health Expenditure per 1,000 population weighted by age, sex and need,
by PCT, 2008/09

Change indicator geography

PCT indicators

- ☐ Cancer bed days
- ☐ Cancer spend
- ☐ Diabetes care
- ☐ Bariatric surgery
- ☐ Suicide mortality
- ☒ Mental health spend
- ☐ Epilepsy prevalence
- ☐ Emergency epilepsy admissions
- ☐ Elective epilepsy admissions
- ☐ Cataract admissions
- ☐ Cataract spend
- ☐ Stroke care
- ☐ TIA care
- ☐ CHD mortality
- ☐ Adult asthma admissions
- ☐ Child asthma admissions
- ☐ COPD bed days
- ☐ Musculo-skeletal spend
- ☐ Knee pre-op scores
- ☐ Knee replacement
- ☐ Hip replacement cemented
- ☐ Hip replacement uncemented
- ☐ Hip pre-op scores
- ☐ Anterior cruciate ligament surgery
- ☐ Hip fractures
- ☐ CKD prevalence
- ☐ Cesarean section spend
- ☐ Abdominal and vaginal excision of uterus
- ☐ Newborn hearing screen
- ☐ Admissions for 75+
- ☐ MRI scans
- ☐ CT scans

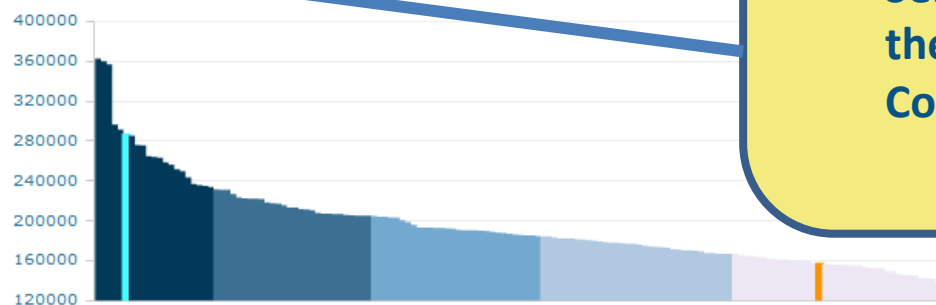
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100
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Legend

Lowest value

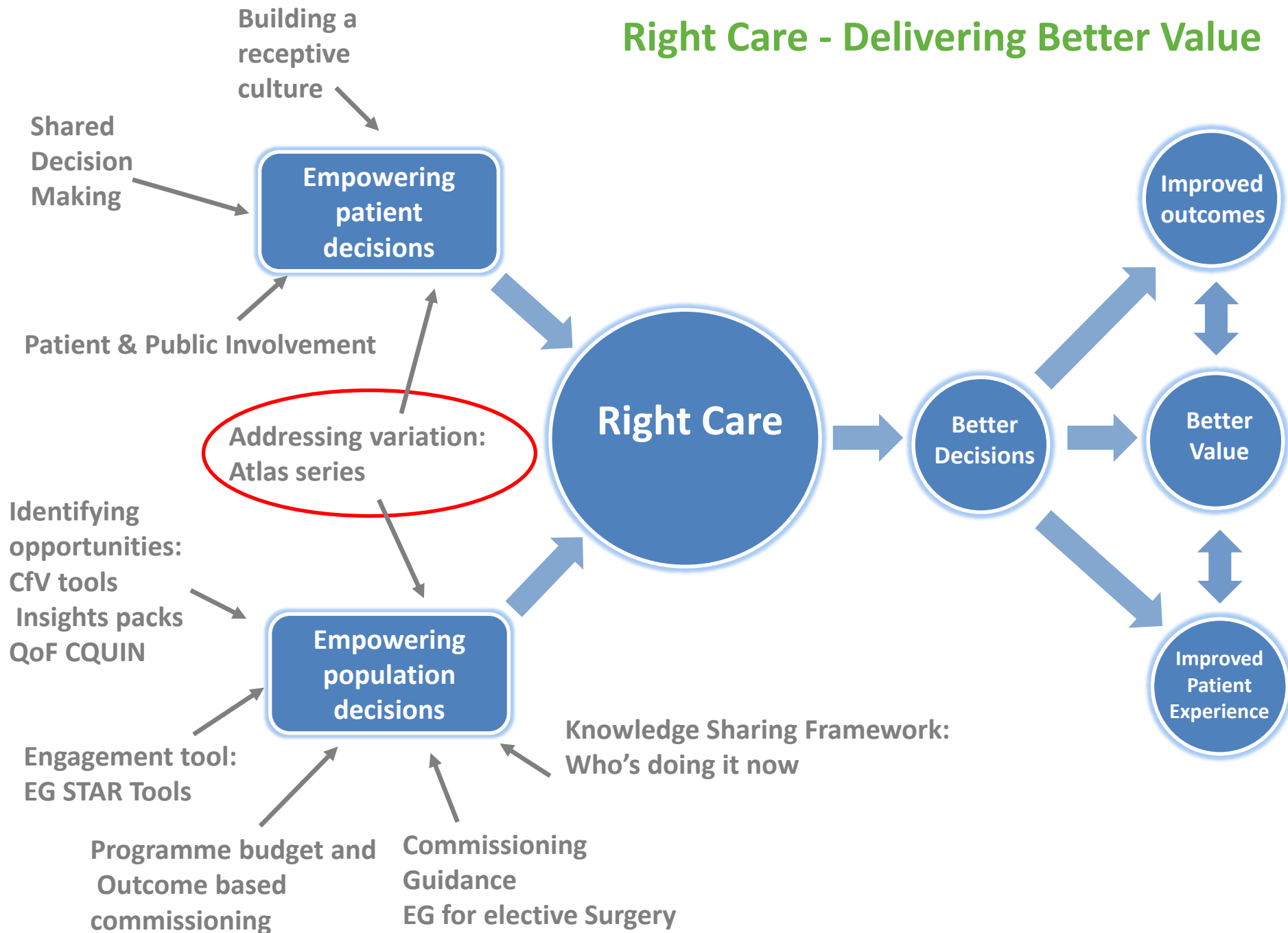
Highest value

| | Area | Value |
|---|------------------------------|---------|
| ● | Dudley | 167,019 |
| ● | Ealing | 221,108 |
| ● | East Lancashire | 172,785 |
| ● | East Riding of Yorkshire | 132,272 |
| ● | East Sussex Downs and Weald | 148,432 |
| ● | East and North Hertfordshire | 155,469 |

First Atlas 2010
**34 maps of variation 11
disease areas**
**Series now covers 7
themed Atlases & 3
Compendium (2015)**


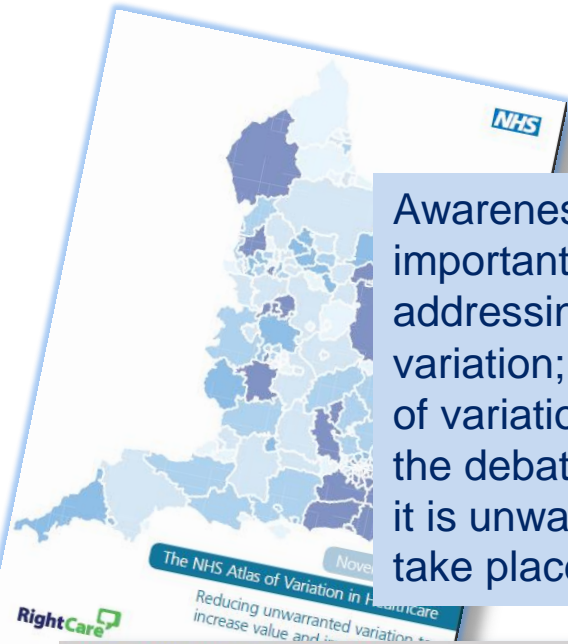
| | | |
|---|------------------------------|---------|
| ● | East Lancashire | 172,785 |
| ● | East Riding of Yorkshire | 132,272 |
| ● | East Sussex Downs and Weald | 148,432 |
| ● | East and North Hertfordshire | 155,469 |
| ● | Dudley | 167,019 |
| ● | Ealing | 221,108 |
| ● | Hounslow | 154,970 |
| ● | Hull | 176,639 |

Right Care - Delivering Better Value



Useful Tools to Help....

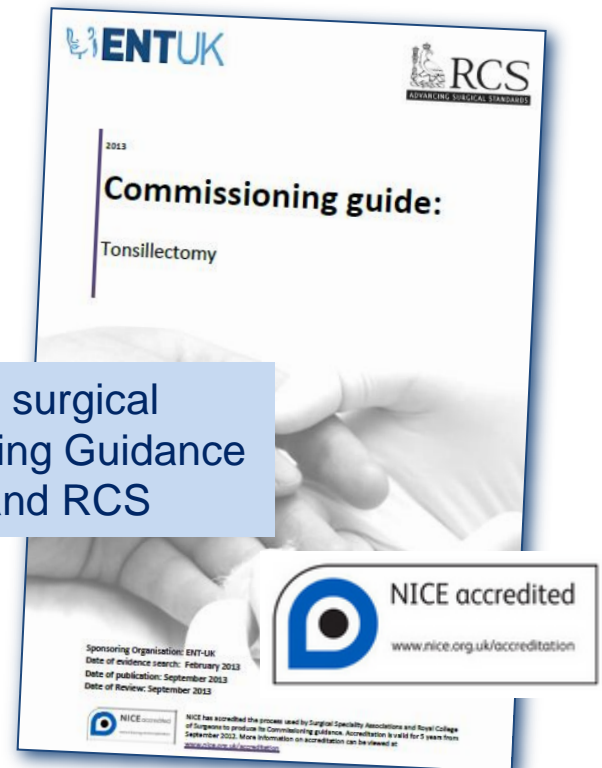
Awareness is the first important step in addressing unwarranted variation; if the existence of variation is unknown, the debate about whether it is unwarranted cannot take place.



Shared Decision Making:
36 PDAs



211 CfV packs &
Pathways on a Page



27 pieces of surgical
commissioning Guidance
with FSSA and RCS

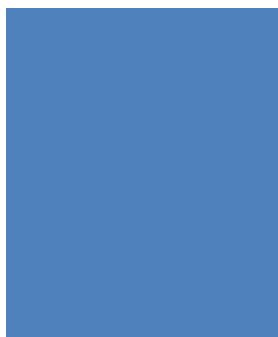
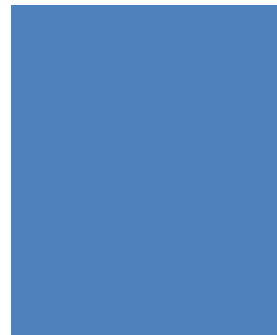


Public Health
England

RightCare

NHS
England

10 ways to use your CfV packs




THE NHS
CONSTITUTION
the NHS belongs to us all

Where West Cheshire are now (and where Bradford could be)



Public Health
England

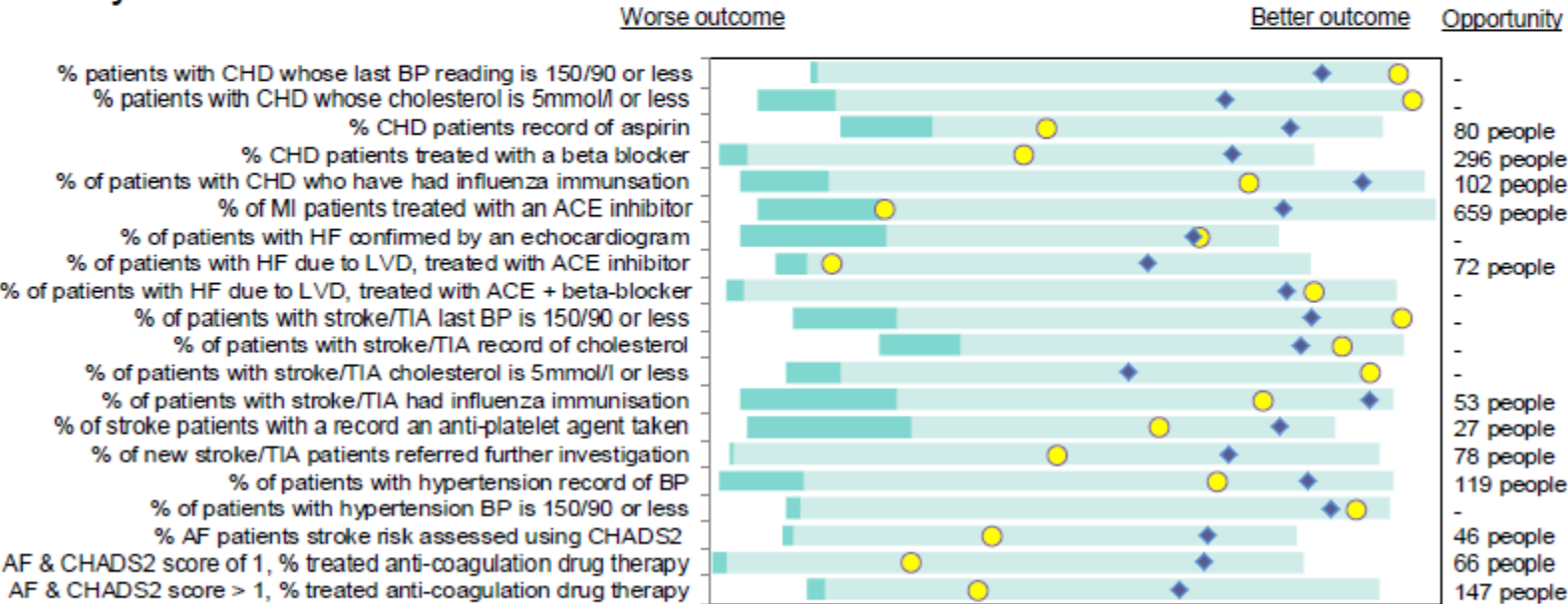
Annex 1: spine charts

KEY: ● CCG value

◆ Benchmark



Primary care



* (p) = PCT based indicator

For data sources used, see slide 23

Where Bradford are now (and where West Cheshire were)...



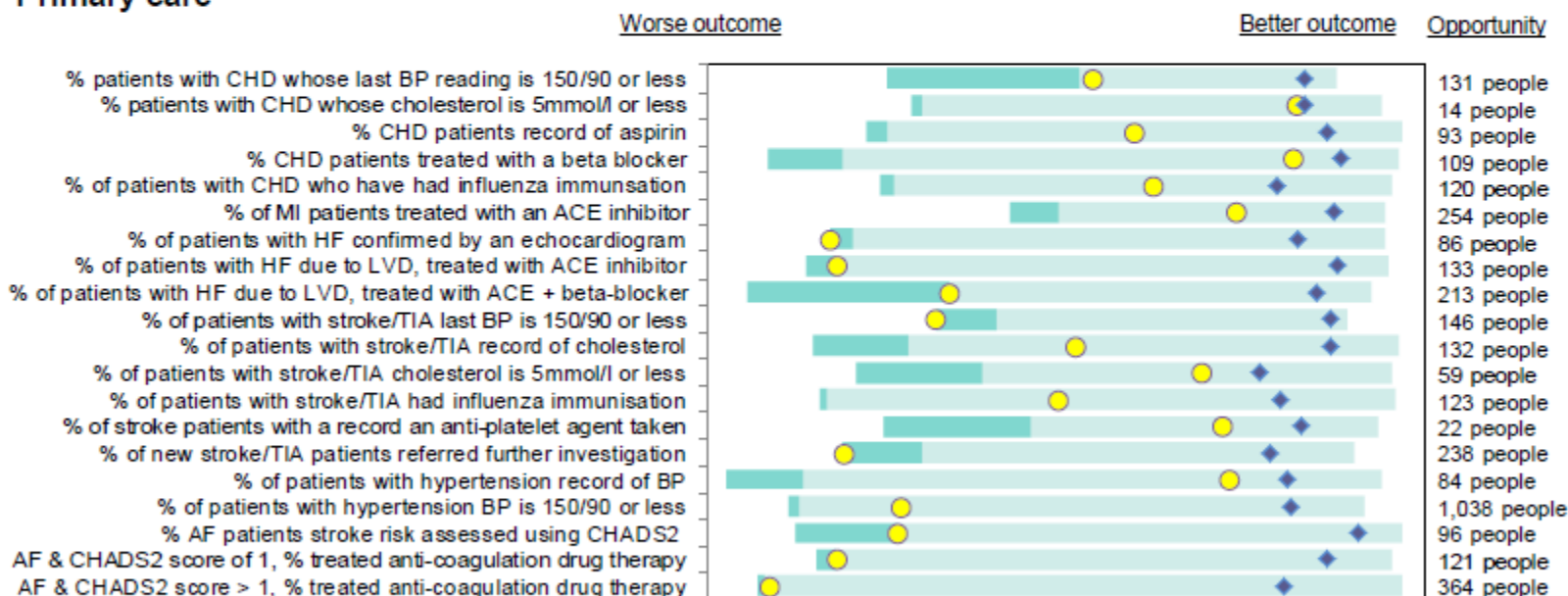
Public Health
England

Annex 1: spine charts

KEY: ● CCG value ◆ Benchmark



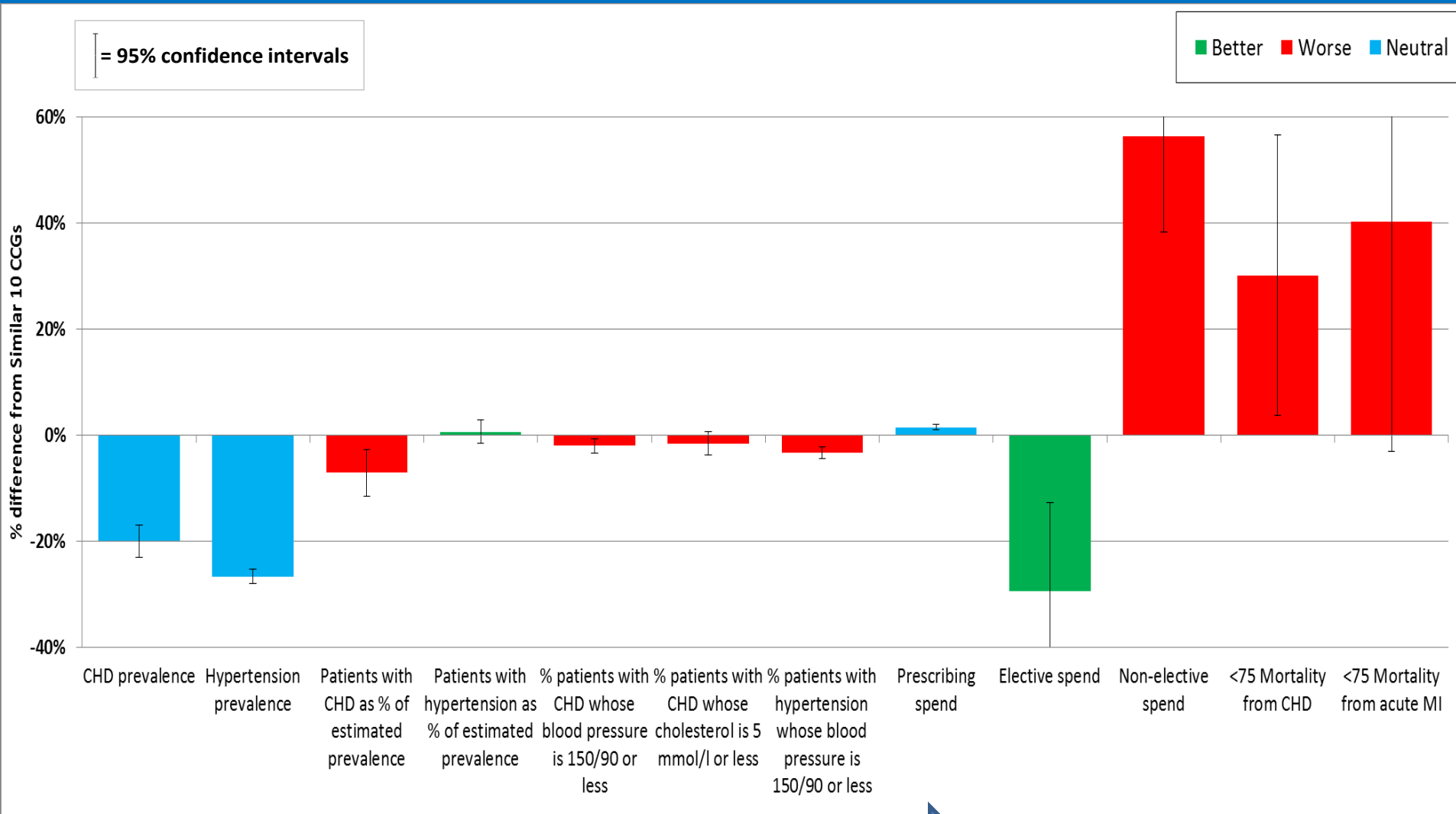
Primary care



* (p) = PCT based indicator

For data sources used, see slide 23

Heart disease pathway



Initial contact to end of treatment

CASE STUDY 1: Plan to Delivery

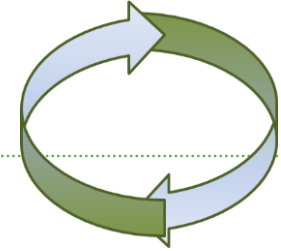
The data was showing.. as highlighted in the Indicative data (NHSE Commissioning for Value pack, October 2013) that the top opportunity for Hardwick CCG was Respiratory Care.

a predominately deprived area with a 102,000 population

a CCG with high prevalence of chronic obstructive pulmonary disease.... with many individuals un-diagnosed

A lower than average number of patients correctly diagnosed with COPD

AND the respiratory pathway was dependant upon hospital care with too many patients admitted for urgent and unplanned care leading to a longer length of stay and higher number of readmission rates



The indicative data revealed that if NHS Hardwick could deliver respiratory care that was 'at least equivalent to the national average' then circa £884,000 of resources could be released for investment in higher value health care.....

DESCRIBE THE NEW MODEL HERE

**INCREASING
VALUE**



POPULATION FOCUS

REFERRED PATIENTS

MOST IN NEED

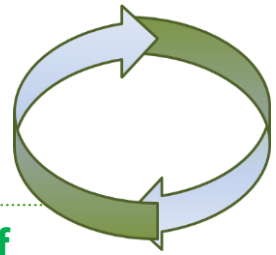
**MOST SEEN &
NOT KNOWN**



The Situation we found

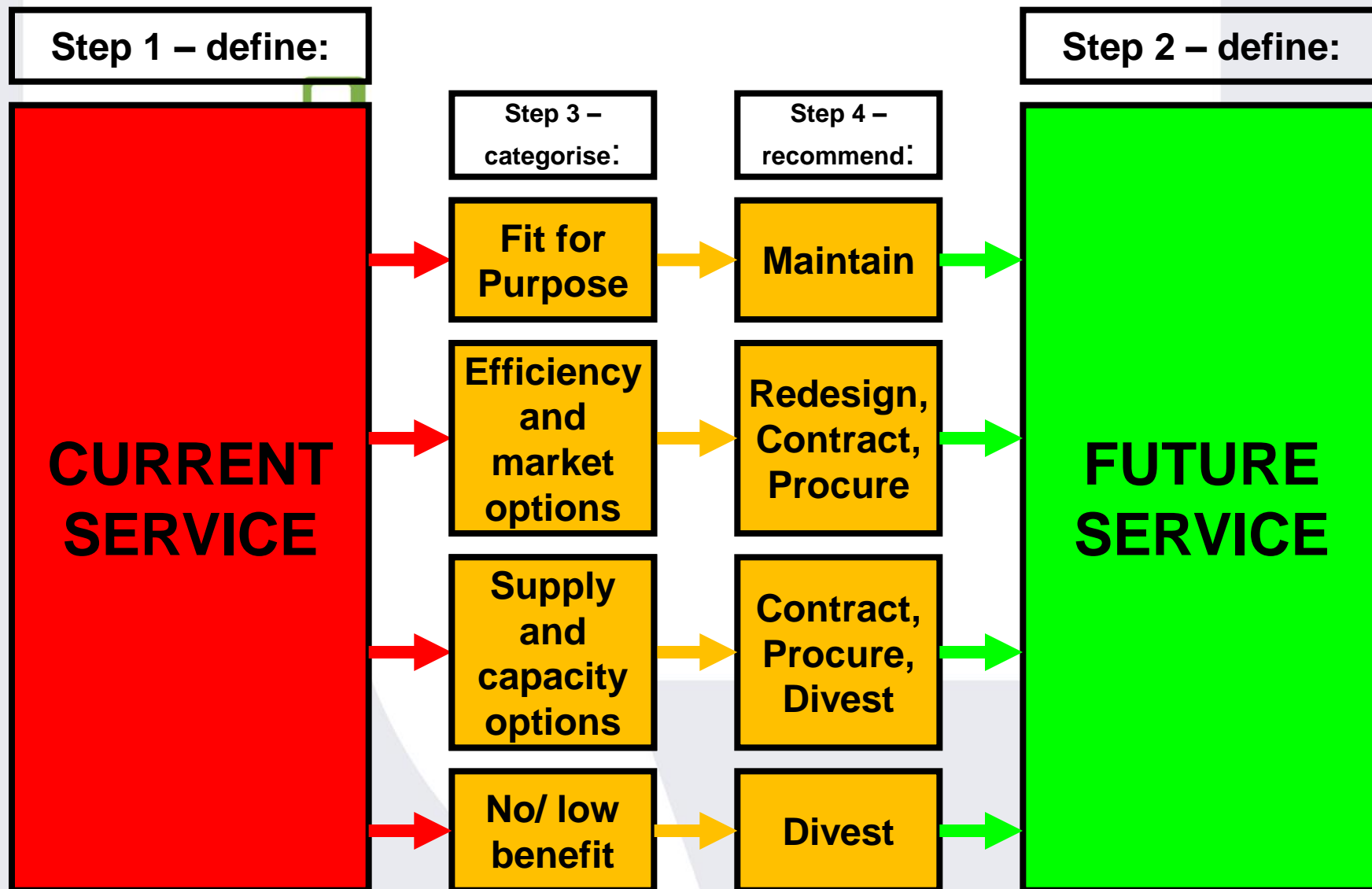


RightCare Principles



- Patient as passive complier
 - Focus on treatment
 - Short term aim to improve quality
 - Good care for known patients
 - Hospital as the focus
 - Plans driven by finance
 - Challenges met by waiting for growth
- ✓ Citizen as co-producer of wellbeing
 - ✓ Focus on prevention, care & reducing harm
 - ✓ Reduce unwarranted variation and increase value
 - ✓ Equitable care for populations
 - ✓ Focus on systems
 - ✓ Driven by knowledge
 - ✓ Challenges met by transformation, releasing resources to invest in higher value health care.

Service Review Pathway – Diagnostic steps



CASE STUDY 1: Plan to Delivery in 7 months –

- **Now implementing –**
 - Agreed and specified COPD pathway
 - Enhanced nebulisers service in primary care
 - Primary care COPD audit and support service to implement findings practice by practice
 - Improved promotion of self-management
 - Improved self-management support
 - Enhanced organisation of Breathe Easy Groups (with British Lung Foundation)
- **Delivered (so far – only just begun) –**
 - 30% reduction in emergency admissions