Value Based Clinical Commissioning of Elective Surgical Care

Emerging Views of Commissioners & Surgeons and Production of High Value Care Pathways

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Executive Summary

The aim of this report has been to make recommendations for consideration by the NHS Operations Board with regard to effective commissioning of elective surgical procedures. The work was commissioned by Professor Sir Bruce Keogh, NHS Medical Director, following widespread expressions of concern from professional bodies that approaches based on lists of procedures deemed to be of 'limited effectiveness', 'low-value' or requiring a 'threshold' result in inequitable patterns of service delivery. The evidence base for such approaches are not thought to be sufficiently robust, and in many cases procedures with well-established evidence of effectiveness, such as cataracts or arthroplasty, have been included.

The paper draws on discussions held between clinicians and commissioners in two SHAs (London and East Midlands). It establishes principles of commissioning which support fully informed shared-decision making that takes into consideration patients individual circumstances, and ensures that they receive appropriate interventions by suitably skilled individuals in line with widely agreed, nationally endorsed pathways of care. It emphasizes the importance of the care pathways rather than individual procedures, and the requirement for audit of points on the pathway against set standards.

Recommendations

Terms such as 'procedures of limited clinical value' have been identified as a barrier to clinical engagement. There should be a change in terminology to reflect a more holistic approach. 'Value based' or 'effective clinical commissioning' is proposed as a more acceptable working title.

Limited lists and blanket bans, which do not take account of the healthcare needs of individual patients, and result in postcode lotteries, should be abandoned.

The NHS Commissioning Board need to clarify how it proposes to 'develop high-level commissioning guidance for GP consortia', 'based on common, nationally produced guidance and evidence' (1).

We propose that the NHS Commissioning Board support the development of 'Value Based Clinical Commissioning Guidance' for elective surgical care pathways through a partnership between the surgical speciality associations and NICE. All relevant stakeholders should be engaged, including clinicians from primary and secondary care, public health, clinical commissioning groups, Royal Colleges, and patient and public representatives. NICE would provide expertise on methodology, project management support and accreditation of surgical speciality associations, as guidance producers, through NHS Evidence.
We propose a structure for Commissioning Guidance that describes:

1. Evidence based, high value, care pathways
2. Specification of expected activity in primary, specialist community, secondary and tertiary care
3. Criteria for primary care referral and specialist intervention
4. Audit and peer review measures to track patient flows and measure patient outcomes
5. Health economic evaluation and measures of sustainability (with 4,from Quality Observatories and the NHS Sustainability Unit)
6. Levers for implementation of high value care pathways e.g. CQUINS
7. Patient and clinician facing information to support shared decision making (delivered through NHS Choices and NHS Evidence)
8. There is a need to encourage and support research into the value that populations derive from different rates of intervention, taking into account the incidence and prevalence of the condition in the population
9. Surgical innovation should be encouraged but only introduced in the context of a research project which will allow the added value to be appraised

Evidence of effectiveness or cost effectiveness should be sought for new and existing procedures, focusing on patient populations that are most likely to benefit from the intervention. Where evidence is lacking, NHS R&D should play a central role in prioritising and commissioning research to allow the added value of the intervention to be appraised.

In collaboration with the East Midlands Quality Observatory we propose to publish a public facing 'Procedures Explorer', based on the Hospital Episodes Statistics dataset, that will allow patients, the public, commissioners and providers to access information on variation in clinical activity and outcome at both a population, provider and GP practice or consultant level.

There should be a review of existing patient and clinician facing information. Effective shared decision-making tools, that allow patients to make informed choices about their management should become more widely used.

The NHS Commissioning Board should consider a key coordinating role for clinical senates and networks in advising and peer reviewing CCG's and providers in their delivery of high value care pathways.

There is a need to encourage and support research into the value that populations derive from the implementation of high value care pathways and specific rates of intervention, taking into account the incidence and prevalence of the condition in the population. Programme budgeting offers a useful framework for considering improvements in outcomes against available resource.

References:

1. Liberating the NHS: Legislative framework and next steps (Dec 2010)

The problem

Work done by the Public Health Commissioning Network in 2009/10 revealed very wide and unexplained variations in policy for many different clinical activities between Primary Care Trusts. Decisions about some clinical activities (e.g. new drugs) were relatively well organised mainly because of the NICE process, but another class of clinical intervention (surgical operations) had wide unexplained variation. It was observed that:

- There was an inconsistent approach to commissioning of surgical procedures.
- Existing surgical procedures were sometimes classified as being of low clinical value with constraints being put on them.
- Large amounts of time was spent by individual surgeons and commissioners debating either individual cases or individual interventions, yet there was little evidence of a strategic grip of the fact that a surgical operation was part of a care pathway for a particular problem. For example, referral for a grommet operation was part of a clinical pathway for the management of parents who were anxious about their child's hearing.
- Involvement of national professional bodies, the Royal College of Surgeons, the Association of Surgeons of Great Britain and Northern Ireland and the Surgical Specialty Committees was deficient or absent.
- The two groups – surgeons and commissioners - used a different language when they met; the former a language based on effectiveness and quality, the latter a language based on value from a population perspective.
- Population aging will be the factor imposing pressure on surgical specialties (notably orthopaedics, urology, and ophthalmology) because of increasing need.

The database that was prepared by the Public Health Commissioning Network caused considerable debate and in some parts of the country aggravated the problem, with commissioners claiming that this was Departmental policy.

Actions taken

The Medical Director of the NHS met with the relevant surgical specialty societies and took action. He asked the Medical Directors of the SHAs and the Right Care team, which is now responsible for the Public Health Network, to meet with the specialist societies to clarify issues and propose solutions.

Two SHAs and the Right Care Programme undertook this work. East Midlands worked with urological surgeons (through BAUS) and with general surgeons (through the Association of Great Britain and Northern Ireland). London undertook to relate to the Royal College of Ophthalmology and the ENT and orthopaedic specialist societies and the Right Care Programme undertook to liaise with plastic surgeons, cardio-thoracic surgeons, maxillo-facial surgeons, spinal surgeons and neurosurgeons - the latter group will also be engaged in work being done by Right Care on epilepsy.

Policy issues

The Department of Health made it clear that a wholesale ban on any particular surgical operation was unacceptable. It did, however, emphasise that new operations should be carried out only in the context of an ethically approved research study. This recognised that innovation and the evaluation of new surgical techniques differed from pharmaceutical innovation and evaluation because of issues such as the learning curve - such issues were raised in two sets of workshops in Oxford organised by the Nuffield Department of Surgery (1, 2, 3).

The lack of registers of operations for specialties other than orthopaedics makes this a difficult policy to implement but the need for investment in research in elective surgery, particularly on the causes and mitigation of unwarranted variation and the value of these interventions at different levels of need and at different rates of provision, will be addressed at a workshop on this topic.

Secondly, it was agreed that it was inappropriate to set single thresholds at a national level, for example a threshold of 6/9 for cataract surgery. Such thresholds might prove useful for audit but the clinician had to take into account the particular needs and values of the individual patient. For example, a person whose livelihood depended on very fine visual discrimination might benefit greatly from a cataract operation even if their vision was 6/9. It was also agreed, however, that the use of thresholds as measures of need was a basis for audit and had a part to play. If, for example, one service was carrying out a large number of operations on people with vision of 6/9 as compared to other services serving similar populations, this would raise an issue for surgeons and commissioners to discuss.

If commissioners lack the ability to control cost by imposing thresholds it would be left to surgical specialties, working in the context of the relevant programme budget to make the best use of the finite resources for the population they were serving. The approach that needs discussion with the NHS Commissioning Board and clinical commissioning groups is one that expects clinicians to live within their allocated budget; if they wish to perform an operation of higher cost, they would need to find the necessary resources by introducing a lower number of interventions. For example, discussions took place with orthopaedic surgeons in which it was emphasised that knee replacement was usually a high value operation but that it would be essential for patients to appreciate the probability of a less favourable outcome, particularly if the symptoms were not severe. However, it was recognised that surgeons needed to consider how use of resources for interventions, such as knee arthroscopy, knee washout operations and repair of cruciate ligaments, consumed resources that could otherwise be used for knee replacement.

Furthermore, it is obvious that there is a difference in the cost of the services provided by different hospitals and there is scope for increasing the number of people treated by some services without increased investment by commissioners. Similarly discussions about bariatric surgery revealed that there is investment in drug treatment of severe obesity that is of much lower value than surgical intervention, offering the opportunity to switch resources and increase value.

These issues need to be discussed with the NHS Commissioning Board; NHS Commissioners involved with such work will be sent this interim report.

Producing Data for Decision Making

Vision

To inform patients and clinicians, as well as commissioners and providers, it is necessary to be able to produce measures that demonstrate activity, decisions and outcomes at all stages along the care pathway. These measures should be developed with expert support, which can be provided by Quality Observatories, lead by the relevant specialist association in close collaboration with commissioners, providers, the public and patients, with input from other partners such as public health and clinical networks.

In order to be able to accurately describe patient flows through the clinical pathway, the activity undertaken and outcomes delivered at each stage a concerted effort is required to make available data including the primary care, community and secondary care patient record. This can be linked, with additional sources such as ONS mortality data enabling end to end tracking of the patient pathway.

Current Reality

The East Midlands Quality Observatory (EMQO) has worked with the Right Care programme to develop and present information to support the work programme. Due to the paucity of access to data from primary care and the interface between primary and secondary care, we have used national Hospital Episode Statistics (HES) data to identify relevant interventions in secondary care to inform workshops focusing on specific care pathways. Data definitions identifying relevant procedures were developed and agreed with the surgical specilasity associations. The data was loaded into an interactive presentation tool that allows data to be interrogated live in the workshops, allowing views of actual and age-sex standardised activity by commissioners or providers, at all levels - from individual GP practice or (anonymised) consultant surgeon, through CCG or speciality team to PCT or hospital Trust. The tool allows users to view activity, readmission rates at multiple time points, length of stay, day case rate, in hospital mortality and PbR spend at each of the levels of granularity described.

A high level of output, showing standardised activity for procedure groups (such as bariatric surgery or procedures for lower urinary tract symptoms) was prepared showing the variation in activity at SHA, PCT and GP practice levels for all of the conditions focused on in the workshops. These were presented as funnel plots showing the breadth of variation at a population level (See Appendix 2). This was used to initiate the workshop discussion and then the interactive tool was used to allow questions to be answered as they arose.

The need for research resources

Discussion with specialist surgical societies reflected discussions that had taken place during the preparation of the NHS Atlas of Variation - namely that it was very rarely possible to say a high rate of surgical intervention was "good" or "bad" or, as a corollary, that a low rate was "good" or "bad".

- A high rate of intervention might reflect:
  - Large numbers of people with severe unmet need or
  - It might reflect what has been called supply side variation with the provision of high levels of resources leading to the ability to offer treatment to people much more mildly affected.
- A low rate of intervention might reflect
  - Large numbers of people in severe need that has not been met or
  - It may reflect the fact that the backlog of severe need has been met and the surgical service is now dealing with incident cases, in comparison with other services which are still at a high prevalence of severe need in the populations.

It is vitally important that research into the value of different rates of intervention in populations is increased. Specialties have spoken of the need for registers to allow the quality of the service and the value of different rates of intervention to be assessed rather than focusing on determining the effects of interventions. Orthopaedics is in the best position to do this because of the national joint register, an excellent resource, and to this end the Nuffield Partners of Surgery has been asked to convene a third seminar on surgical research - this time focusing on variation. Professor Jack Wennberg, who has pioneered research in this area and is the outside expert and facilitator, has been invited.

References:

2. McCulloch P, Altman DG, Campbell WB et al. (2009) No surgical innovation without evaluation: the IDEAL recommendations *Lancet* **374**(9695):1105-12.
3. Ergina PL, Cook JA, Blazeby JM et al. (2009) Challenges in evaluating surgical innovation *Lancet* 374(9695):1097-104.
4. Barkun JS, Aronson JK, Feldman LS et al. (2009) Evaluation and stages of surgical innovations *Lancet* 374(9695):1089-96.

Discussion paper:

Value Base Clinical Commissioning of Elective Surgical Care – Emerging Views on Underpinning Principles

Introduction

Most PCTs have developed policies on procedures of limited clinical effectiveness, which include criteria to guide treatment and funding decisions. These criteria aim to ensure the NHS commissions interventions which are effective and evidence based and conversely disinvests from interventions where this is not the case.

These policies can also be interpreted as impeding access and rationing care. The Federation of Surgical Speciality Associations (FSSA) has expressed concerns about the strength of the evidence base underpinning the referral or treatment criteria and PCTs' approaches in developing policies, including the extent of clinical involvement. National work has found inconsistencies between policies across the country. The profile of these issues has increased alongside the drive to improve efficiency in the NHS. These policies form part of most PCTs' QIPP programmes.

In response to these concerns Strategic Health Authority Medical Directors working with key stakeholders including the FSSA, commissioners and providers of surgical services are leading work that aims to improve arrangements. An early goal is to agree to a position statement on key principles around commissioning such activity in the future.

Position in London

In London each Cluster has a policy on these issues. Whilst there are common elements there are also differences in procedures included and in some of the related referral criteria. There has been clinical involvement in policy development although processes have differed. Policies typically cover two main areas:

1. **Treatments and procedures with restricted access requiring prior approval:** This usually involves the referring clinician submitting an individual funding request to the Individual Funding Request Panel on an individual patient basis demonstrating that criteria have been met or why treatment should be funded in an exceptional case where criteria is not met. These predominantly comprise cosmetic procedures, although Individual Funding Request processes do also apply to a wider range of treatments, drugs and therapies, including new and experimental treatments not normally available through the NHS.

2. **Treatments and interventions with restricted access criteria that that do not require prior approval as long as criteria are met:** In these circumstances commissioners may require audit of activity to monitor compliance and stipulate

these requirements in provider contracts. An individual funding request and prior approval may apply where criteria are not met.

Aspects of processes and criteria used to determine whether prior approval is or is not required can also differ.

The Medical Director of NHS London is leading a discussion on the development and implementation of high value care pathways. The remainder of this paper summarises emerging views from discussions held between; NHS London and ENT UK, RCO, BAO; East Midlands SHA and ASGBI, BAUS; DH Right Care team and BAPS, SCS, BAOMS, SBNS, and a questionnaire circulated to all of the speciality association members of the FSSA by NHS London.

Emerging views from Clinical Advisory Groups

An overarching and strongly held view, is the need to reframe the approach so that the focus shifts from interventions to pathways of care. Emerging views on principles to underpin commissioning guidance, summarized below, build on this. Discussions strongly advocate a change in terminology to reflect the shift in focus. Current terminology (e.g. lower clinical effectiveness, lower clinical value or lower priority) has been identified as a barrier to clinical engagement. *Effective or value based commissioning* is proposed as a more acceptable working title.

Maximize quality and value from resources available (enable delivery of QIPP)

All groups believe that a focus on right care at the right time supported by clinically agreed, evidence based pathways that are subject to audit will improve quality and cost-effectiveness of care across the pathway and the wider system of care with greater overall benefits compared to an approach focused on interventions in isolation.

A pathway approach can be used to drive better value and outcomes for people with a particular condition at a population level and programme budgeting offers a useful framework for considering improvements in outcomes against available resources[1]. Variation in the observed versus expected number of patients on a pathway for a given population (this could be at practice or clinical commissioning consortia level) and variation in progression along the pathway can be indicators of whether key outcomes and best value are being achieved.

For individual patients the approach should aim to achieve the best possible outcomes and patient experience taking account of individual needs, preferences and values.

Pathway guidance should indicate areas where opportunities exist for both QIPP improvements across the system and local systems should agree on improvement goals and monitor progress towards these. Increased demand is forecast in the management of particular conditions, including some conditions that are more associated with older age.

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[1] http://www.rightcare.nhs.uk/downloads/Right_Care_2011_Commissioning_for_Value_Feb_2011.pdf (accessed on June 7th 2011)

Guidance should be based on pathways of care that encompass the whole system of care for particular conditions

In this context a pathway of care defines best practice, essential components and minimum clinical standards of care for every patient in a given situation[2]. Interventions, where relevant, should be considered in this context and not in isolation. Options and evidence for alternative and less invasive management should be included

This approach gives greater recognition to the distinctive role of GPs and general practice within the health care system[3]. GPs predominantly refer to seek expert opinion on the management of a patient's condition and not for a specific intervention.

The approach fits with proposed future commissioning arrangements in which GPs and other clinicians, through clinical commissioning groups, will have a greater role in assessing needs and commissioning care for a local population and in ensuring that improvements to patient care happen in an integrated way and support joined-up care and better population health outcomes.[4]

A pathway approach is more likely to lead to a reduction in referrals by guiding treatment of patients who can be managed in primary care alongside timely referral at the appropriate point in the pathway as opposed to patients who cannot. It aims to identify all patients who should be referred as opposed to all patients who are referred which can be a consequence of some demand management processes i.e. it considers patients not referred who should have been and patients referred to secondary care who need not have been.

Guidance should be developed jointly by primary and secondary care clinicians and involve the wider multi-disciplinary team

There is significant evidence that for guidance to be effective, GPs and secondary care clinicians, in communication with peers, need to be jointly involved in evidence review and the decision-making process about what is included in guidance and how to implement it[5]. Clinical leadership and ownership is therefore essential and should encompass the multi-disciplinary team.

This approach reflects the policy direction in placing significant emphasis on outcomes, clinical leadership and accountability and a collective clinical voice leading service design and improvement for a local population. Discussions indicate that stronger clinical leadership will result in greater prominence being given to transformation of systems of care for defined populations, which also reinforces the pathway approach.

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[2] http://rightcare.wordpress.com/2011/06/08/cameron-on-integrated-care/ (accessed on 22 June 2011)
[3] The King's Fund (2011) *Improving the quality of care in general practice. Report of an independent inquiry commissioned by the King's Fund*. The King's Fund, London.
[4] Department of Health (2011). Government response to the NHS Future Forum report. Department of Health, London.
[5] Audit Commission. Reducing spending on low clinical value treatments, Health briefing, April 2011.

Guidance should be evidenced based and comply with national guidelines where available; guidance should take account of new technologies and enable access to contribute to the evidence base

Many sources of evidence and care pathway guidance exist (e.g. NICE, Map of Medicine, Pathways for Health) which should be built on to avoid unnecessary and costly duplication. Local clinical ownership remains critical so an approach that sets out key elements of the care process (e.g. standards and outcomes) but allows local flexibility in how the pathway is implemented is favoured.

Guidance will need to be revised and updated as relevant new evidence emerges and a process will need to be in place to do this, ideally on a "do once and share" basis.

To be useful pathway guidance must be accessible to providers, commissioners of care, patients and the public. Information should include compliance against guidance and outcomes to inform commissioning and patient choice. This should be part of the information revolution.

A means of equitable access to new technologies in their evaluative stages, for example based on research trial principles, has been highlighted. Arrangements need to encompass horizon scanning to identify emerging technologies and should link to the NIHR Health Technology Assessment programme and the Regional New Drugs arrangements.

Guidance should be designed to support and enable primary care improvement

Primary and secondary care clinicians have identified support and development of general practice knowledge and skills as a key benefit of guidance based on a pathway approach. All three clinical advisory groups have indicated opportunities to support improvements that would enhance patient care and enable more patients to be managed by primary care without a need for referral to secondary care. Identifying and addressing these opportunities is identified as a high priority and an important outcome from this work.

In this approach, equity in access and consistency in thresholds for referral would be promoted through clear criteria at key points of decision and progression along the pathway. Thresholds, rather than rules, recognize that there will be a need to apply clinical judgement to individual circumstances. The content and structure of guidance should enhance knowledge and skills to facilitate this. Training and education processes (utilising various channels) should support implementation and compliance.

Whilst there is some appreciation for the rationale behind referral management (or refinement) centres, overall there is little support within clinical advisory groups for this approach. It is felt that these arrangements can lead to a dilution of referral skills and elicit poor referral practice and behaviours and their cost effectiveness has been questioned. Discussions have signalled significant agreement with the conclusions and

recommendations from a Kings Fund study into referral management approaches[6]. These include the view that a consultant feedback supported referral management strategy built around peer review and audit with clear referral criteria and evidence-based guidelines is most likely to be both cost –and clinically – effective.

The need to keep systems simple and limit the administrative demands on clinicians' time has been emphasized. Equally, it is recognized that clinicians' need to accept accountability for compliance and be able to demonstrate this.

Guidance should specify clinically determined criteria for progression along the pathway and expected outcomes with relevant measures. Audit of compliance against these criteria should be the principal (and preferred) monitoring tool

Clinical responsibility and accountability is inherent in this approach. Where national guidelines exist, compliance against this should be audited and monitored more systematically. However, there is a very strong view that as a general principle audit should be more strongly embedded in guidance developed and that both clinicians and commissioners have a role in ensuring audit is carried out and results acted upon.

Adherence to and impact of guidance should be measured through audit along the pathway; this would enable progression along the pathway to be measured against clinically agreed criteria, including access to interventions and outcomes. Pathways should also reflect the role of the MDT, where appropriate, for both direct care and criteria for progression.

Audit against criteria would provide data to:

- Gauge quality and compliance of GP referrals and secondary care treatment decisions against agreed criteria e.g. secondary care clinicians could lead audit of GP referrals, commissioners could lead audit of treatment in secondary care and both primary and secondary care practice could be subject to peer review
- Enable referral practice and activity volumes to be monitored (for example against contract plans) whilst minimising the need for clinicians to make individual funding requests and minimising delay and uncertainty for patients; this may involve a trade off for providers with a commitment to systematic audit in return for a less bureaucratic system
- Enable patients who do not meet criteria thresholds to progress along the pathway where clinicians judge this to be appropriate e.g. non-compliance would need to be justified with a clinical reason and be subject to audit
- Identify unwarranted variation for further investigation and action as determined appropriate. Clinical advisory groups have expressed the view that root causes of variation are wide-ranging and often contextual; consequently unwarranted variation needs to be determined locally e.g. at the level of individual referrer.
- Give the public more information and support patients in making choices about their care
- Enable feedback and peer review to inform education programmes and guideline refinement

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[6] The King's Fund (2010) *Referral Management, Lessons for success.* The King's Fund, London.

Guidance should be consistently delivered

Once guidance is developed, the aim should be to ensure that it is effectively applied for every eligible patient on the pathway. This means that local healthcare systems need to be as reliable as possible in consistently delivering care as defined in the guidance. Pathway guidance is in itself a vehicle for more consistent and effective care delivery; however, there is evidence that even in well performing systems processes are not always followed[7].

This approach should be enabled by strategies that increase the reliability with which guidance will be applied. It should be possible, for example, to identify factors that would contribute to the effective implementation of pathway guidance, use this information to gauge the extent to which it is likely that guidance will be consistently delivered in a local area (i.e. a form of reliability index), and implement strategies that mitigate risk of unreliability in implementation. This could be linked to levers and incentives to enable implementation.

Having common guiding principles supported by key stakeholders is an important step forward but effective implementation of pathways at a local level will be essential to realise benefits in improved outcomes, patient experience and reduced costs. Clinical advisory groups have identified examples of pathway redesign where the potential improvements and efficiencies have not been realised. This is particularly the case where the distribution of activity across the pathway changes and efficiencies are dependent on capacity and resources being taken out of the system, particularly from secondary care. Greater alignment of levers and incentives across the pathway to support implementation is needed. Current perverse incentives need to be addressed. Commissioning for pathways of care and development of pathway based tariffs that reflect desired outcomes should be considered.

[7] Nolan T, Resar R, Haraden C, Griffin FA (2004). *Improving the Reliability of Health Care.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement.

Right Care Elective Surgery Project

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Surgical Specialty:	Urology
Key Issues e.g. LUTS	LUTS – develop referral criteria/ community provision Circumcision – GP awareness of normal physiology/ referral criteria Asymptomatic scrotal swelling – direct access to USS Percutaneous tibial nerve stimulation – research setting only
Actions Taken/ Work Done	Review of procedures of limited value and prioritisation July 2011 Review of evidence base (complied by Bazian) July/ Aug 2011 Creation of 'Procedures Explorer' (EMQO) July/ Aug 2011 Consensus meeting to describe high value care pathways Sept 2011 - British Association of Urological Surgeons - Royal College of Surgeons - PCT Cluster commissioners, public health, CCG leads - GPs, patients, providers
Products	**Phase I Description of high value clinical pathways Oct 2011** Evidence base (Bazian) Patient/ Clinician facing information Measures to describe process of care and outcomes Levers to support implementation Research questions arising
Milestones/ Next steps	**Phase II Development of high value clinical pathways March 2012** Consult on and develop Phase I high value care pathways - NHS Commissioning Board/ NICE/ NHS Evidence/ NHS R&D - speciality associations/ Royal Colleges - commissioners/ providers/ patients Seek examples of good practice - speciality associations/ Royal Colleges - commissioners/ providers/ patient groups Share examples of good practice - NHS evidence – QIPP case studies - Right Care casebook Develop health need/ process and outcome measures (EMQO) Health economic evaluation (EMQO. PHOs) Develop levers to support implementation Review Patient/ Clinician facing information - NHS Choices - shared decision making tools - clinical decision support systems – GP/ 2Y care **Consider development of new pathways Oct 2012**

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Surgical Specialty:	General Surgery
Key Issues e.g. LUTS	Bariatric/ Metabolic Surgery – change perception, health economic evaluation, community provision of specialist services (tier 3) Inguinal Hernia – reduce referral asymptomatic hernia/ registry PR Bleeding/ Haemorrhoids – screening/ scoring tool, one stop clinic
Actions Taken/ Work Done	Review of procedures of limited value and prioritisation July 2011 Review of evidence base (complied by Bazian) July/ Aug 2011 Creation of 'Procedures Explorer' (EMQO) July/ Aug 2011 Consensus meeting to describe high value care pathways Sept 2011 - Association of Surgeons of Great Britain and Ireland - Royal College of Surgeons - PCT Cluster commissioners, public health, CCG leads - GPs, patients, providers
Products	**Phase I Description of high value clinical pathways Oct 2011** Evidence base (Bazian) Patient/ Clinician facing information Measures to describe process of care and outcomes Levers to support implementation Research questions arising
Milestones/ Next steps	**Phase II Development of high value clinical pathways March 2012** Consult on and develop Phase I high value care pathways - NHS Commissioning Board/ NICE/ NHS Evidence/ NHS R&D - speciality associations/ Royal Colleges - commissioners/ providers/ patients Seek examples of good practice - speciality associations/ Royal Colleges - commissioners/ providers/ patient groups Share examples of good practice - NHS evidence – QIPP case studies - Right Care casebook Develop health need/ process and outcome measures (EMQO) Health economic evaluation (EMQO. PHOs) Develop levers to support implementation Review Patient/ Clinician facing information - NHS Choices - shared decision making tools - clinical decision support systems – GP/ 2Y care **Consider development of new pathways Oct 2012**

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Surgical Specialty:	ENT
Key Issues e.g. LUTS	Inequity in access to treatments, differential referral practices and inconsistent thresholds; limitations of GP knowledge and skills; variation in referral: surgery conversion rates; GPs refer for advice on management of a condition not for a specific intervention; can make better use of wider MDT skills; need for systematic audit of outcomes
Actions Taken/ Work Done	Key issues, challenges, and opportunities debated: April-May 2011 Principles of an alternative approach developed: May-June 2011 Priority pathways agreed and illustrative pathway guidance drafted: June-July 2011 Proposed principles shared and debated e.g. cil, London Clinical Senate August-Sept 2011 Modelling of variation and quantification of QIPP opportunities commenced September 2011
Products	Set of proposed principles for clinical commissioning of elective procedures, which command broad clinical support Three example clinical care pathways: 1. Childhood hearing loss 2. Sino-nasal symptoms 3. Acute sore throat
Milestones/ Next steps	Data analysis to illustrate potential QIPP opportunities for each pathway (for inclusion in guidance) End of 2011 Event to share and discuss pathways Early 2012

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Surgical Specialty:	Ophthalmology
Key Issues e.g. LUTS	Cataract pathway: strong evidence base of effectiveness, high volume activity, demand forecast to rise; inconsistency in access and variation in referral rates; opportunities to improve quality of referral decision earlier in the pathway; high new: follow-up ratio in secondary care; need to balance demand:supply taking account of all potential patients.
Actions Taken/ Work Done	Key issues challenges, and opportunities debated — June 2011 Cataract guidance developed for one London Cluster discussed by Clinical Advisory Group and Royal College of Ophthalmologists (RCO) – diverging views on inclusion of visual acuity criterion, which is not supported by the RCO — July 2011 Discussions about wider QIPP opportunities in the eye care pathway — October 2011
Products	The guidelines for cataract surgery that were subject to discussion have been adopted by a second London Cluster though not endorsed by the RCO. Guidelines include a visual acuity criterion to be considered alongside other criteria as a guide and not a rule – clinical judgment needs to be applied and patient's views and circumstances taken into account.
Milestones/ Next steps	Work is taking place to analyse variation in referral from primary care and secondary care activity plus and programme budgeting data to inform further debate about opportunities for improving pathways for eye care. The CAG membership to be reviewed and enhanced to reflect wider focus. The approach and specific milestones for further work have not yet been determined.

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Surgical Specialty:	Orthopaedics
Key Issues e.g. LUTS	Rising demand for joint surgery (demographic and lifestyle changes); longer implant survival rates, more surgery at a younger age; variation in primary care referral rates; variation in outcomes e.g. infection rates and revisions; variation in access to orthopaedic specialists; lack of information transparency to inform patient choice and commissioning.
Actions Taken/ Work Done	Key issues, challenges, and opportunities debated May-June 2011 Principles of an alternative approach developed June- August Priority for pathway development and QIPP opportunities identified August 2011 Proposed principles shared and debated e.g. London Clinical Senate Sept 2011 Proposed scope of project to design exemplar orthopaedic pathways and outcomes agreed October 2011
Products	Set of proposed principles for clinical commissioning of elective procedures, which command broad clinical support. Project initiation document and project plan - London focus with broader applicability to: demonstrate case for change; quantify potential quality and productivity improvements; apply principles to develop two exemplar pathways (hips and knees); examine future requirements for the orthopaedics; make recommendations to drive improvements through transparent usage of data; determine implementation approach.
Milestones/ Next steps	Confirm Project Steering Group and structure End of 2011 Project period to (estimate) Summer 2011 Take forward recommendations Autumn 2012

Right Care Elective Surgery Project

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Surgical Specialty:	Spinal/Neurosurgery
Key Issues e.g. LUTS	Back Pain Surgery for Epilepsy

Actions Taken/ Work Done	**For Back Pain:**
	- Contact with President of Society of British Neurological Surgeons (SBNS); Miss Anne Moore
	- System Design Workshop planned in Somerset with
	    o Matthew Dolman
	    o Alf Collins

Products Planned	**Phase I Description of high value clinical pathways Jan 2012** Activity, spend data and evidence base on Right Care's Systems Planning Support (SPS) Patient/ Clinician facing information on SPS Measures to describe process of care and outcomes and pathway of care where surgery is one of many options of care. Research questions arising
Milestones/ Next steps	**January System Design Workshop** In Somerset with: SBNS Somerset PCT GPs Commissioners Patient Groups Pain Specialists

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Surgical Specialty:	Cardiothoracic Surgery
Key Issues e.g. LUTS	Transcatheter Aortic Valve Implantation (TAVI)
Actions Taken/ Work Done	• A meeting was arranged with the British Association of Cardiothoracic Surgeons. The principal concern was the 'post-code lottery for TAVI'. • Commissioners were equally concerned about TAVI.
Products Planned	• A discussion has taken place among commissioners about TAVI.
Milestones/ Next steps	• A workshop needs to be arranged on TAVI in the context of programme for cardiovascular disease

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Surgical Specialty:	Plastic Surgery
Key Issues e.g. LUTS	The President of BAPRAS explained that aesthetic surgery was not a huge issue as far as they were concerned. The main issues for plastic surgery have been outlined in Appendix 3.
Actions Taken/ Work Done	Actions for plastic surgery have been outlined in Appendix 3.
Products Planned	See Appendix 3
Milestones/ Next steps	See Appendix 3

Appendix 1

Value, effectiveness and quality

It is important to distinguish between value, effectiveness and quality. During some discussions with clinicians, managers and patient representative groups, the Right Care Team has been challenged about a particular intervention because its use is supported by evidence of effectiveness. Although all high-value interventions must be effective, not all effective interventions are of high value

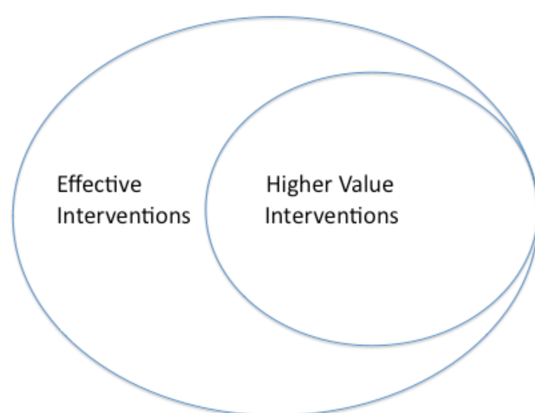


Figure 1: Illustrates how all high-value interventions must be effective, though not all effective interventions are of high value.

An understanding of this fact is important when considering the insights of the late Avedis Donabedian, who created the concepts of quality assurance in healthcare. Donabedian pointed out that as resources were increased, for instance, by increasing the rate at which an elective operation was performed or the proportion of people receiving a drug or decreasing the interval between screening tests, value improves quickly at first but then slows down, known as the Law of Diminishing Returns.

All healthcare, even of high quality, can do harm as well as good, and harm is directly proportional to the resources invested. When the increase in both benefit and harm is plotted on the same graph, there is a J-shaped curve of maximum benefit to harm, called the point of optimality by Donabedian (see Figure 2).

Thus, an intervention when provided at a higher rate will remain effective, but the added value will be less for the population. It is possible that greater benefit could be obtained for the whole population if the resources expended on providing higher rates of operation were invested to help another group of patients with the same type of disease or another group of patients with a different category of disease.

High value for populations and for individuals

Although the focus of *The NHS Atlas of Variation in Healthcare* is primarily population-based, identifying unwarranted variation is also of vital importance to the individuals within that population.

The relationship between the rate of activity and benefit and harm for the population was discussed in the previous section. As the number of interventions increases, the relationship between benefit and harm changes for the population as a whole. From the perspective of an individual patient, change also occurs because as the rate of intervention increases there is a point at which the clinical indication for the intervention starts to change.

For example, there has been an increase in the number of people undergoing elective surgery during the last decade. Before this period of increase, patients undergoing elective surgery were primarily those in severe need who were likely to benefit greatly and who accepted the probability of harm. Harm occurs in all services, even those of high quality, but for a certain proportion of patients it is a risk worth taking. However, as the backlog of people in severe need on the waiting list is reduced, the number of people in severe need consists of only those who deteriorate during the course of a year, referred to as the incidence of people in severe need. If the rate of surgery remains at a high level, or increases, the operation will be offered to people with less severe need. The benefit these people are likely to obtain will be smaller because their suffering prior to operation is not as great as that for those in severe need. However, as both the probability that there will be harm and the magnitude of that harm remain the same, the offer made to those in less severe need is different from that made to people in severe need (see Figure 3).

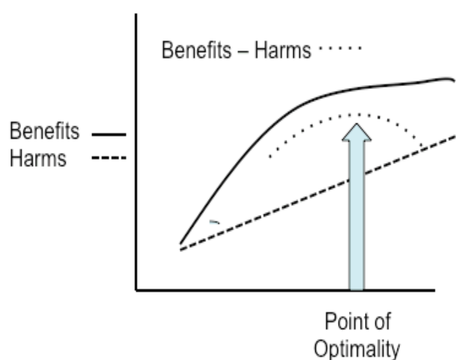


Figure 2: Donabedian's Point of Optimality

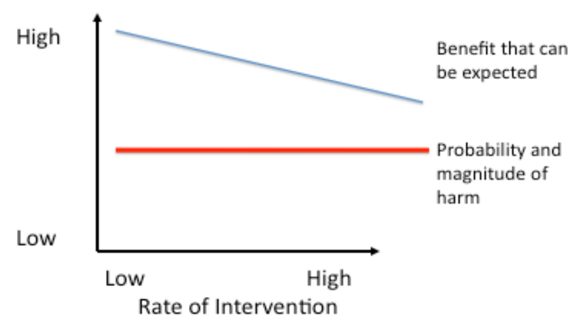


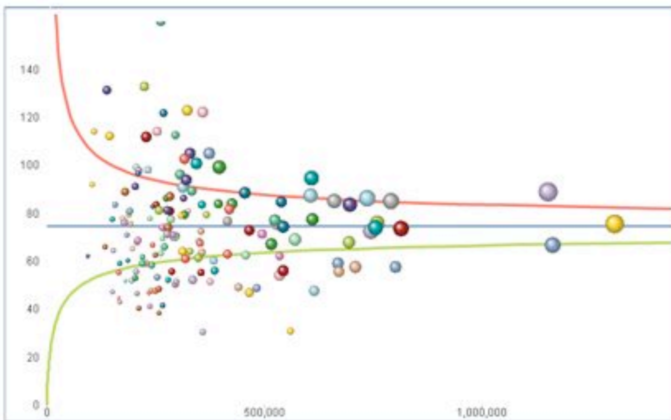
Figure 3: Benefit diminishes as magnitude of harm rises, with increasing rate of intervention

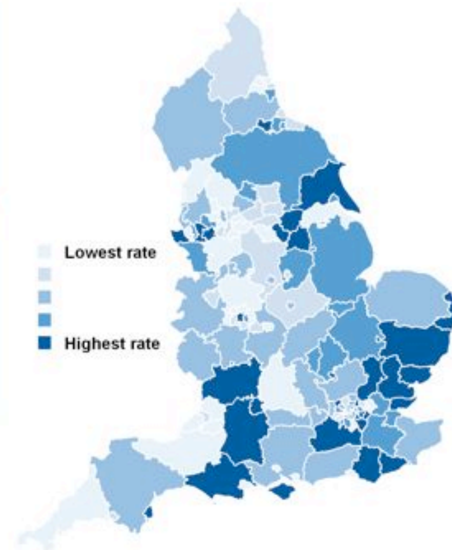
Thus, the Right Care Workstream is concerned with care for both populations and patients, and ensuring that the right patient gets the right treatment in accord with their particular values. To help ensure that the right patient gets the right treatment, Right Care has developed a suite of patient decision aids made available through NHS Direct so that patients can access them when considering what are known as "fateful decisions". Given the time constraints in a consultation, it is impossible for clinicians to communicate all the information required to help a patient weigh up the risks and benefits of an intervention and relate them to the patient's values.

APPENDIX 2:

FUNNEL PLOT DISPLAYING THE PCT LEVEL VARIATION IN THE SURGICAL MANAGEMENT OF LOWER URINARY TRACT SYMPTOMS

PCT level variation: LUTS





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Ordnance Survey 100039906

National activity: 37,357

Max DSR: 159 per 100,000

Min DSR: 30 per 100,000

Variation: 430%

Coefficient of Variation: : 29%

APPENDIX 3:

NOTE OF A MEETING WITH THE PRESIDENT OF THE BRITISH ASSOCIATION OF PLASTIC RECONSTRUCTION AND AESTHETIC SURGERY (BAPRS) MR TIM GOODACRE

Reviewing the list, Mr Goodacre explained that many of the issues that were of concern to commissioners were relatively uncommon operations which were not provided in some services because of pressures on plastic surgery time. Because plastic surgery engages with so many different aspects of the health service and because commissioners do not understand all the issues involved, plastic surgeons felt they had been unfairly criticised for the growth of their departments and expenditure on their specialty. The major causes of increased expenditure were not aesthetic operations but the increasing involvement of plastic surgeons in other specialties of which four were identified as being particularly demanding.

Cardiac Surgery
There has been significant growth in the work done by plastic surgeons as part of cardiac surgery teams. Problems with the chest wall following surgery (sometimes caused or aggravated by the internal mammary artery in revascularisation) require a significant amount of resource but plastic surgery teams are not funded directly by commissioners for this work.

Cancer work
As surgical intervention for cancer increases, plastic surgeons are required for simple reconstruction, (e.g. breast reconstruction) and for the management of skin and muscle flaps to restore a degree of normal function to the patient who had a major operation.

Trauma
Increasing the involvement of plastic surgeons in both the acute phase of trauma (e.g. head injuries) and reconstruction work following trauma is consuming a significant amount of plastic surgical time and theatre time.

Survival of people with severe handicap
There are a number of conditions which were formally fatal at an early age but which are no longer fatal because of much greater neo natal intensive care and some of these young people require extensive plastic surgery.