unlocking variation

Reducing unwarranted variation is the answer to improving people's health and outcomes and to creating a sustainable health system. And the RightCare programme could hold the key. Steve Brown reports

RightCare is far from a new programme. It can trace its roots back to the launch of the programme budgeting initiative in the early 2000s. This required commissioners to identify their spend across 23 different programmes of care and, over the years since, the RightCare programme has set this spend information alongside growing information around disease prevalence, activity and outcomes. But over the last year, the pace has picked up in a major way.

There have been RightCare pioneers for several years. But at the end of 2015, NHS England announced an 'expansion and industrialisation' of the programme in support of the *Five-year forward view*.

An expanded team of 20 delivery partners in the NHS England-hosted RightCare team is supporting clinical commissioning groups to start using the improvement approach, which highlights key areas of variation for CCGs (see RightCare basics box, page 17). Wave one, involving 65 CCGs, got under way in February 2016 with the remaining 144 local commissioners forming the second wave in December.

Tackling variation is seen as one of the major ways the NHS will close its £22bn efficiency gap by 2020/21. With Lord Carter's work on productivity and the *Getting it right first time* initiative supporting providers to address variation, RightCare is aimed specifically at commissioners. 'RightCare is about delivering the best care to patients, making the NHS's money go as far as possible by identifying and dealing with unexplained variation in healthcare,' says Matthew Cripps, national director of NHS RightCare.

NHS England's expansion of the programme comes with big expectations. Of the service's £22bn efficiency requirement by 2020/21, the spending review's assumptions were that £4.3bn would come from activity-related efficiencies in commissioners. New models of care, specific work around urgent and emergency care and self-care all make contributions.

The National Audit Office's *Financial sustainability of the NHS* report put RightCare's share at £1.5bn, although other sources put the figure at £1.7bn. This savings expectation really kicks in this year – *Healthcare Finance* understands that the original spending review assumptions anticipated that about a third of the RightCare total contribution would be delivered in 2017/18.

Professor Cripps says the targets are achievable. 'We're encouraged by progress in wave one,' he says. 'The focus on better patient outcomes and increased value we tested when piloting the RightCare approach previously is holding true when implemented at scale.'

> **"The focus on better patient outcomes and increased value we tested when piloting the RightCare approach is holding true when implemented at scale"**
> **Matthew Cripps, NHS RightCare**

There have been some concerns that CCGs are using RightCare data to justify higher thresholds to access certain services and so reduce spend – with hips and knee replacements in particular in the news. While making no direct comment about specific cases, it is understood that NHS England has recently written to CCGs to underline how RightCare data should be used in these service areas.

The letter restates earlier comments in commissioning for value musculoskeletal (MSK) focus packs that high activity should be a trigger for further analysis, not immediate changes to access. 'There is strong evidence that hip and knee replacements are extremely cost-effective interventions when warranted by clinical need and patient preference,' the packs say. 'High rates should only be interpreted as an opportunity to reduce activity after further investigation.'

Given the rapid increase in expectations for RightCare-related savings, it is lucky that CCGs are not all starting from scratch. For some, it is about accelerating and embedding the use of data. Or, as Mr Cripps puts it, 'helping commissioners to optimise their use of the tools and establish a common view of the problem'.

Part of the roll-out is about sharing what has already been shown to work. Last year for example, RightCare published a cardiovascular disease prevention pathway to signpost easy wins for improvement. Within this it flags up Bradford's *Healthy hearts* programme, which was launched in 2014 following analysis of RightCare data.

That programme has seen some 6,000 cholesterol lowering statin users switched to a different generic statin and a further 7,000 at risk patients started on the drug, in line with NICE guidelines, without putting an unmanageable burden on general practice. Other work has looked at atrial fibrillation and high blood pressure.

Youssef Beaini, GP and CVD specialty lead across Bradford Districts, Bradford City and Airedale, Wharfedale and Craven CCGs, says CVD was already on the radar from earlier public health data – with Bradford Districts having the seventh worst death rate for strokes and heart attacks among under 75s across all CCGs.

'But RightCare packs definitely focused our minds,' he says. 'It is very clear data that helped us to focus on areas of low hanging fruit. Without this focus, programmes can just languish. But it gave us a framework to think through our CVD aspirations. It was a great catalyst.'

The ongoing *Healthy hearts* campaign has already delivered some

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RightCare – the basics

RightCare looks to address unwarranted variation in access, quality, outcomes and value – in particular helping to address both overuse and underuse of services. The overarching aim is to optimise population healthcare in a way that drives financial sustainability.

The programme talks about 'triple value'. Allocative value describes how well assets are distributed between programmes of care (such as cancer or respiratory), between systems in each programme (asthma and COPD, for example) and within each system (prevention, drug therapy or rehabilitation).

Technical value describes how well resources are used to deliver valid outcomes. Personalised value describes how well an actual outcome relates to the values and hopes of each individual.

There are three stages:

- Using spend and outcome data to decide where to look for improvement opportunities
- Planning what to change
- Developing practical solutions and deciding how to change.

It is an iterative process, with priorities changing as areas are addressed or as data is refreshed, ending up with continuous improvement being business as usual.

Commissioning for value data packs are produced for each CCG. 'Where to look' packs (refreshed in January this year) highlight the five top service areas where CCGs should look for improvement.

These are supplemented by focus packs that drill deeper into areas such as cancer, musculoskeletal and long-term conditions. The data packs have also been recut to show opportunities across sustainability and transformation plan footprints.

good outcomes and is being expanded, but Dr Beaini says RightCare data is now used routinely to help identify priorities for the CCGs. Respiratory and diabetes are new services currently under the spotlight. He encourages other CCGs not yet using the data in detail to do so and welcomes the new mandatory approach across England.

A number of CCGs in wave one of the roll-out say RightCare has already proved useful in confirming local priorities for improvement.

Ian Baines, director of organisational development for three CCGs covering Cannock Chase, Stafford and Surrounds, and South East Staffordshire and Seisdon Peninsula, underlines this. 'Our organisations have been in various aspects of special measures and turnaround for two to three years and as a consequence we have developed a strong relationship with business intelligence around our QIPP programmes and improvement work,' he says. 'We were already data driven, so when the RightCare programme came along, the principles aligned nicely with what we were already doing.'

But it has been useful in reinforcing existing approaches and extending some of the data sources. The 2016/17 QIPP programme contained projects that broadly addressed the priority areas highlighted in the CCGs' 'where to look' data packs. For the new year, the CCGs are taking a slightly different approach, using the data to feed into broader analysis around variation in primary care as well as including reference to the RightCare approach and data as part of every QIPP project.

Cumbria CCG, another wave one body, also credits RightCare with providing useful and focussed supplementary intelligence on where to target improvement. It had already identified pain management within its MSK services as needing to be overhauled. It knew it had an overly acute model of care that didn't meet NICE guidance. And staffing difficulties had led to some services in the north of the county being outsourced to the private sector.

MSK savings

On joining the programme, RightCare data provided confirmation of this diagnosis on MSK services, with January 2016 data showing the CCG was spending nearly £8m more on elective and day case admissions than the best five CCGs from a peer group of 10.

On top of this, it was exceeding the average on non-elective admissions and prescribing. More detailed data showed high relative spend on back pain injections. 'We were benchmarking very high on the amount of surgical intervention and it was clear that we didn't have alternatives to that acute service in place,' says Ray Beale-Pratt, Cumbria CCG's business, finance and performance manager.

All the pointers were towards a revised NICE compliant pathway based on a biopsychosocial model of care – and taking this approach for all pain, chronic fatigue and medically unexplained symptoms, not just back pain. 'RightCare data helped confirm what we already knew,' explains Mr Beale-Pratt. 'It was a case of triangulation, making it a stronger argument for change, and giving us confidence around the business risk and affordability [of the changes].'

High intensity focus

Early users of RightCare data, the two clinical commissioning groups Blackpool and Fylde and Wyre, used commissioning for value data packs and other data sources to identify unscheduled care services as an improvement priority.

A small group of service users were seen to be consuming a disproportionate amount of the £86m unscheduled care spend. Further data showed the top 100 frequent 999 callers called 1100 times in three months, resulting in about 1,000 A&E attendances and 300 admissions.

With high levels of self-harm incidents associated with these cases, it was clear that patient outcomes were poor despite the high spending levels.

A new support mechanism was needed for these high-intensity users. So advanced paramedic Rhian Monteith set out to provide a 'de-medicalised' service based on emotional intelligence, empathy and coaching. She contacted each high-intensity user, focusing on their issues and needs and not the nature of their emergency calls.

'My role was to listen to what the issues were and work through what was real and not real; not looking at solutions initially, but active listening and personalised coaching,' she says. 'Then my role was to unpick things one at a time to a position when they can flourish – it might be an eviction that's triggered a crisis, unresolved grief or no sense of purpose.'

Ms Monteith would then help address specific issues, bringing in other services where needed. 'The concept is to first provide emotional support and then practical support,' she says. Clients were encouraged to contact Ms Monteith when they needed to talk, instead of 999, or if they recognised any crisis triggers. And, with relapse common after about three months, access channels remained open to help the client course-correct and move forward again.

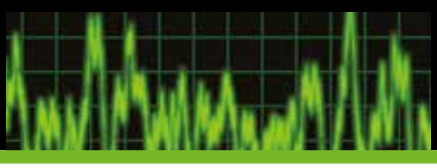
The results have been impressive. Over 15 months, 999 calls and accident and emergency attendances fell by around 90%, admissions by 82% and recorded self-harm incidences by 98%. And the big reductions were all in the first three months. In total the study suggests the 15-month pilot delivered more than £2m savings.

Ms Monteith says that while there is no formal 'discharge', users typically become less reliant on the service after about three months. And while clients can re-access the service at any point, simply by making a call, it is at this point that she can think about taking on new clients.

At Blackpool and Fylde and Wyre CCGs, the focus expanded to high-intensity service users, not just 999 callers. The programme has also started to look at high users of primary care services and those patients frequently self-presenting on wards.

Ms Monteith is now supporting a national rollout of the work for RightCare. A resource pack was published in January suggesting local areas can see results in as little as five months from starting the initiative. Some 30 CCGs are taking work forward and replicating Blackpool's individual lead approach, with Ms Monteith believing each lead could support 50-70 clients per year to help these vulnerable people flourish.

Blackpool's 'where to look' opportunities, January 2016



Helping Slough on its data journey

The use of data to inform service improvement is now embedded in the way Slough operates. Sangeeta Saran, associate director of planned care, says the CCG was already on this 'data journey' before RightCare emerged, with clinicians analysing prescribing data. 'But it had been a relatively blunt tool, with comparison limited to our own population and neighbouring commissioners,' she says. 'RightCare gave us a much greater breadth of data.'

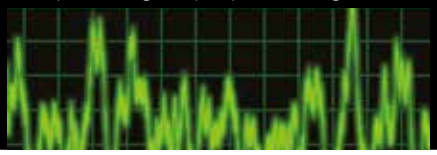
RightCare data, supplemented by local data and analysis, highlighted diabetes as a priority for improvement. Ms Saran says the local diabetes service in 2012/13 was low cost with poor outcomes.

The data suggested two prongs of attack. The town's 16 GP practices exhibited wide-ranging prevalence of diagnosed diabetes and different outcomes in terms of meeting key process targets. It also highlighted poor engagement with South Asian people (40% of its total population), where prevalence of diabetes can be six times higher.

A general practice training programme aimed to improve the identification of people with or at risk of diabetes. This has reduced variation between practices in terms of diabetes identification and an increase in the numbers of patients receiving the eight national recommended diabetes care processes.

The South Asian community has also been targeted with a lifestyle intervention programme. '[The existing service] wasn't tailored to their needs, it wasn't ethnically sensitive,' says Ms Saran. Instead of simply talking about five fruit and vegetables a day, this community needs help to understand how they can replace or reduce certain foods used in cooking – ghee, palm oil white rice and salt all being known problem ingredients.

Both programmes have contributed to an increase in detection rates. Those at risk of developing diabetes are also more engaged and being formally reviewed. More generally, control of diabetes is improving – the percentage of people meeting blood glucose, blood pressure and cholesterol targets has more than doubled.



With support from clinical pharmacists, practices have also reduced prescribing costs. 'Following the RightCare process, we've moved from low outcomes and low cost to high outcomes and low cost,' says Ms Saran.

The approach is now planned to be rolled out across two neighbouring CCGs (Bracknell and Ascot; Windsor, Ascot and Maidenhead) and Ms Saran says collectively the commissioners believe they can save in annual costs, while improving the consistency and outcomes of services.

Slough's diabetes prevalence, from long-term conditions pack 2016

The standard referral pathway now for the county's new persistent symptom management service is for triage in a community-based service, instead of direct GP to acute services in all but urgent or complex cases. After a multi-disciplinary assessment, patients might receive a range of therapies either one-to-one or in group settings.

A year in and the service now receives more than 100 referrals a month. Patients like it and Mr Beale-Pratt says outcome measures have been 'consistently excellent'.

GP attendances are also expected to show a reduction, especially for those patients with medically unexplained symptoms who are regular attenders. Importantly, there has been a major shift in referrals away from secondary care intervention. Early indications are that the new community service addresses patients' needs in a sustainable manner, rather than simply delaying the need for acute care.

Cumbria is quick to emphasise that cutting costs was not the prime motivation. The changes sought to improve outcomes and address the fact that current services were not sustainable. But the new service has also been a 'financial success' with significant savings to the health economy being delivered.

Capturing these improvements across all commissioners will be important in terms of demonstrating the value of the RightCare approach centrally. CCGs have to prepare quarterly reports. This helps the centre to identify good practice that they can help to share more widely (see box, page 18). But it is also how CCGs will report on the financial improvements being delivered.

Wave one CCGs were asked to identify savings equal to 1% of turnover or 30% of the opportunities identified in their RightCare packs. This has risen to 40% for wave two CCGs.

Some managers detect a change in emphasis, with an increasing focus on delivering savings. However, RightCare prefers to talk about the 'co-ordinated reallocation of capacity' or CROC rather than savings. Resource needs to be taken out of unwarranted interventions or sub-optimal care and reallocated to meet or avoid growing demand or to tackle unseen demand.

NHS England's February board paper references one STP that has around 500 beds being used for potentially unwarranted activity. At the same time, the footprint area has an estimated 43,000 undetected members of the population with at least one of five conditions that drive overuse of secondary care. 'There is likely to be at least some cause and effect within this variation,' it says.

Optimising the system

Mr Cripps insists that it is not as simple as closing acute beds in favour of community services. 'What our analysis shows is that some patients are in hospital who could more appropriately be cared for in a sub-acute setting or for whom better co-ordinated care could have avoided a hospital admission,' he says.

Meanwhile, for other patients their condition deteriorates while they wait for a hospital bed.

'The key thing to focus on is optimising the whole system,' says Mr Cripps, 'which may result in investment in community services reducing the need for hospital beds, but in most places is also likely to see beds used for frail elderly patients being made available for emergency admissions or elective surgery while the elderly are supported in their own homes. This lowers the cost of all parts of the system by deploying resources for better outcomes.'

It has taken several years for RightCare to become part of mainstream NHS commissioning. It has good central support with commissioners and clinicians appearing to like the data-driven approach. But in many ways, the real work starts now, as all eyes will be on what it can actually deliver in terms of improved outcomes and better value services.