Don't forget to join in the conversations on twitter
Tweet us at **#quality2019**

E5 #qfe5

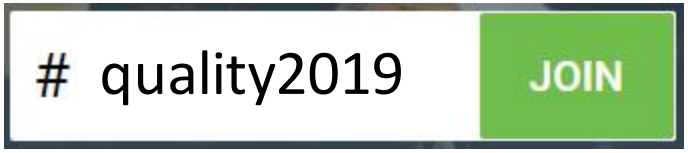
Institute *for* Healthcare Improvement

BMJ

How to Create a Better Value Healthcare System at a National Level

sli.do

www.sli.do



Today's room is…

Carron

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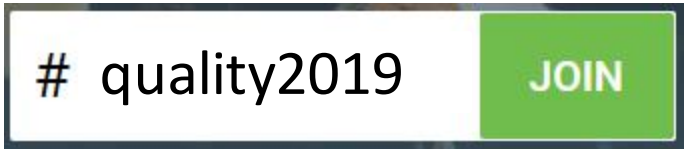

Do you know the people at your table?

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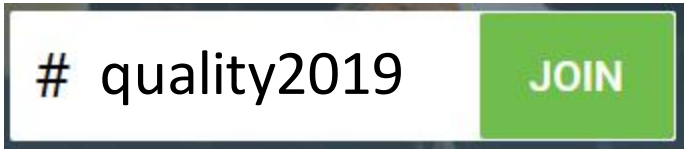


Do you think your healthcare systems assesses value of what it does?

Dr Gregor Smith

Deputy Chief Medical Officer for Scotland

@DrGregorSmith

REALISTIC MEDICINE

A story about sore knees….

What is ‘Realistic Medicine’?

healthier scotland
SCOTTISH GOVERNMENT

Scottish Government
Riaghaltas na h-Alba
gov.scot

REALISTIC MEDICINE

As healthcare professionals we must:

Listen to our patients - find out what matters most to them - and help them make an informed choice;

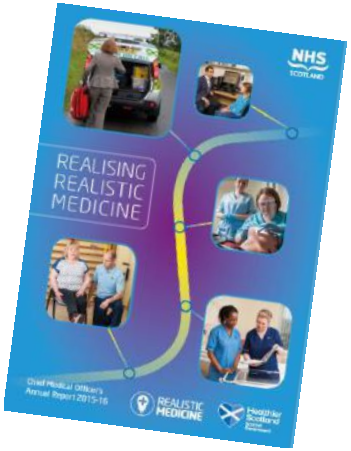
Address over-treatment (not just under-treatment)

Challenge variation in clinical practice; and

Offer higher value care

REALISTIC MEDICINE

- **As part of the National Clinical Strategy work-stream a Realistic Medicine team will be established** within Scottish Government. This will ensure the correct policy and operational environment at a national level so the numerous examples of local Realistic Medicine practice can thrive.
- **The Scottish Health Council and the ALLIANCE will explore with Scottish people what Realistic Medicine means** to them during 2017, and how best it can be co-produced.
- **The national health literacy plan 'Making it Easy' will support Realistic Medicine** by helping everyone in Scotland to have the confidence, knowledge, understanding and skills to live well with any condition they have.
- **The consent process for people we care for and support in Scotland will be reviewed** by the Scottish Government, General Medical Council and the Academy of Medical Royal Colleges to update advice to clinicians following the Montgomery Supreme Court judgement.



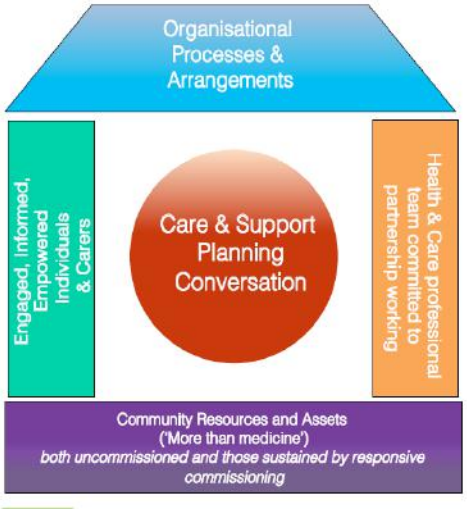
- **The Professionalism and Excellence in Medicine Action Plan will be refreshed** aligning and prioritising high impact actions that will support clinicians with Realistic Medicine.
- **A Scottish Atlas of Variation will be published and a collaborative training programme for clinicians initiated** to create better understanding and aid identification of unwarranted variation and promote high value care.
- **A single national formulary will be developed** to help achieve more equitable, greater value-based care so that the potential population benefit from medicines use can be maximised.
- **The principles of Realistic Medicine will be incorporated as a core component of lifelong learning in medical education**; in undergraduate and specialty training programmes and through continuing professional development.

The Scottish Government

It's about:

Good communication

Asking the right questions



Citizen's Panel and Jury

REALISTIC MEDICINE

healthier scotland
SCOTTISH GOVERNMENT

REALISTIC MEDICINE

citizens' jury
a new direction

"What should shared decision-making look like and what needs to be done for this to happen?"

Asking the Right Questions Matters

To help ensure you have all the information you need to make the right decisions about your care, please ask your doctor or nurse:

- Is this test, treatment or procedure really needed?
- What are the potential benefits and risks?
- What are the possible side effects?
- Are there simpler, safer or alternative treatment options?
- What would happen if I did nothing?

ChoosingWisely UK

REALISTIC MEDICINE

Healthier Scotland

High quality care that isn’t appropriate **is** still **low value care**

REALISTIC MEDICINE

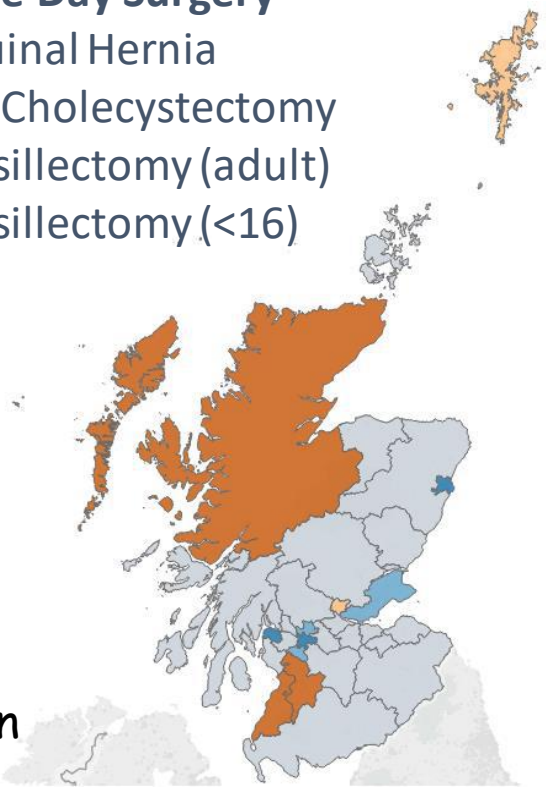
Scottish Atlas of Healthcare Variation

https://www.isdscotland.org/Products-and-Services/Scottish-Atlas-of-Variation/

Surgical Procedures
- Hip replacement
- Knee replacement
- Cataracts >65
- Cholecystectomy
- Hernia
- Tonsillectomy

Same Day Surgery
- Inguinal Hernia
- Lap Cholecystectomy
- Tonsillectomy (adult)
- Tonsillectomy (<16)

Prescribing
- Heart Failure
- Statins 45+
- Stroke
- Triple Whammy 65+



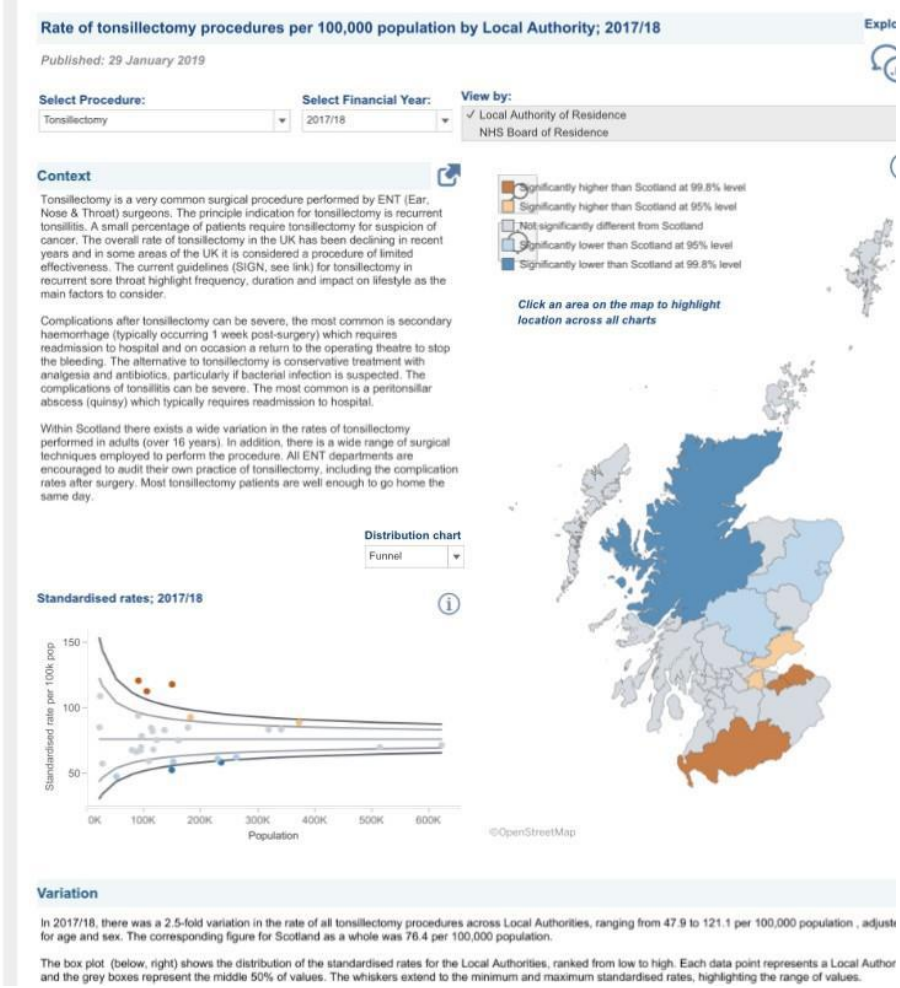
"This is excellent. I would be happy to help with any future development to look at provision for cardiovascular disease in Scotland."

"Great start - hope it expands to a wider range of indicators."

"Very interesting to explore the reasons that sit behind the variations - good to have the numbers to support opening those discussions."

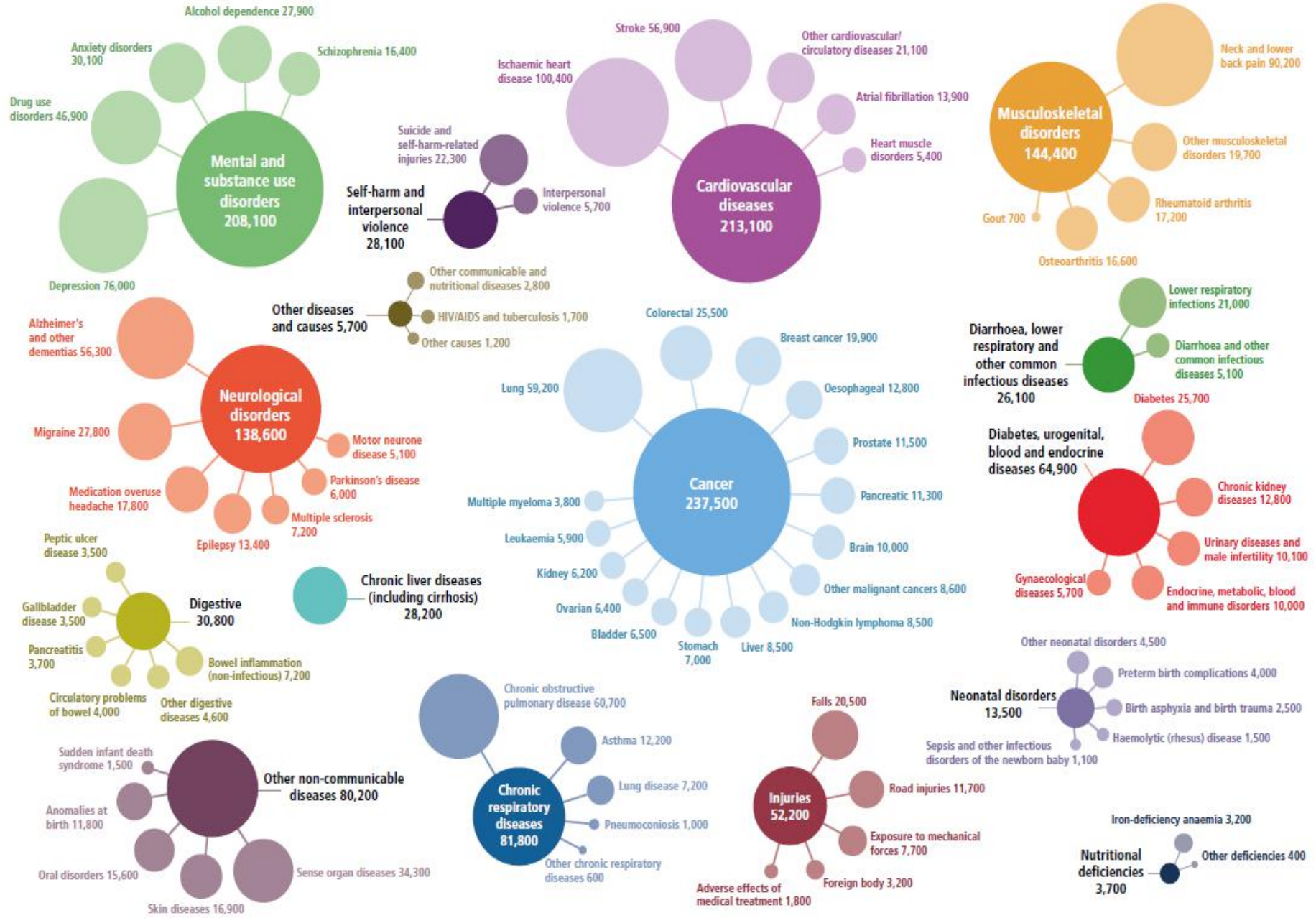
Scottish Atlas of Healthcare Variation

https://www.isdscotland.org/Products-and-Services/Scottish-Atlas-of-Variation/



- Tonsillectomy – 2.5 fold variation in use across Scotland
- Deliberation within clinical community about reasons
- Identification of drivers of unwarranted variation
- Consensus statement

Burden of disease in Scotland, 2015



Note: Disability-adjusted life years rounded to the nearest 100. • Scottish burden of disease study • www.scotpho.org.uk/comparative-health/burden-of-disease/overview

Keeping in touch or Questions

cmo@gov.scot

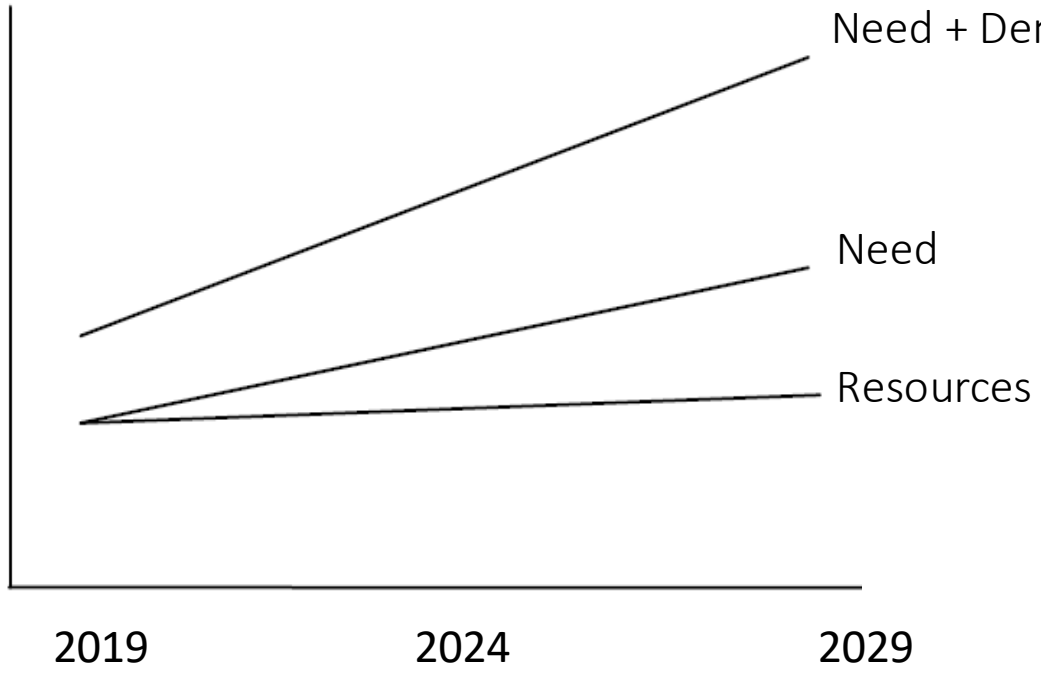
@DrGregorSmith

REALISTIC MEDICINE

Muir Gray

Director
Better Healthcare; England

If we do nothing, need and demand will increase by about 20% in the next decade and resources will not



…Resources:

- workforce
- leadership bandwidth
- carbon
- capacity to change
- money

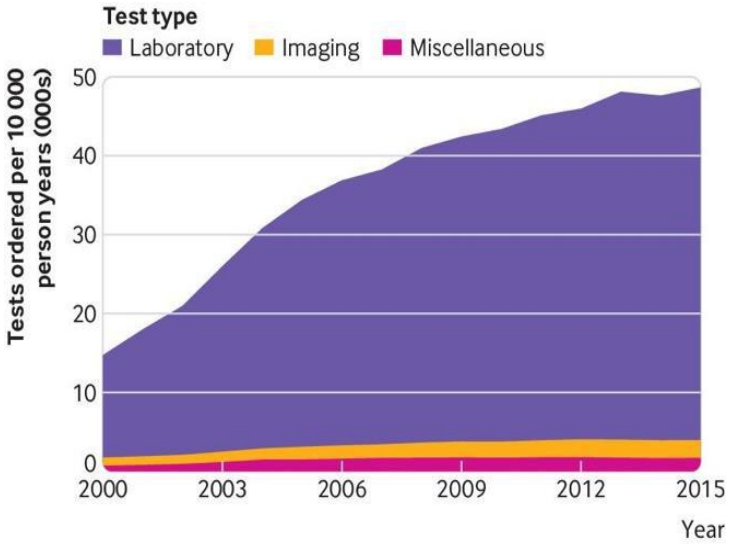
All of these are finite

There are three main causes for the increase in need and demand

1. Population ageing

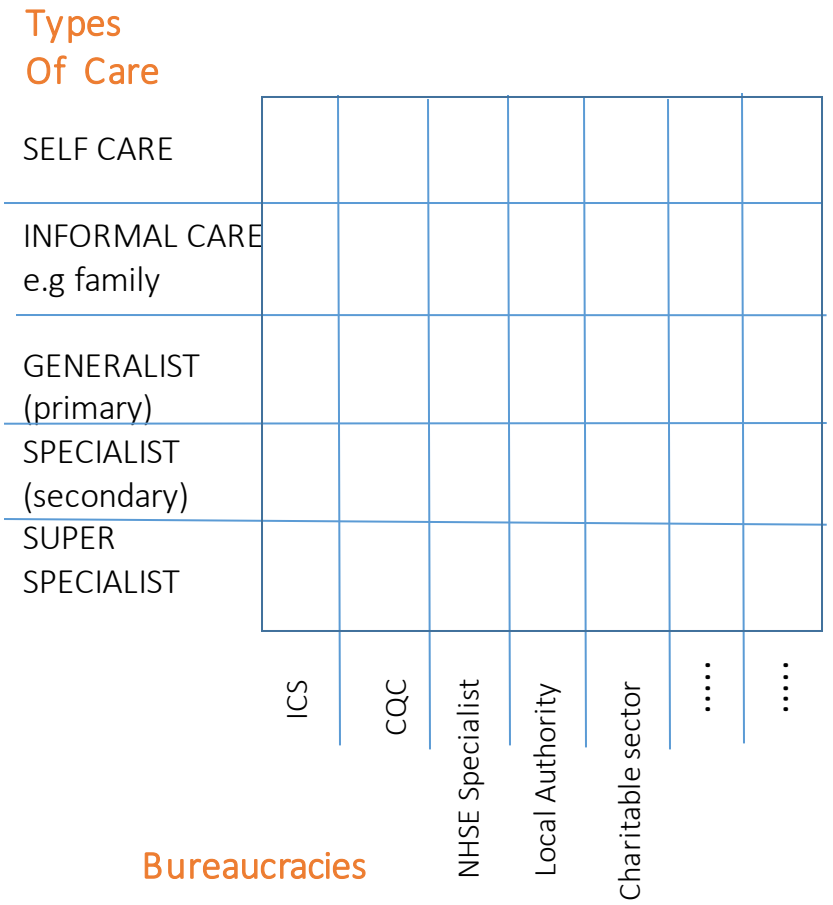
2. Development of new expensive but effective interventions

3. The ‘increasing volume and intensity of clinical practice’



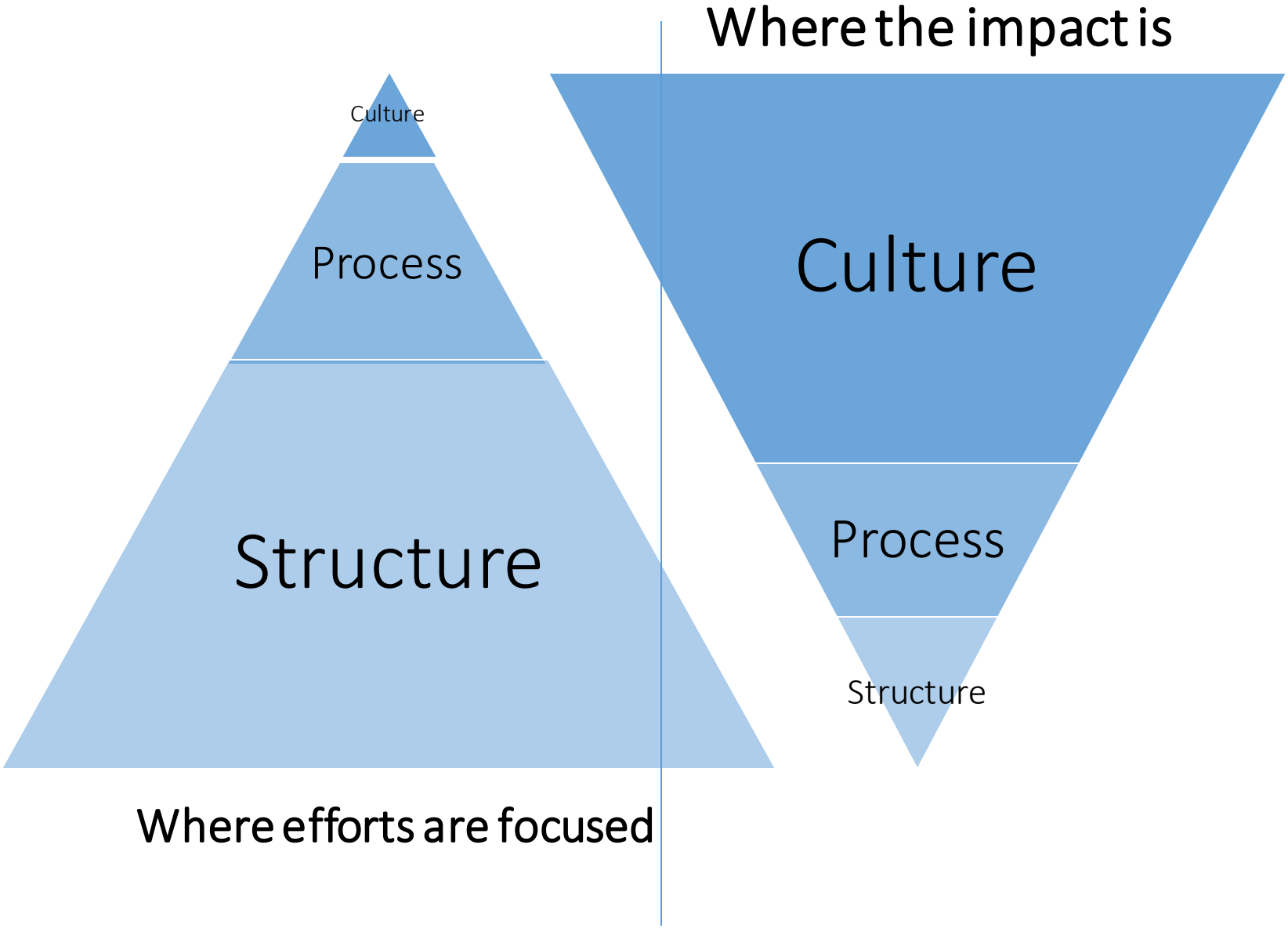
But they exist in the culture of 2D Healthcare

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



The Aim is **triple value**

- Personal value, determined by how well the outcome relates to the values of each individual and, from the population's perspective, two different types of value
- Population value , determined by how well the assets are allocated to different sub groups in the population
- Technical value , determined by how well resources are used for all the people in need in the population


Where the impact is
Culture
Process
Structure
Culture
Process
Structure
Where efforts are focused

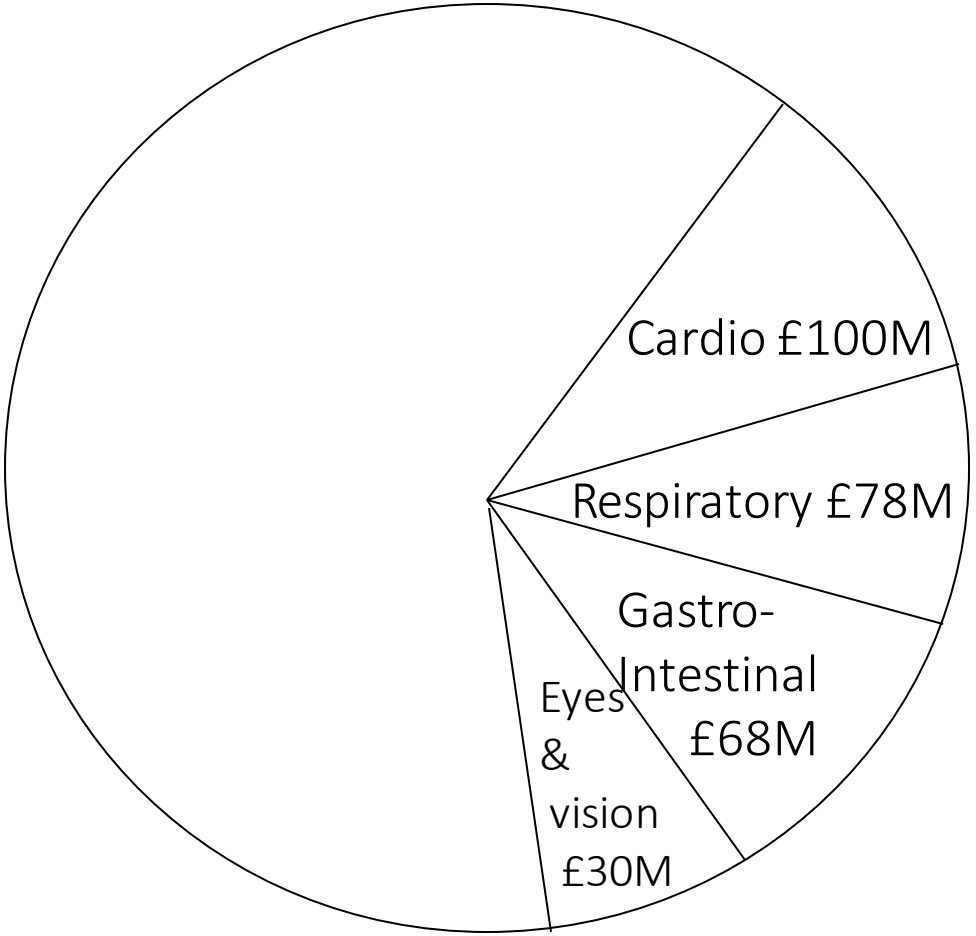
INCREASING VALUE FOR POPULATIONS AND INDIVIDUALS IS BY

- 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 delivered by networks
- CREATE THE CULTURE OF STEWARDSHIP

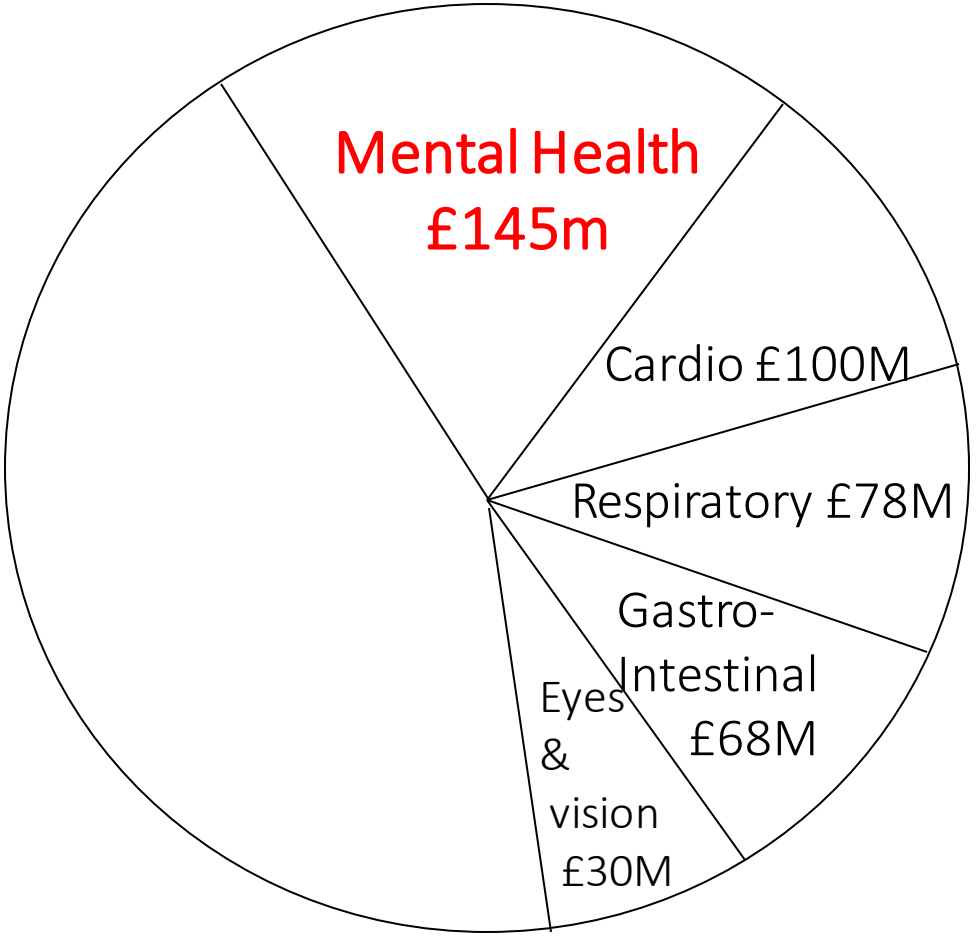
- Is the service for people with epilepsy better in Wien than the service in Milano?
- Which network for frail elderly people in London, Barcelona or Rotterdam provides the best value?
- Do women with pelvic pain getter better value care in Stockholm or Madrid or Berlin?
- Do people with asthma getter better value care in Leuven or Paris or London?

ALLOCATE RESOURCES OPTIMALLY

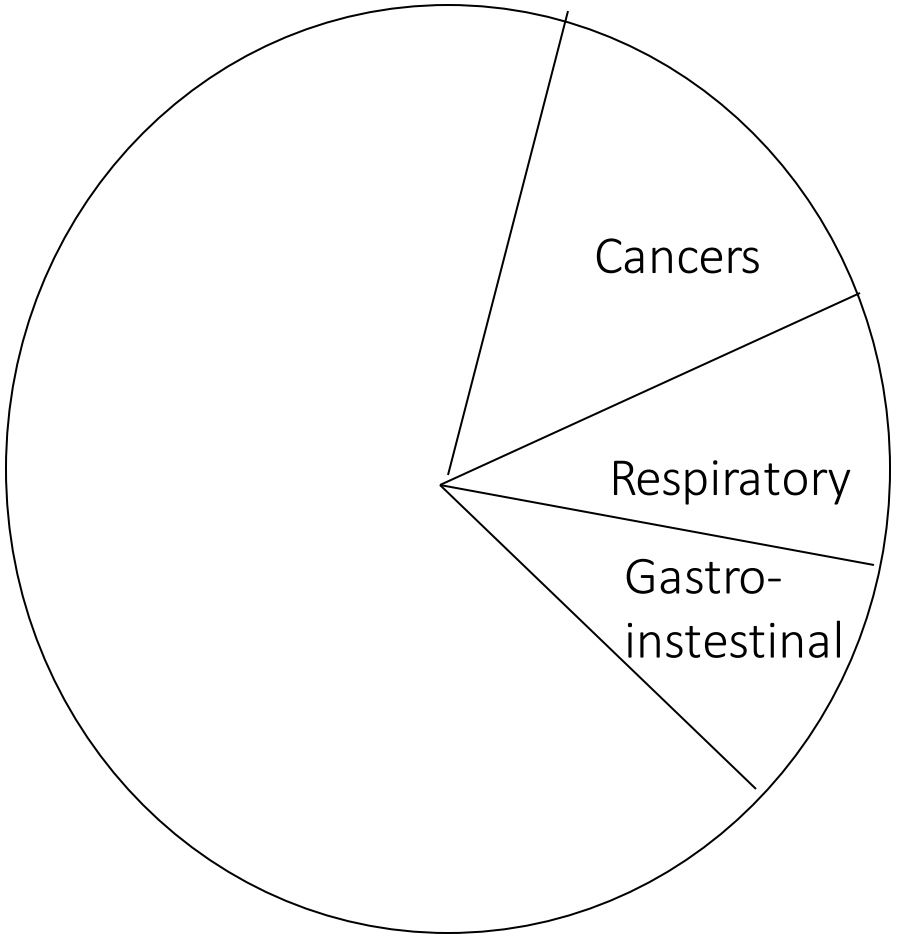
This might be a typical spend per annum for a geography. How much for mental health?

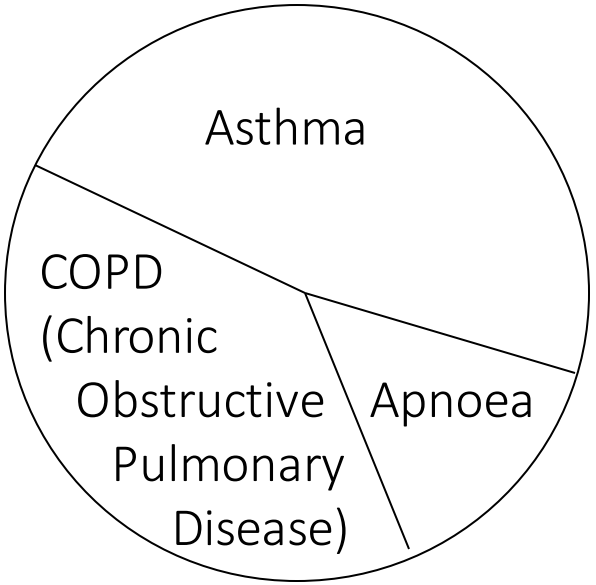


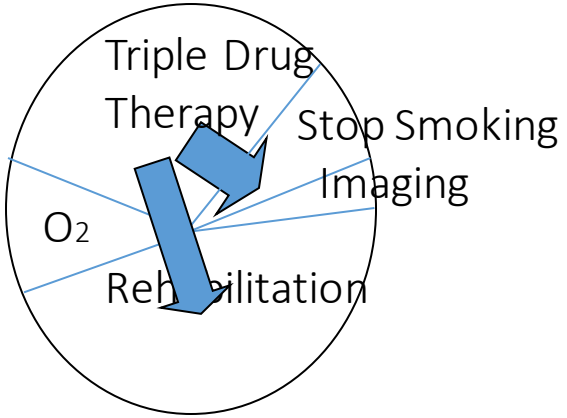
Who is responsible for allocative efficiency?



Who makes these decisions?

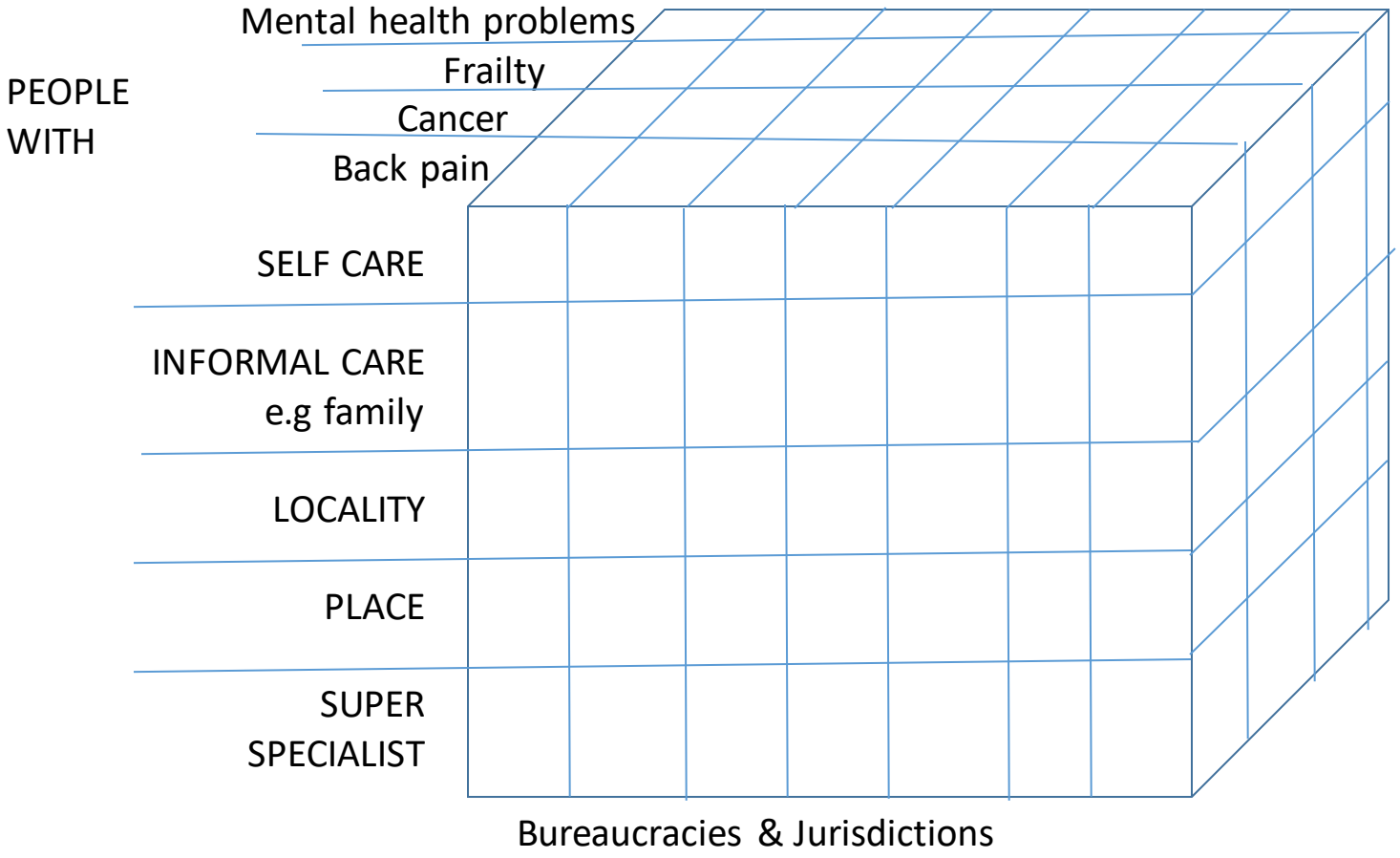




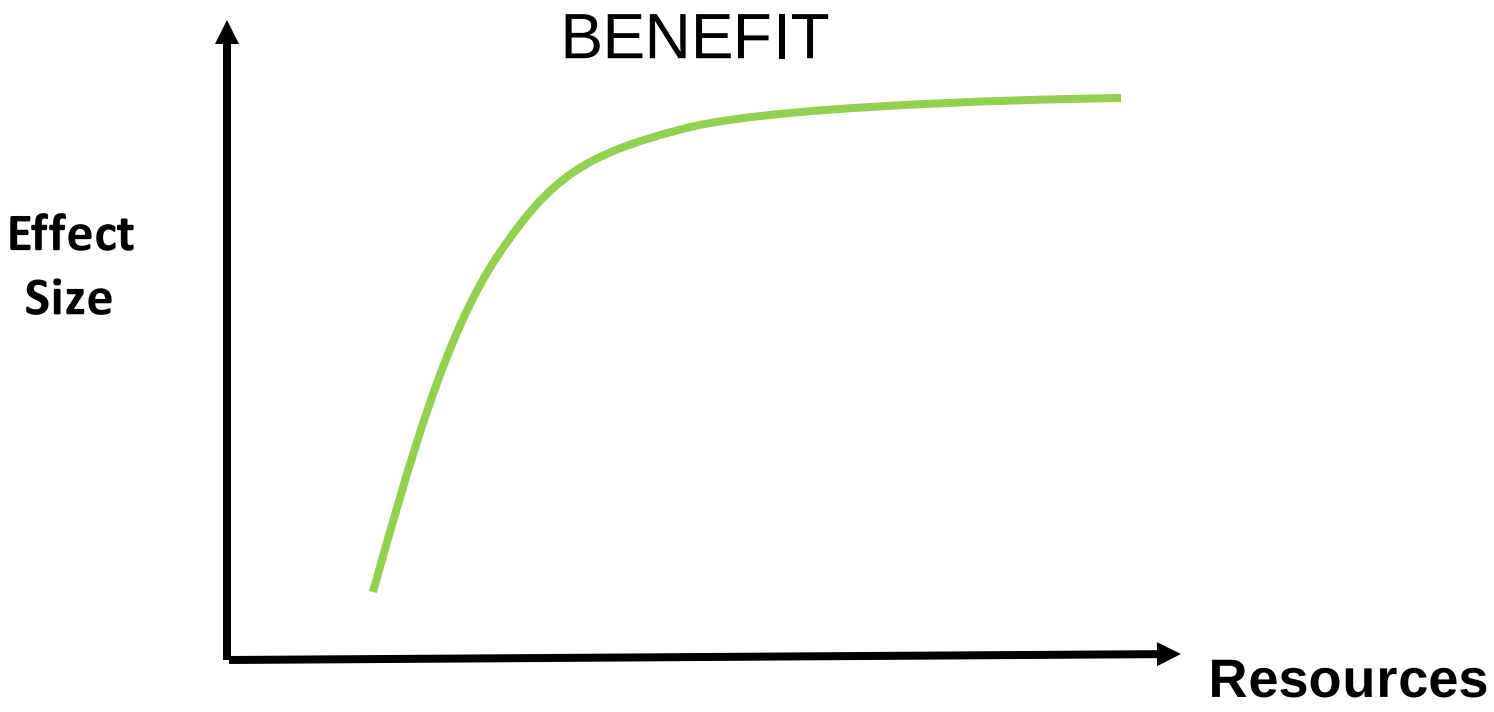


USE THE ALLOCATED RESOURCES OPTIMALLY

- Is the service for people with liver disease in Tayside better than the service in Grampians?
- Which service for frail elderly people in the Scotland provides the best value?
- Which service for children with mental health problems improved most in the last year ?
- Who is responsible for the quality outcome and value of the service for people with Bipolar disorder in the Borders?
- Who is responsible for the service for women with pelvic pain in Dumfries and galloway?
- How many services are there for people with MusculoSkeletal Disease in the Lothians and which gives best value?
- Is the variation in outcome for COPD increasing or decreasing?
- .Who is responsible for publishing the Annual Report on care for people with Parkinson's Disease in Tayside and the Lothians?


Mental health problems
Frailty
Cancer
Back pain
PEOPLE WITH
SELF CARE
INFORMAL CARE e.g family
LOCALITY
PLACE
SUPER SPECIALIST
Bureaucracies & Jurisdictions

USE THE ALLOCATED RESOURCES OPTIMALLY
What has Donabedian taught us on value?



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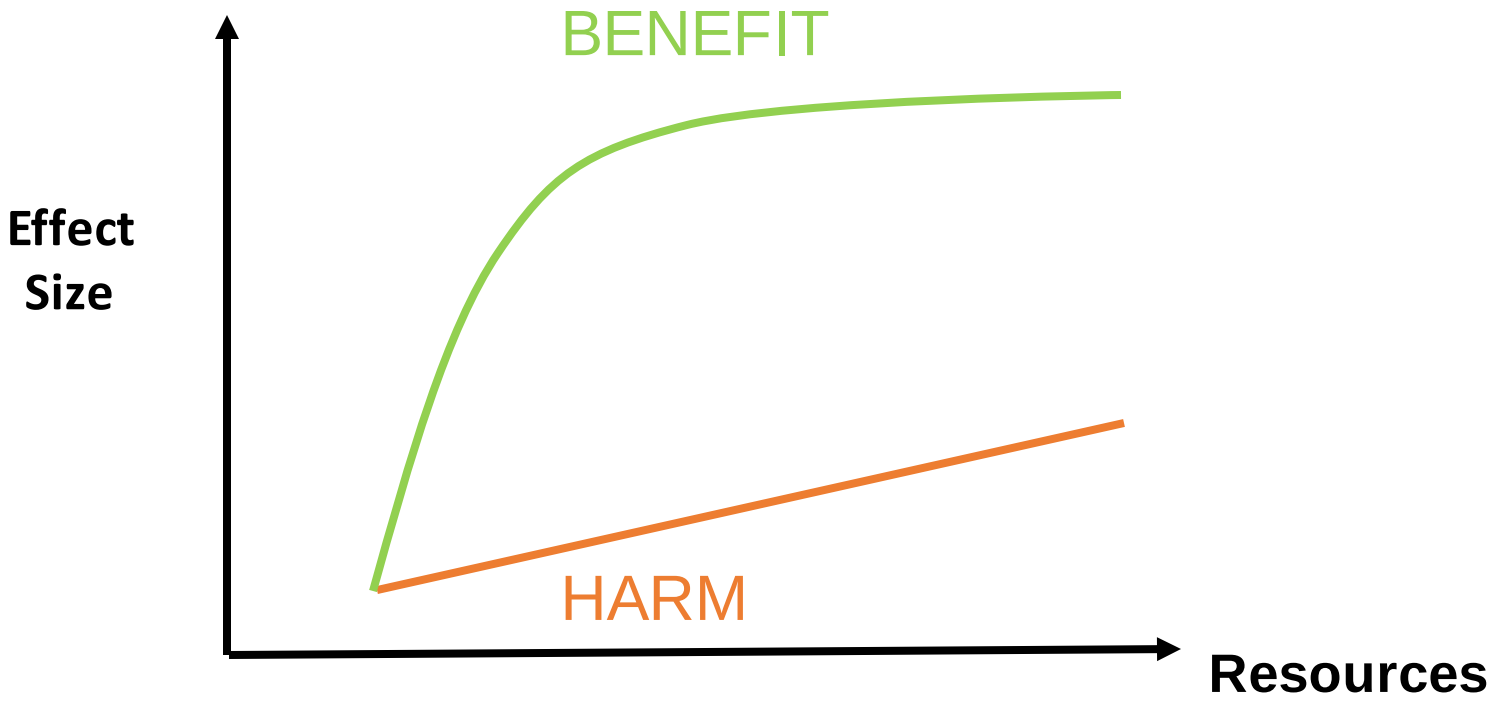

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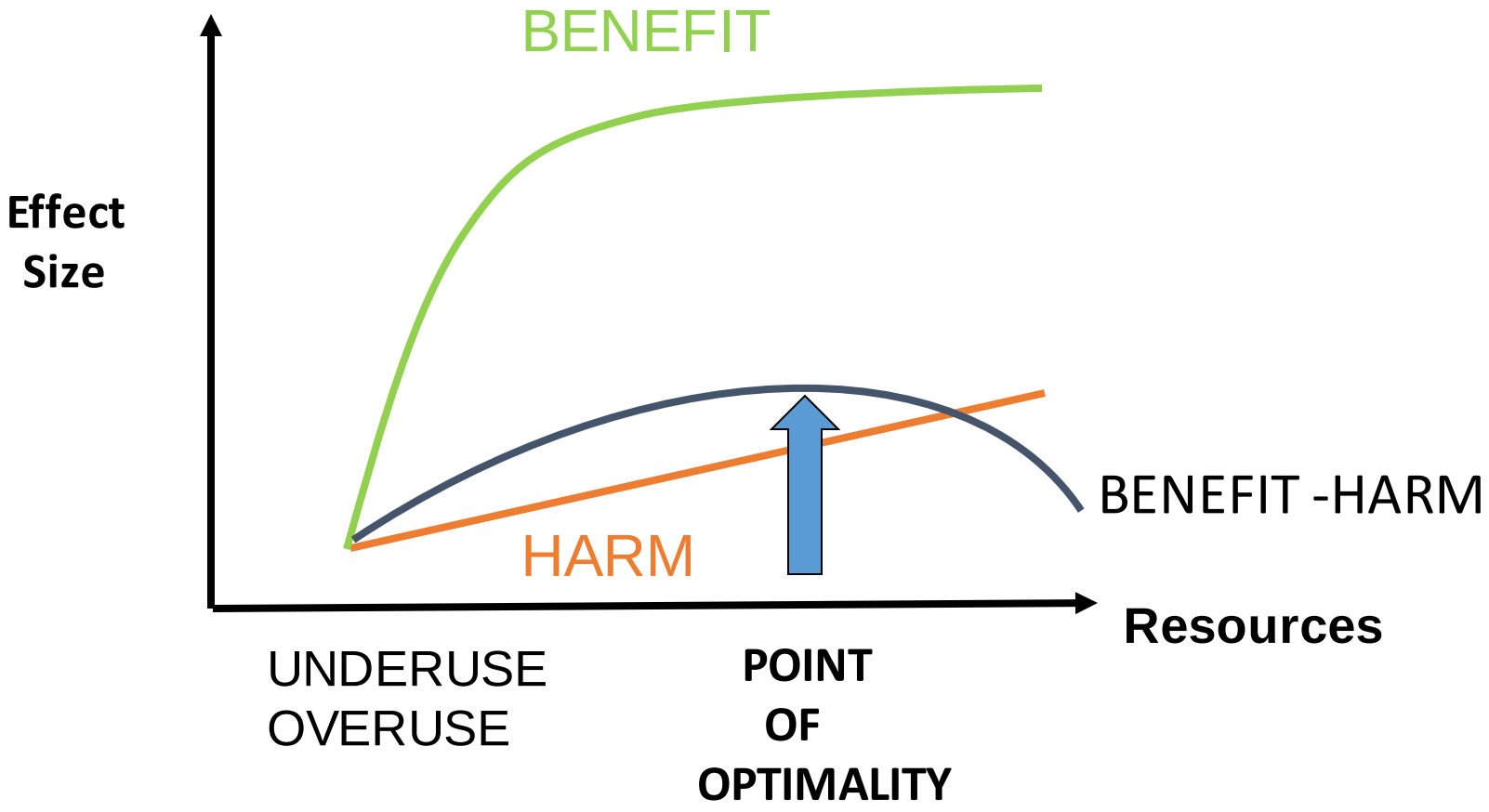
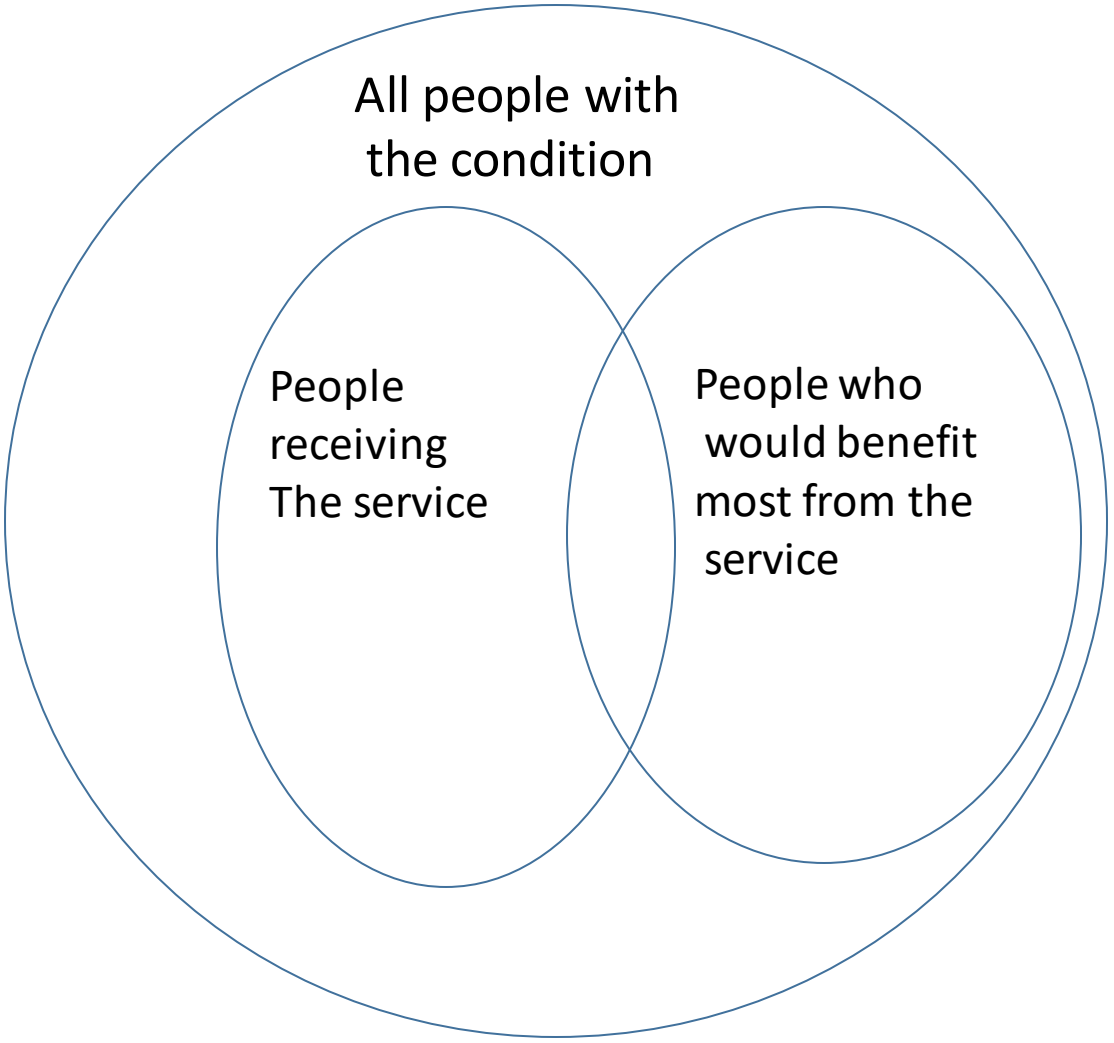
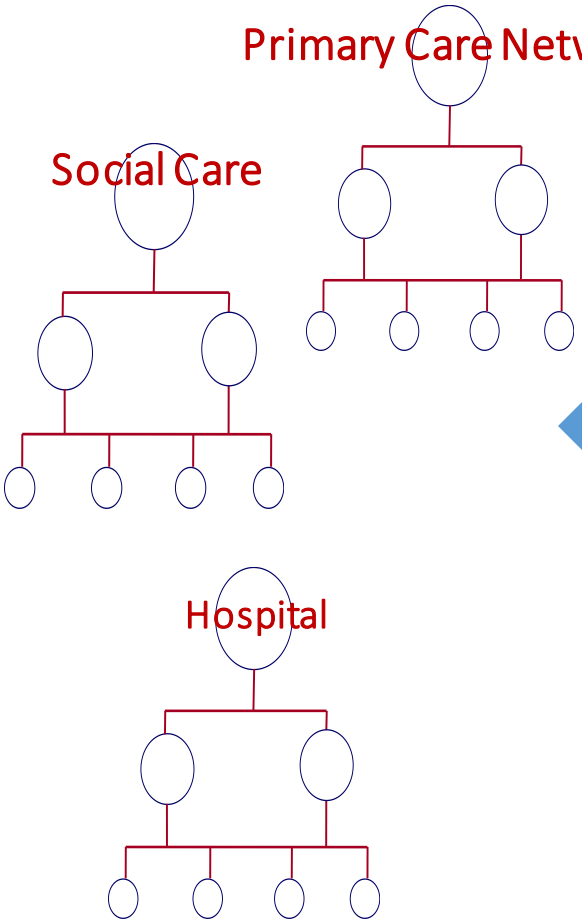


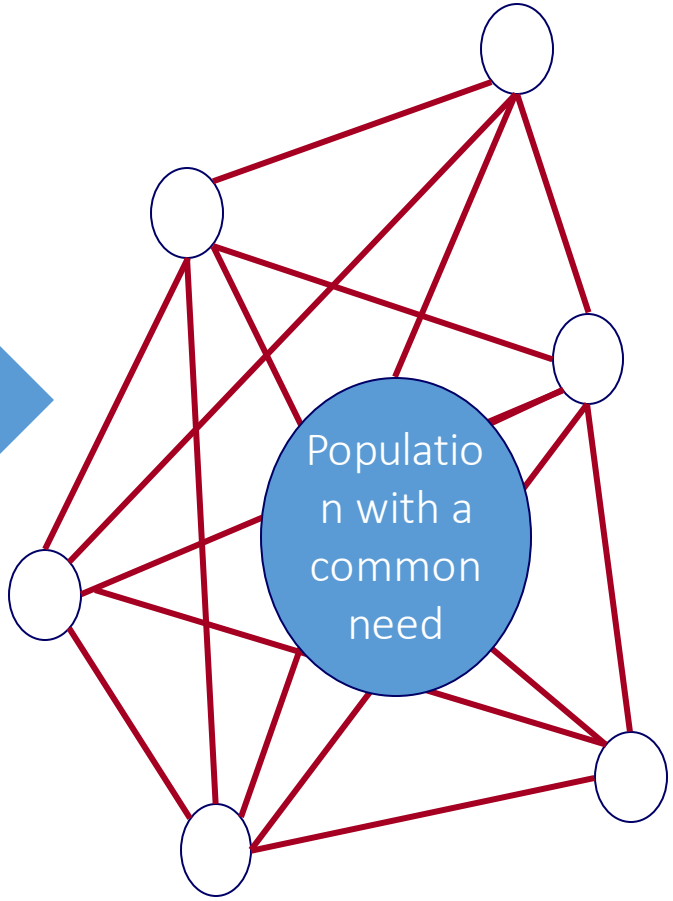

All people with
the condition
People
receiving
The service
People who
would benefit
most from the
service


The right
People
receiving
the specialist
service
All people with
the condition who do
not need to see the
specialist service practice
healthcare supported by
generalists who are
themselves supported
by specialists

We need to create networks alongside hierarchies… Communities of Value



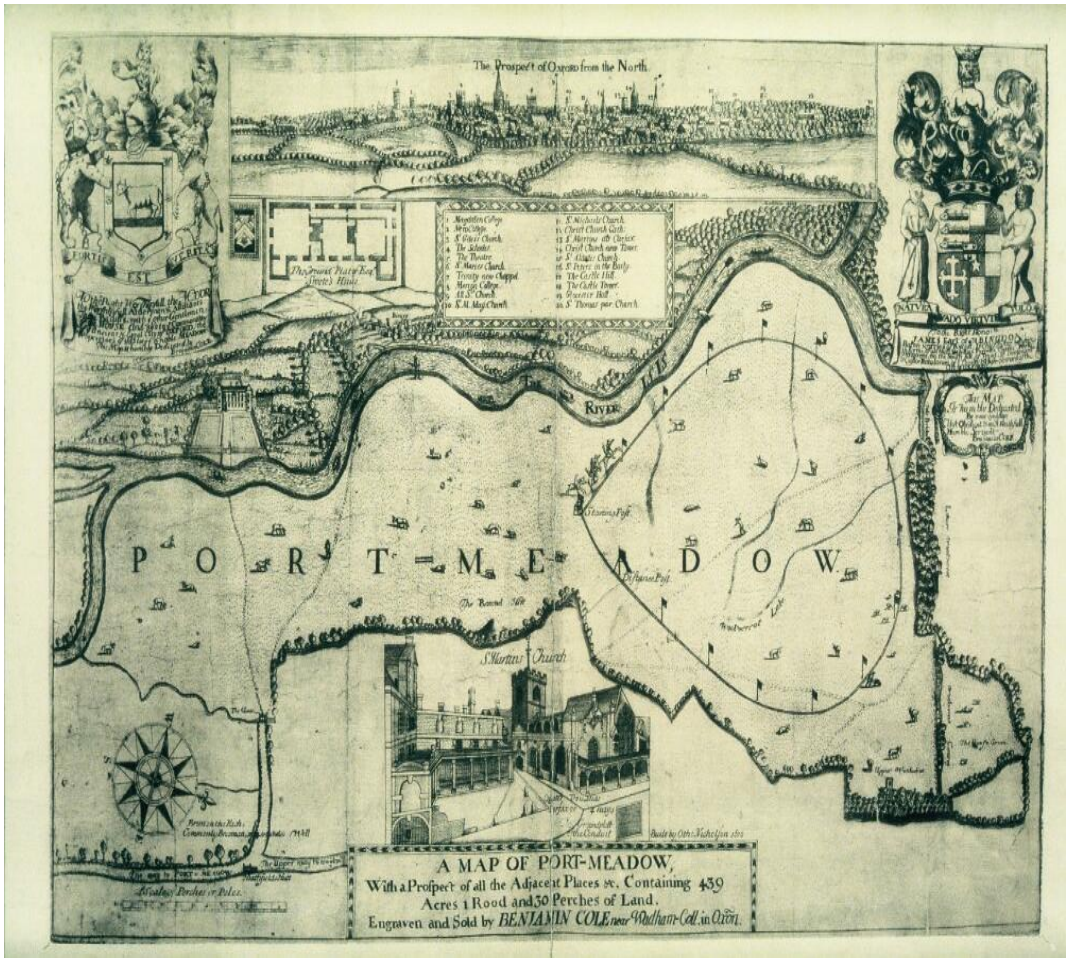
Hierarchies *and* population-centred networks - Communities of Value (CoV)

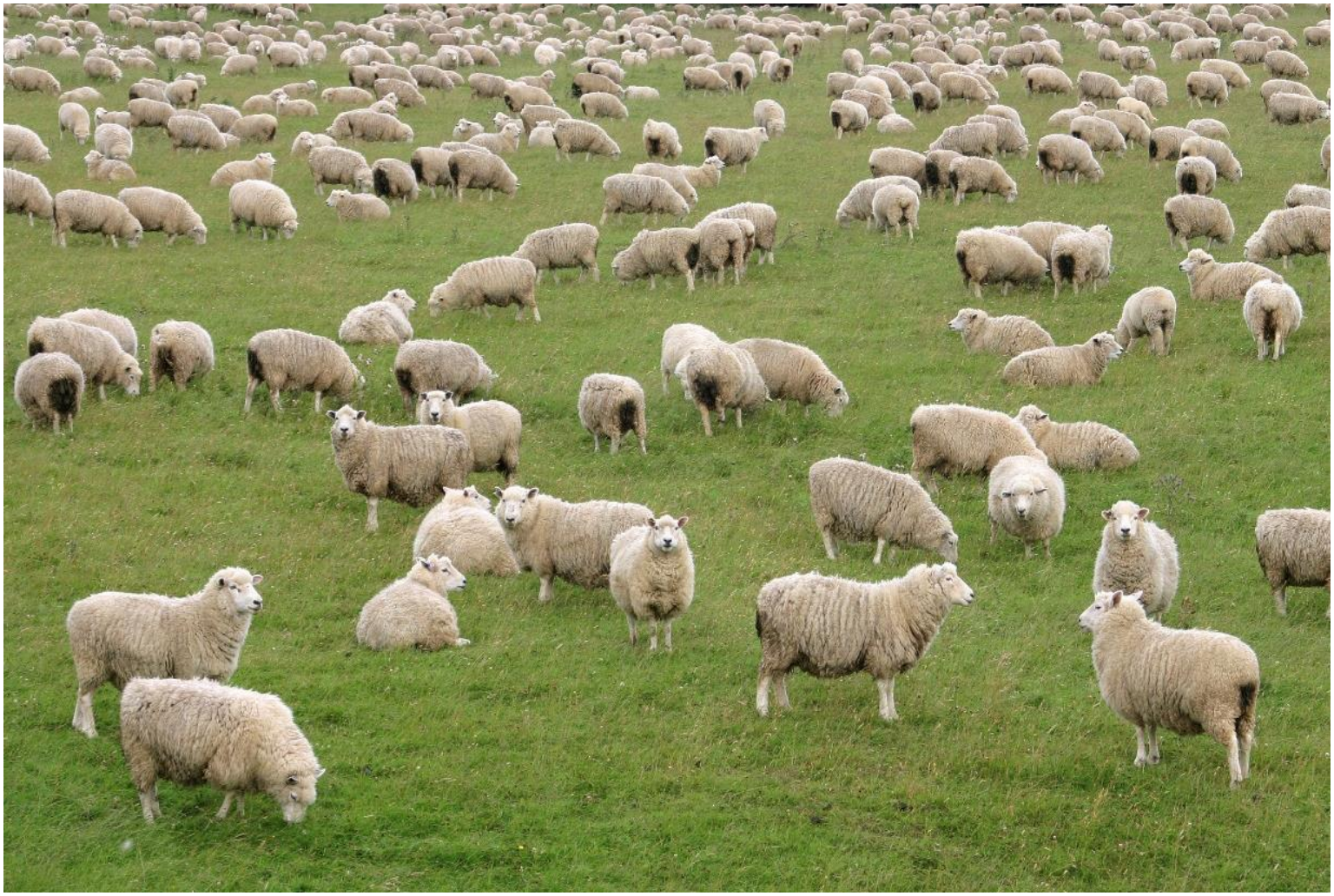


Hierarchies

Community of Value

Create the culture of stewardship 300 acres of grazing given to the freeman of Oxford by Alfred the Great





The new implantable device for CHF is on its way

ACADEMY OF
MEDICAL ROYAL
COLLEGES

Protecting resources, promoting value: a doctor's guide to cutting waste in clinical care

November 2014

ACADEMY OF
MEDICAL ROYAL
COLLEGES

Protecting resources, promoting value: for whole populations

A core duty for everyone working in the NHS

November 2019

Population and Personal value improvement is not a one-off process

The Triple Aim?
Hit the sweet spot:
Outcomes Based Accountability

Hugh McCaughey,
Chief Executive, South Eastern Health & Social Care Trust

Celine McStravick,
Director, National Children's Bureau

Emma Hannaway,
Head of Performance, South Eastern Health & Social Care Trust

South Eastern Health and Social Care Trust

ncb
Working with children, for children

impact
delivering transformation

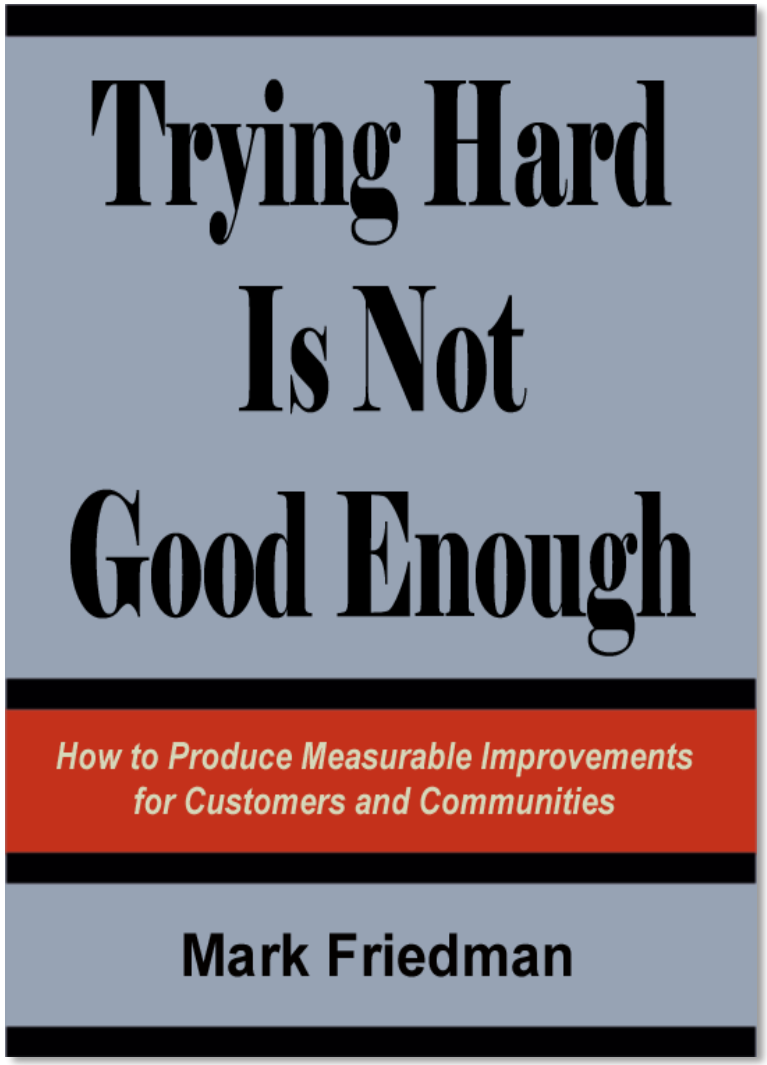
About NCB

Using evidence to improve outcomes for children, families and communities

POLICY | PROOF | PARTNERSHIP | PRACTICE | PARTICIPATION

National Children's Bureau

What is OBA?



National Children's Bureau

What is OBA?

…a disciplined way of thinking, taking action and demonstrating impact

National Children's Bureau

To OBA or not to OBA?

- Start with the outcome
- How do we know if we are achieving that outcome? (indicator)
- The story behind the data – Why?
- Embed collaboration and evidence of what works to "turn the curve"
- Use the data to monitor progress

National Children's Bureau

To OBA or not to OBA?

- Embed performance management
  - How much did we do?
  - How well did we do it?
  - **IS ANYONE BETTER OFF?**

National Children's Bureau

What did the PfG promise?

- The approach taken in this Framework draws on the techniques set out by Mark Friedman in his book 'Trying Hard is Not Good Enough', which describes a range of practical techniques supporting an increased outcome focus in public policy.

National Children's Bureau

Programme for Government Framework

THIS FRAMEWORK REMAINS SUBJECT TO POLITICAL AGREEMENT

Programme for Government Framework

Our purpose: Improving wellbeing for all – by tackling disadvantage and driving economic growth

OUTCOMES	INDICATORS
We prosper through a STRONG, COMPETITIVE regionally balanced economy	• Private sector NI Composite Economic Index • External sales • Rate of innovation activity • Employment rate by council area • % change in energy security of supply margin
We live and work sustainably – protecting the environment	• % all journeys which are made by walking/cycling/public transport • Greenhouse gas emissions • % household waste that is reused, recycled or composted • Annual mean nitrogen dioxide concentration at monitored urban roadside locations • Levels of soluble reactive phosphorus in our rivers and levels of Dissolved Inorganic Nitrogen in our marine waters • Biodiversity (% of protected area under favourable management)
We have a MORE EQUAL SOCIETY	• Gap between highest and lowest deprivation quintile in healthy life expectancy at birth • Gap between % non-FSME school leavers and % FSME school leavers achieving at Level 2 or above including English & Maths • % population living in absolute and relative poverty • Employment rate of 16-64 year olds by deprivation quintile • Economic inactivity rate excluding students • Employment rate by council area
We enjoy long, healthy, active lives	• Healthy life expectancy at birth • Preventable mortality • % population with GHQ12 scores ≥4 (signifying possible mental health problem) • Satisfaction with health and social care • Gap between highest and lowest deprivation quintile in healthy life expectancy at birth • Confidence of the population aged 60 years or older (as measured by self-efficacy)
We are an INNOVATIVE, CREATIVE, SOCIETY, where people can fulfil their potential	• Rate of innovation activity • Proportion of premises with access to broadband services at speeds at or above 30Mbps • % engaging in arts/cultural activities • Confidence (as measured by self-efficacy) • % school leavers achieving at least level 2 or above including English and Maths
We have more people working in better jobs	• Economic inactivity rate excluding students • Proportion of the workforce in employment qualified to level 1 and above, level 2 and above, level 3 and above, and level 4 and above • Seasonally adjusted employment rate (16-64) • A Better Jobs Index • % people working part time who would like to work more hours • Employment rate by council area • Proportion of local graduates from local institutions in professional or management occupations or in further study six months after graduation

THIS FRAMEWORK REMAINS SUBJECT TO POLITICAL AGREEMENT

Programme for Government Framework

Our purpose: Improving wellbeing for all – by tackling disadvantage and driving economic growth

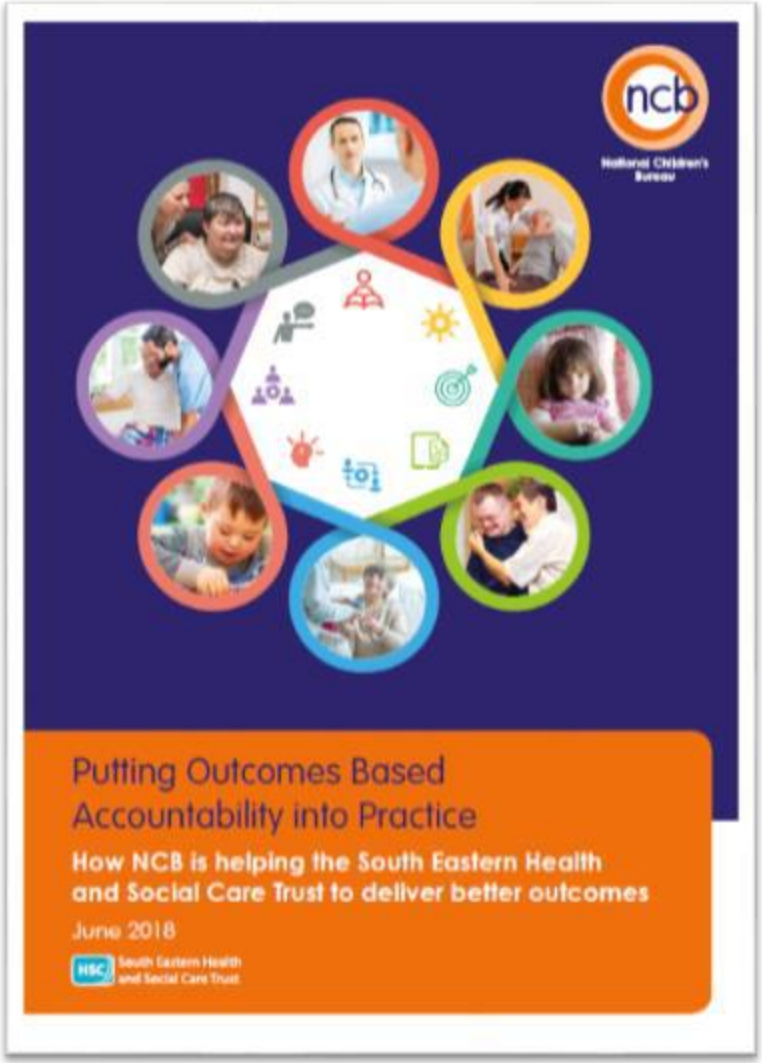
OUTCOMES	INDICATORS
We have a SAFE COMMUNITY where we respect the law, and each other	• Prevalence rate (% of the population who were victims of any NI Crime Survey crime) • A Respect Index • % the population who believe their cultural identity is respected by society • Average time taken to complete criminal cases • Reoffending rate
WE CARE FOR OTHERS AND WE HELP THOSE IN NEED	• % population with GHQ12 scores ≥4 (signifying possible mental health problem) • Number of adults receiving social care services at home or self directed support for social care as a % of the total number of adults needing care • % population living in absolute and relative poverty • Average life satisfaction score of people with disabilities • Number of households in housing stress • Confidence of the population aged 60 years or older (as measured by self-efficacy)
We are a shared, welcoming and confident society that respects diversity	• A Respect Index • % who think all leisure centres, parks, libraries and shopping centres in their areas are "shared and open" to both Protestants and Catholics • % of the population who believe their cultural identity is respected by society • Average life satisfaction score of people with disabilities • Confidence (as measured by self-efficacy)
We have created a place where people want to live & work, to visit and invest	• Prevalence rate (% of the population who were victims of any NI Crime Survey crime) • Total spend by external visitors • % of the population who believe their cultural identity is respected by society • Nation Brands Index • A Better Jobs Index
We connect people and opportunities through our infrastructure	• Average journey time on key economic corridors • Proportion of premises with access to broadband services at speeds at or above 30Mbps • Usage of online channels to access public services • % of all journeys which are made by walking/cycling/public transport • Overall Performance Assessment (NI Water) • Gap between the number of houses we need, and the number of houses we have
We give our children and young people the BEST START IN LIFE	• % babies born at low birth weight • % children at appropriate stage of development in their immediate pre-school year • % schools found to be good or better • Gap between % non-FSME school leavers and % FSME school leavers achieving at Level 2 or above including English and Maths • % school leavers achieving at Level 2 or above including English and Maths • % care leavers who, aged 19, were in education, training or employment

These Outcomes will be delivered through collaborative working across the Executive and beyond government and through the provision of high quality public services.

SEHSCT case study:
Putting OBA into Practice

"OBA helps to simplify our language so it is a better platform for intra governmental and interagency working"

"NCB was excellent at adapting it to our circumstances and trying to simplify the process"



"OBA is simple but it is not simple to do as it is about cultural change and organisational change"

ncb
National Children's Bureau

Moving to Outcomes South Eastern Health & Social Care Trust

Emma Hannaway,
Head of Performance & Information

29 March 2019

South Eastern Health and Social Care Trust

Traditional Performance

- TARGET: 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department.
- TARGET: No patient should wait longer than 12 hours in an Emergency Department to be treated, discharged home or admitted
- TARGET: 90% of complex discharges should take place within 48 hours.

BUT – DOES THIS MEASURE PERFORMANCE?
IS THIS WHAT GOOD LOOKS LIKE?

Patients suffering as direct result of NHS wait-time failures

Doctors speak out as figure… worst ever performance

▲ NHS march in London. In January a re… waited to be admitted to a hospital. Pho…

Patients are suffering as a d… waiting-time targets, docto…

▲ New data from NHS England shows th… hours, against a 95% target. Photograph…

More patients than ever bef… treatment last month as wi… put unprecedented…

Hospital A&E units in England dealt with just 76.1% … hours last month, statistics released on Thursday sh…

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Health

…st level for 15 years in

Share

…t level since the four-hour

…itals appeared to be coping well

…ed or admitted in four hours - well

…an they should with hospitals …se needing to be kept in.

Belfast Telegraph DIGITAL

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Patient in two-day wait for an Ulster Hospital bed

By Mark Bain
January 17 2019

A patient had to wait almost tw…

The South Eastern Trust said la…

It is understood the patient had … spent in a dedicated nursing are…

In the past two weeks there hav… at the hospital - the time set by … discharged or admitted - a sligh…

Pressure on the health service i…

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February was the 'toughest month EVER for the NHS': A&E waits spiral to record low AGAIN as cancer treatment targets are missed for 37th month running, 'shameful' statistics show

- More people than ever are waiting more than four hours to be treated in A&E
- People waiting a month for treatment after cancer diagnosis is at all-time high
- Record numbers of people have to wait two months or more for cancer therapy
- Experts warn the NHS is crippling under pressure despite a 'mild' winter

Programme for Government

- 12 strategic outcomes
- Clear direction of travel -continuous improvement on the essential components of societal wellbeing
- Every aspect of government
  - attainment of good health
  - education,
  - economic success
  - confident and peaceful communities.
- Target those things that make real improvements to the **quality of life** for the citizen

Programme for Government Framework

HSC South Eastern Health and Social Care Trust

Ageing Population

- Over 75 year-olds account for:
  - c20% ED Attendances
  - 45% admissions
  - Length of stay 3 days longer
- 25% of all admissions will die within next year
- 48% of all deaths in NI are in Hospital
- Hospital admissions in old age may indicate a shift from a healthy life to a life of compromised health

"We've been wrong about what our job is in medicine. We think our job is to ensure health and survival.

But really it is larger than that. It is to enable well-being"

Atul Gawande, Being Mortal: Illness, Medicine and What Matters in the End

South Eastern Health and Social Care Trust

SET Journey

- Move towards outcomes over last 3 years
- Redefining what good performance looks like
- Focus on impact for patients' lives

- Start with outcome - **people aged 65+ living in SET experience physical and psychological well-being and live well until the end of life**
- Listen to patients
  - want to be treated in their own home / local community

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OUTCOME 4: We enjoy long healthy active lives
OUTCOME 8: We care for others and help those in need
PCOP OUTCOME: People aged 65 + living in SET experience physical and psychological well-being and live well until end of life

Enhanced Care at Home Service (ECAH) Report Card:

The Enhanced Care at Home (ECAH) service has been developed through an Integrated Care Partnership (ICP) to provide person centred care for individuals presenting with acute needs in their own home. This is a multi-professional team which includes GP and Consultant Geriatrician input, delivering a higher acuity level of care, closer to home for our older population. This is a time limited alternative to hospital admission thus reducing hospital admissions, or facilitating an earlier hospital discharge. The person's condition can be managed by the ECAH team in their own home/normal place of residence and all treatment administered and monitored according to individual needs.

Service Update:

- ECAH has been operating within the Ards and North Down sectors from January 2016. The service has now rolled out to both the Down and Lisburn sectors from January 2018 and June 2018 respectively.
- The ECAH service delivery model has been refined to reflect the different levels/tiers of care required from GP (tier 1) care at home to Consultant support (tier 2 geriatrician, tier 3 hospital consultant), all within a distinct team.
- We are one! Since 1st April 2018 the Rapid Response Nursing service has integrated within the ECAH team enabling care of the acute patient through to chronic disease management.

Finance Update: Feb 2018 – Jan 2019

Expenditure incurred on the project by SET from Feb 2018 to Jan 2019 was £858,348. In addition we estimate the annual cost of the *GP LES* is *£123,396*. This would give a total cost for the project for the period Feb 2018 to Jan 2019 of *£981,744.*

Total Cost avoided = £922,566 for the period Feb 2018 to Jan 2019.

Integrated Care Partnerships
Health and Social Care

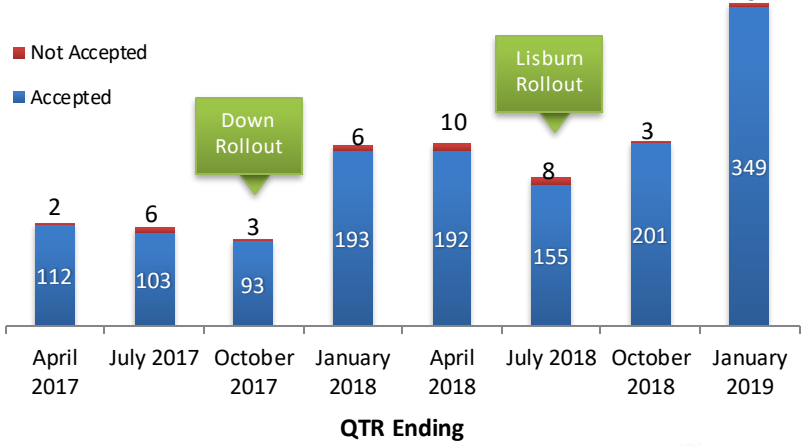
South Eastern Health and Social Care Trust

PCOP OUTCOME: People aged 65 + living in SET experience physical and psychological well-being and live well until end of life

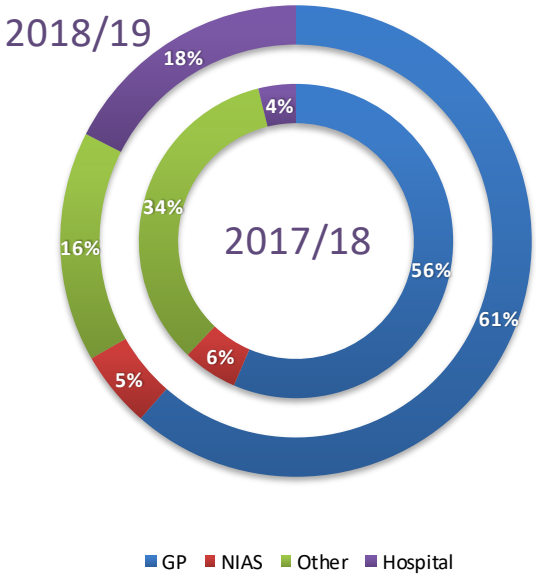
Enhanced Care at Home (ECAH)

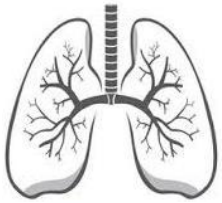
How much did we do?

New Referrals



Referral Sources



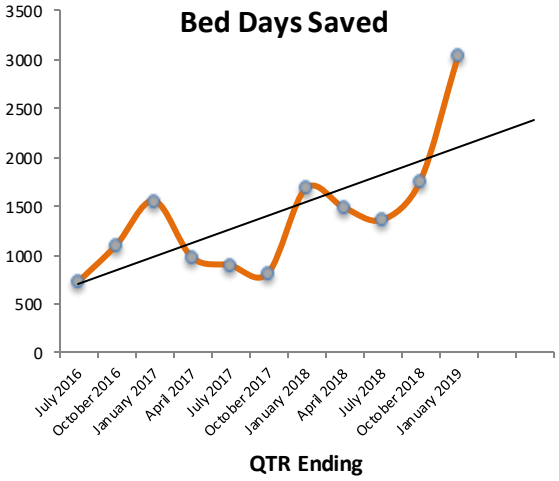


577 patients referred with a Respiratory condition

40% of referrals

How well did we do it?

Bed Days Saved

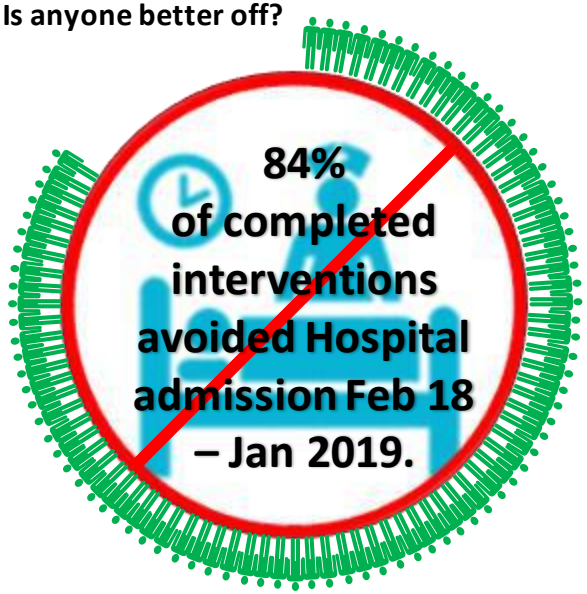


Patient Destination on discharge

Apr 17 – Jan 19

Own Home	81%
Hospital Setting	16%
Alternative Destination	2%

Is anyone better off?



67%

of interventions lasted 10days or less Apr 17 – Jan 19

Meaning **1,181** patients received hospital quality care in their own home and recovered quicker compared to average COE Hospital length of stay

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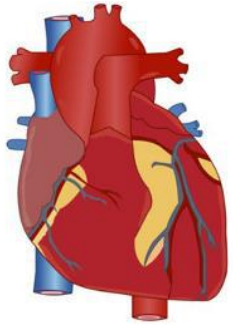
OUTCOME: WE ENJOY LONG, HEALTHY, ACTIVE LIVES

SERVICE PROFILES

About 'Cardiac Rehab *Heart Failure Programme*':



Patients referred by the Heart failure service to the cardiac rehab team are assessed for suitability for the programme and risk stratified as per ACPICR guidelines.

Each patient undergoes a baseline functional capacity test, (either shuttle walk test or six minute walk test) and *a programme* of exercise is prescribed by the cardiac rehabilitation team for each patient. The 10 week programme is implemented alongside educational sessions.

Prior to commencement and on completion of the programme patients are asked to complete a questionnaire, integrating the Minnesota (QOL) and HAD score(Anxiety and Depression) assessment tools plus a physical activity questionnaire.

Other information collected pre and post rehab:

B/P, Heart rate,
Lipid profiles, Smoking status
Height, weight, BMI and waist circumference
Patient satisfaction questionnaire at completion

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OUTCOME: WE ENJOY LONG, HEALTHY, ACTIVE LIVES

'Cardiac Rehab Heart Failure Programme'

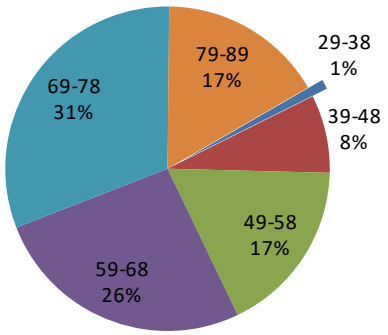
Reporting Period: Jan-Dec 2018

How much did we do?

103

People started Heart Failure classes during 2018

Age Group of class participants



How well did we do it?

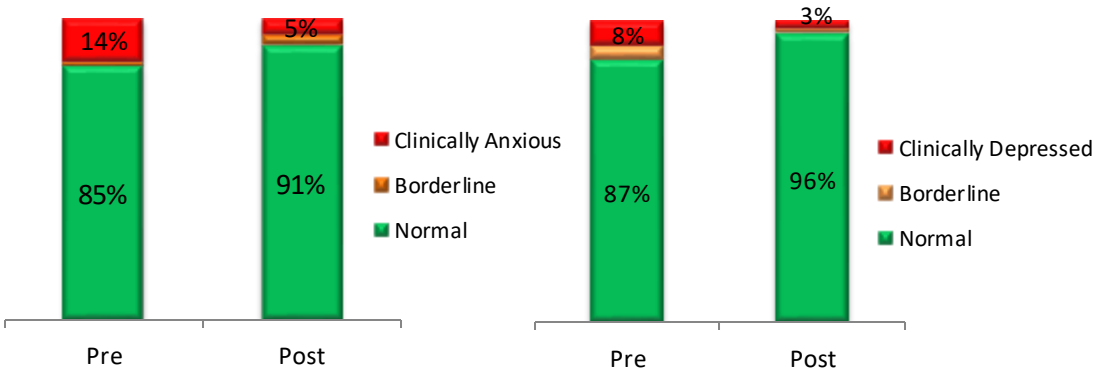
Certified - Meeting all 7 quality standards set out by the BACPR

Functional capacity test

85% (75 out of 88) showed an improvement of 8% or more at the end of the programme

Is Anyone Better Off?

Hospital Anxiety & Depression Scale (n=79)



14% of patients who started the programme were clinically anxious and 8% clinically depressed. At the end of the programme 5% of patients were scored as clinically anxious and 3% clinically depressed

Exercise Levels

91% (80 out of 88) reported an increase in exercise levels at home since rehab

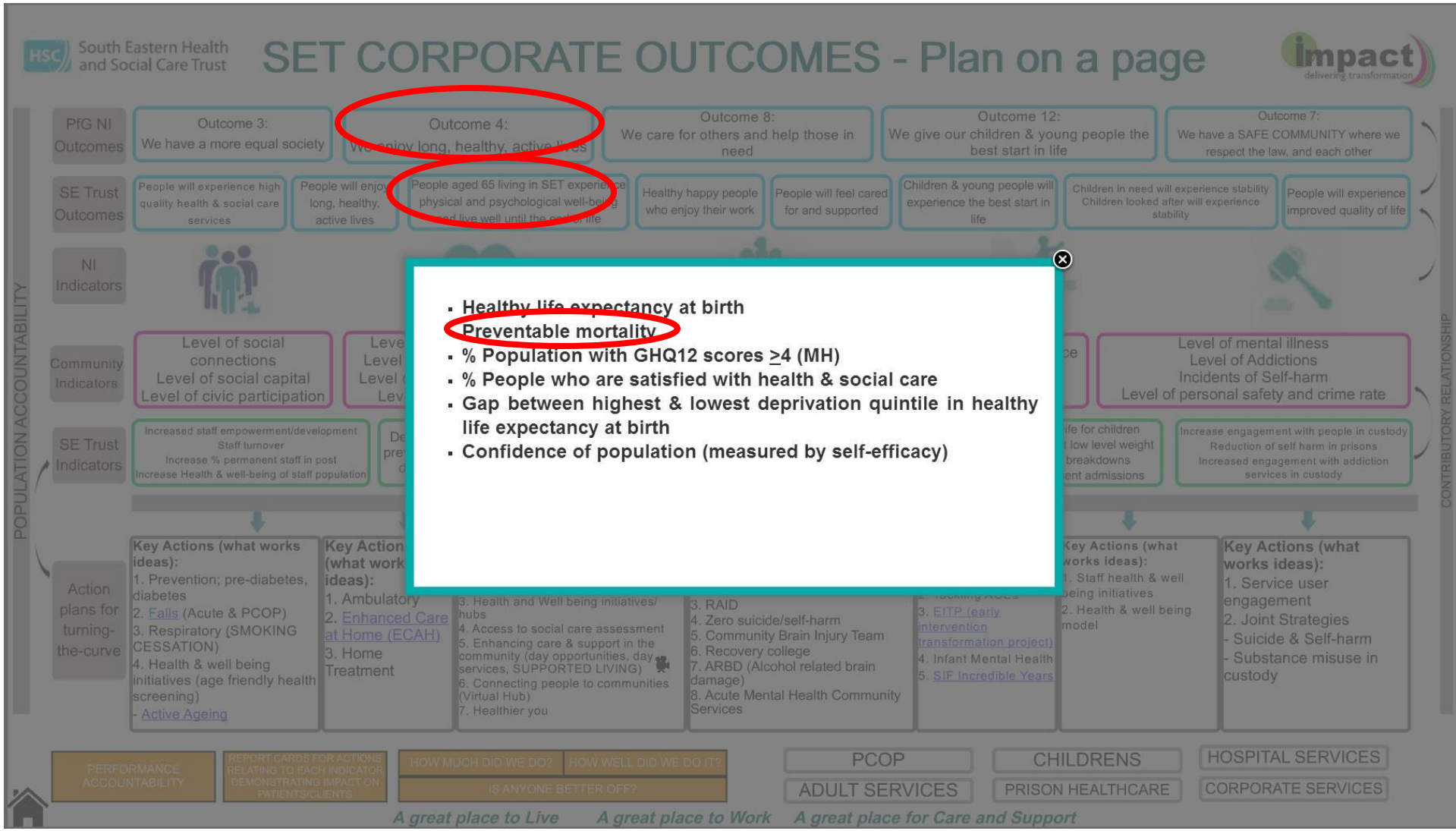
Minnesota Living with Heart Failure Questionnaire

79% (22 out of 28) showed an improvement in their QOL at the end of the programme

How do we link this to Population Health Outcomes?

- Started with driver diagrams
- Not sustainable long term
- Wanted an easy, visual, live and interactive approach
- Developed a web based system to measure our contribution to population health
- ‘Plan on a page’

Plan on a page



- **Healthy life expectancy at birth**
- **Preventable mortality**
- **% Population with GHQ12 scores ≥4 (MH)**
- **% People who are satisfied with health & social care**
- **Gap between highest & lowest deprivation quintile in healthy life expectancy at birth**
- **Confidence of population (measured by self-efficacy)**

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What have you learnt or
What are you going to take home and apply?

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