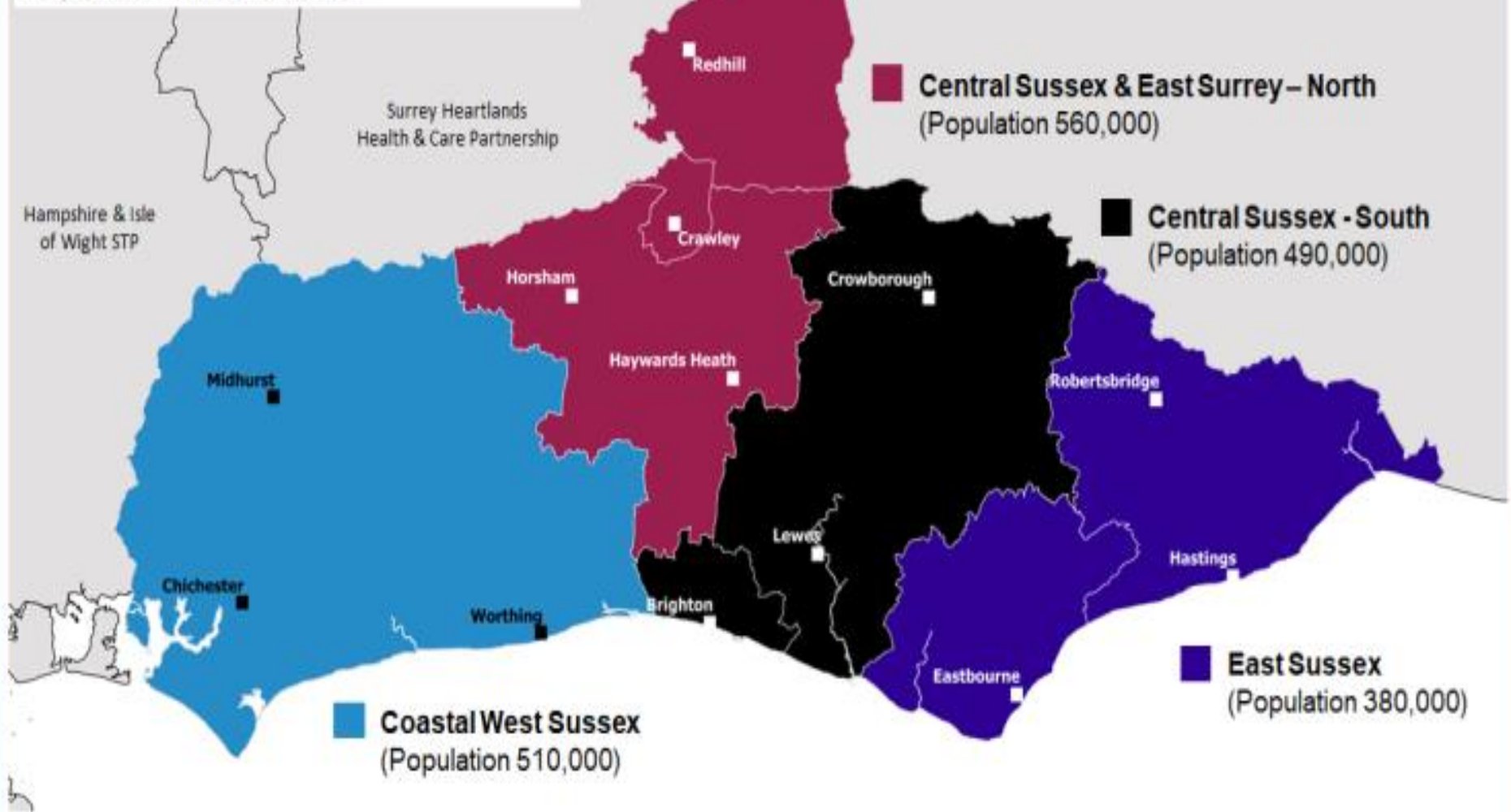


Co-creation of Best Possible Value Solutions to Unwarranted Clinical Variation

**Dr Karen Eastman, Lead for Unwarranted Clinical
Variation, Sussex Health and Care Partnership**

SUSSEX AND EAST SURREY

SUSTAINABILITY & TRANSFORMATION PARTNERSHIP
Population served: 1,940,000



Across Sussex and East Surrey:

- 8 Clinical Commissioning Groups
- 4 Local Authorities
- 5 NHS Hospital Trusts
- 1 Out-of-Hours Urgent Care Provider
- 2 Community Health Providers
- 209 General Practices
- 2 NHS Mental Health Trusts
- 1 NHS Ambulance Trust
- 1 Cancer Alliance



Achievement of the best outcomes for individual patients and for the public within available resources.

Doing less of things that add little or no value to patients.

Requires the development and use of standardised outcome measures that are more relevant to patients (such as the impact on their functional status and wellbeing).

Shared decision making - more active involvement with well-informed patients.

Recognising unwarranted local variation in the delivery of high value care and addressing it.

Where can we seek the evidence?



What's different this time?

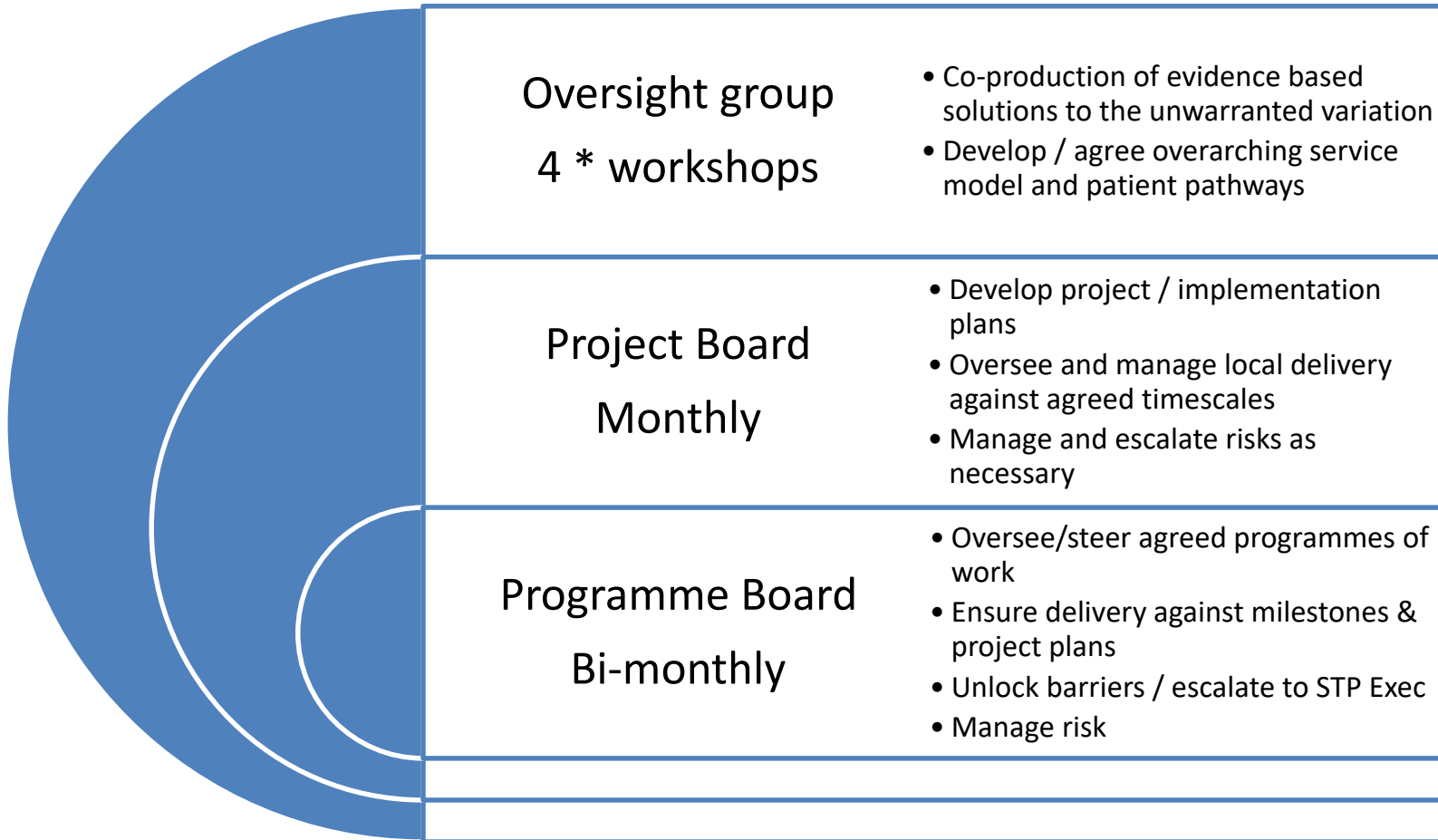


Senior sign off – CEOs,
Medical Directors of all Trusts.
Bob Alexander as Executive
Sponsor

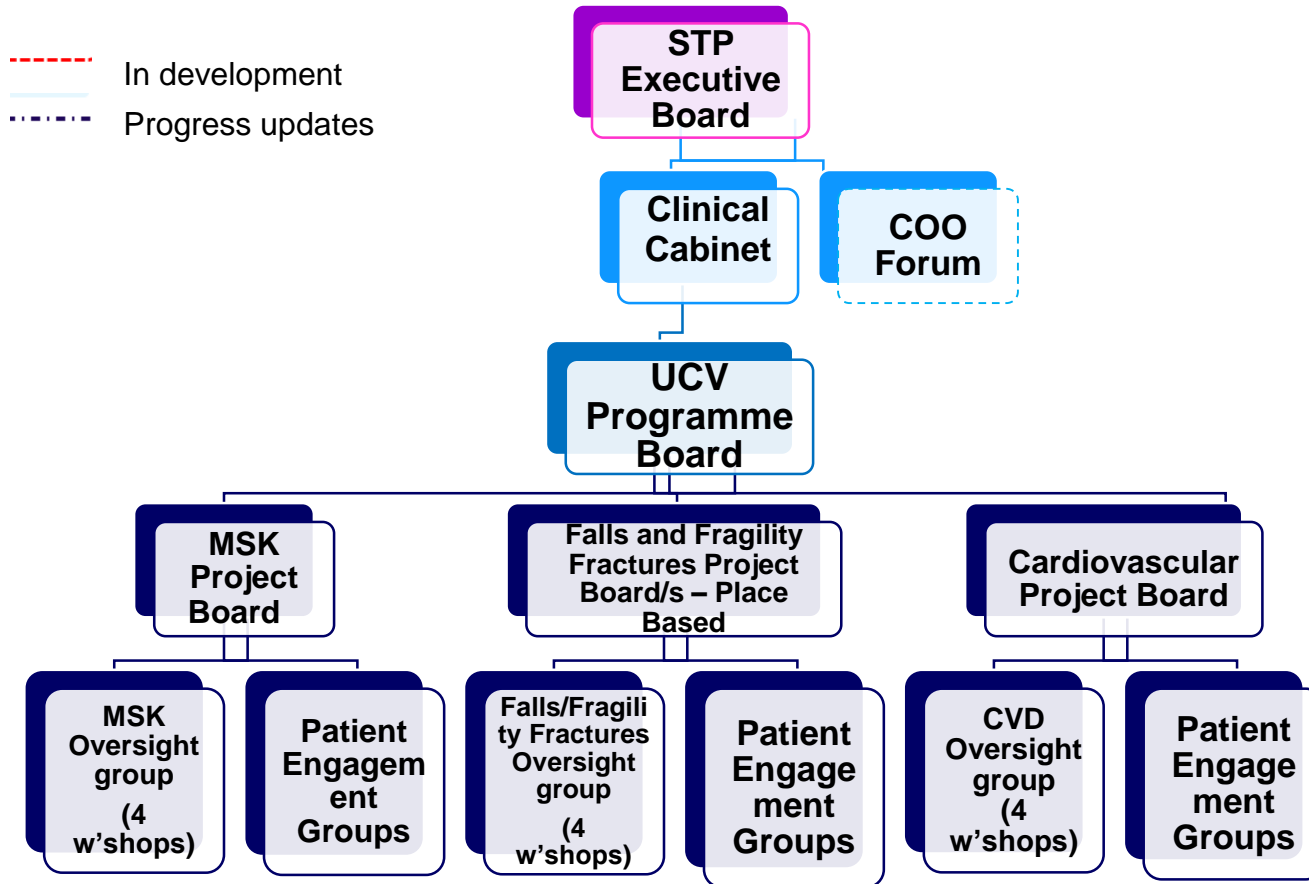
Evidence Based and
Collaboratively co-produced
care pathways with Senior
Stakeholders

Widely socialised and
supported Programme +
Strategic Commissioning
approach across the STP

Unwarranted Clinical Variation : Remit and frequency of groups



UCV Governance: Information Flows and Reporting Pathways



Spend Opportunity - on discharges/admissions per 1,000 age-sex weighted population to best 5 CCGs in peer group

Disease Area	Spend area	Spend opportunity (£000)		17/18
		15/16	16/17	
Cancer & Tumours	Elective	1,367	1,143	
	Non-Elective	595	611	
	Prescribing	2,095	2,337	
Circulation Problems (CVD)	Elective	6,312	4,498	5,754
	Non-Elective	1,932	2,791	6,914
	Prescribing	2,590	3,422	4,017
Endocrine, Nutritional and Metabolic Problems	Elective	625	818	
	Non-Elective	835	1,105	
	Prescribing	7,660	8,773	
Gastrointestinal	Elective	1,568	3,878	
	Non-Elective	612	1,610	
	Prescribing	1,833	2,851	
Genitourinary	Elective	680	1,964	
	Non-Elective	1,103	334	
	Prescribing	1,396	2,142	
Mental Health Problems (all)	Prescribing	2,179	2,579	
Musculoskeletal System Problems (Excludes Trauma)	Elective	10,475	13,291	12,694
	Non-Elective	303	939	1,716
	Prescribing	165	196	201
Neurological System Problems	Elective	1,930	2,146	
	Non-Elective	3,323	2,894	
	Prescribing	2,799	3,582	
Respiratory System Problems	Elective	1,025	1,749	1,692
	Non-Elective	1,118	2,019	5,278
	Prescribing	962	2,137	2,389
Trauma & Injuries	Elective	1,846	2,203	1,836
	Non-Elective	2,317	3,551	4,657
	Prescribing	636	575	533

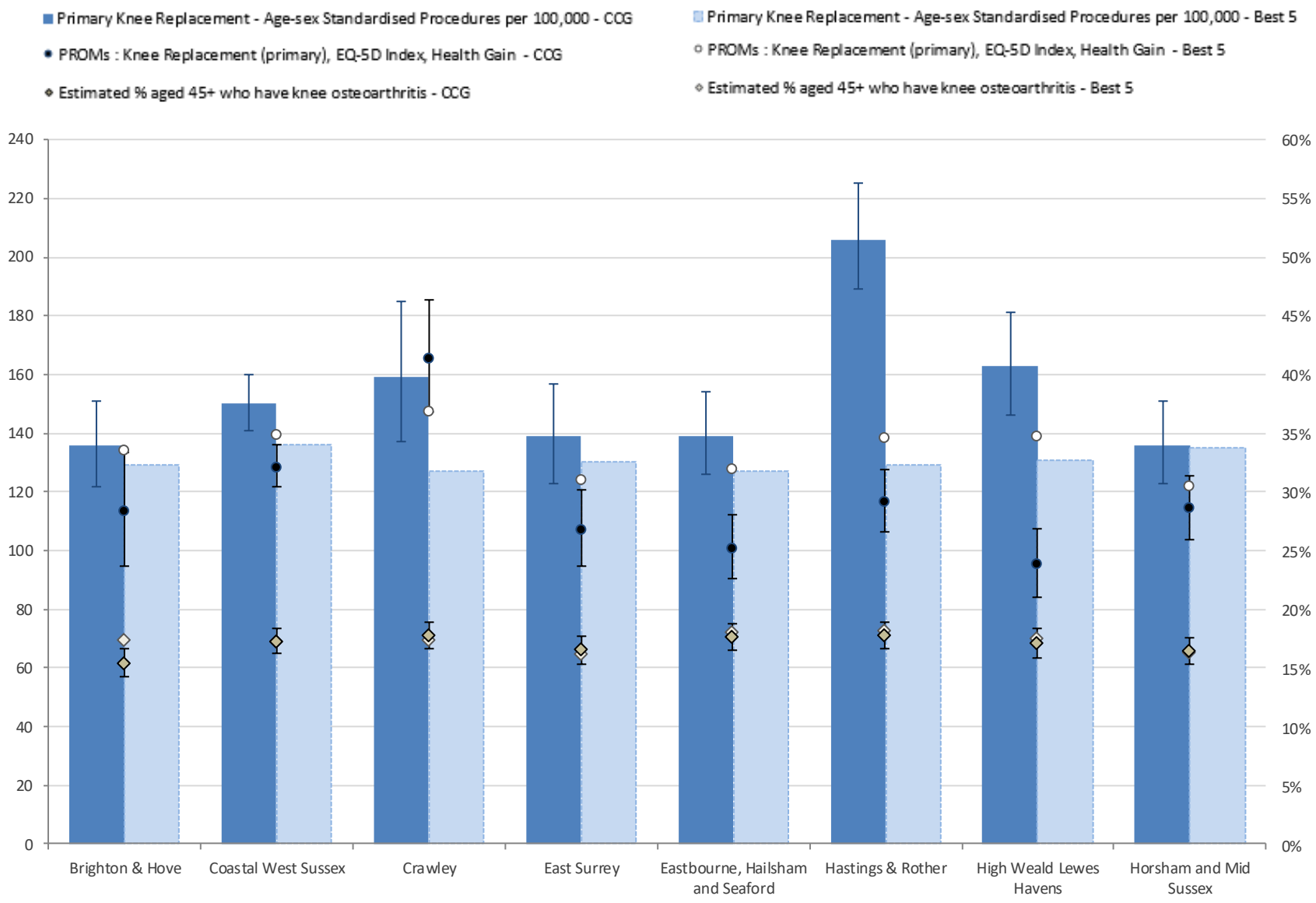
Disease Area	Spend	£000	Quality	No. of patients, life-years, referrals, etc.
Musculoskeletal System Problems (Excludes Trauma)	<ul style="list-style-type: none"> Spend on elective and day-case admissions Spend on non-elective admissions Spend on primary care prescribing Spend on admissions relating to fractures where a fall occurred 	<ul style="list-style-type: none"> 11,518 404 152 1,744 	<ul style="list-style-type: none"> MSK - Rate of bed days % osteoporosis patients 50-74 treated with Bone Sparing Agent % patients 75+ years with fragility fracture treated with BSA Hip replacement, EQ-5D Index, average health gain Knee replacement, EQ-5D Index, average health gain Hip replacement emergency readmissions 28 days Hip fractures in people aged 65+ Hip fractures in people aged 65-79 Hip fractures in people aged 80+ % fractured femur patients returning home within 28 days Hip fracture emergency readmissions 28 days 	<ul style="list-style-type: none"> 5,398 9 148 589 428 33 278 35 88 107 56

Holistic Approach
Self-Management
Plan/programmes
Shared Decision
Making

Patient Information
Exercise
Weight Loss

Ensuring core
treatments are tried
first will help reduce
referrals and improve
outcomes for those
who do go on to
surgery

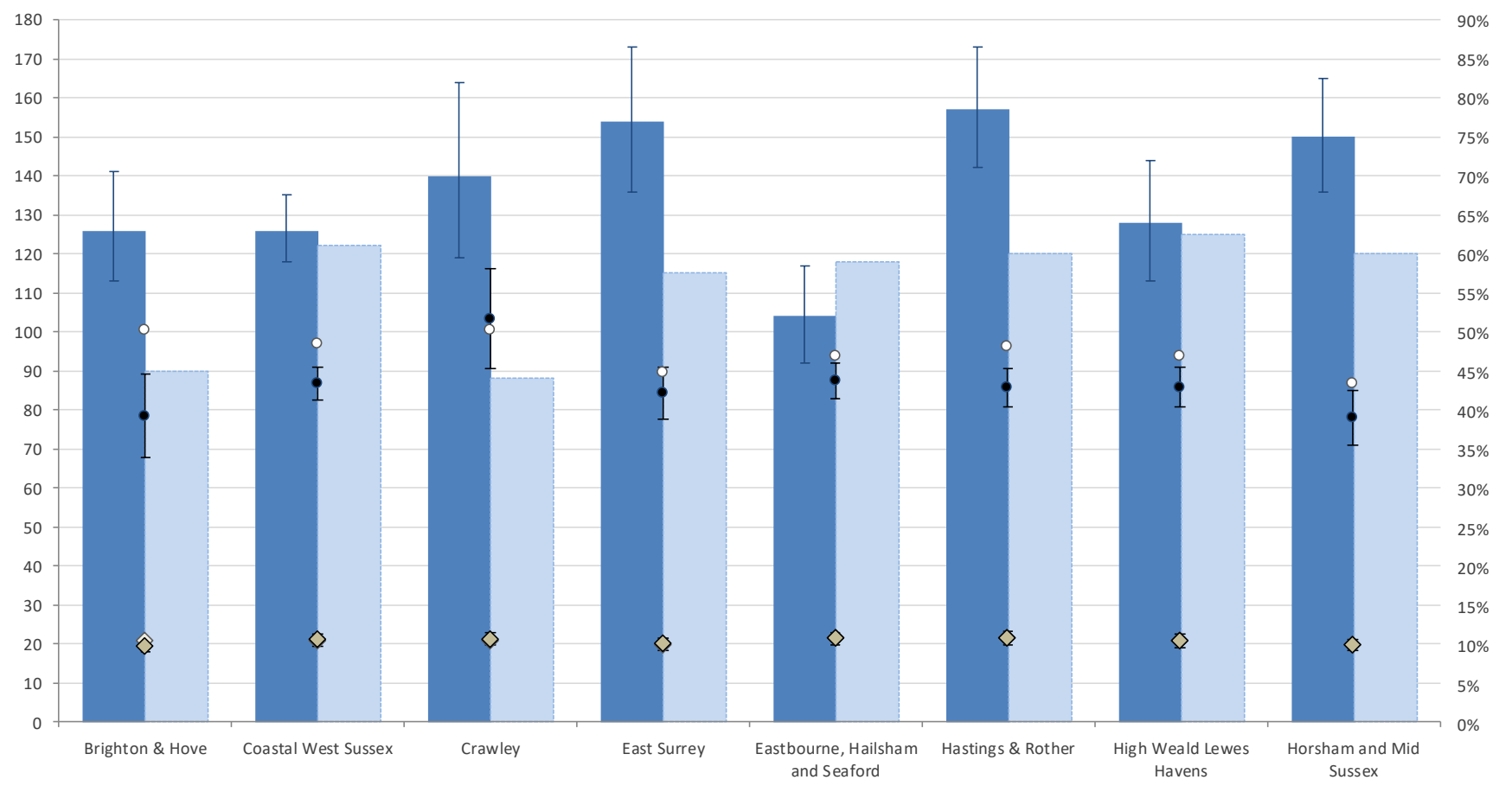
Knee Replacements



National Commissioning Data Repository (NCDR) – Hospital Admissions Databases, SUS+ SEM (Secondary Uses Services Plus, Standard Extract Mart) - 2017/18
 English Longitudinal Study of Ageing Wave 1 (2000/01) – Wave 5 (2010/11), Arthritis Research UK Musculoskeletal Calculator (now Versus Arthritis) - 2012/13
 Patient Reported Outcome Measures (PROMs), NHS Digital - 2016/17 (Final)

Hip Replacements

- Primary Hip Replacement - Age-sex Standardised Procedures per 100,000 - CCG
- Primary Hip Replacement - Age-sex Standardised Procedures per 100,000 - Best 5
- Hip Replacement (primary), EQ-5D Index, Health Gain - CCG
- Hip Replacement (primary), EQ-5D Index, Health Gain - Best 5
- ◆ Estimated % 45+ who have hip osteoarthritis - CCG
- ◆ Estimated % 45+ who have hip osteoarthritis - Best 5



National Commissioning Data Repository (NCDR) – Hospital Admissions Databases, SUS+ SEM (Secondary Uses Services Plus, Standard Extract Mart) - 2017/18
 English Longitudinal Study of Ageing Wave 1 (2000/01) – Wave 5 (2010/11), Arthritis Research UK Musculoskeletal Calculator (now Versus Arthritis) - 2012/13
 Patient Reported Outcome Measures (PROMs), NHS Digital - 2016/17 (Final)

Same prevalence of knee and hip osteoarthritis as demographic peers

High spend in THR & TKR compared to demographic peers

Lower EQ-5D Index Health Gain post surgery

NICE Pathway recommends conservative management (exercise/weight management/patient education) before consideration for surgery as can reduce pain, improve function and avoid need for joint replacement

CEC Policy mirrors NICE – minimum 6 months conservative management + SDM



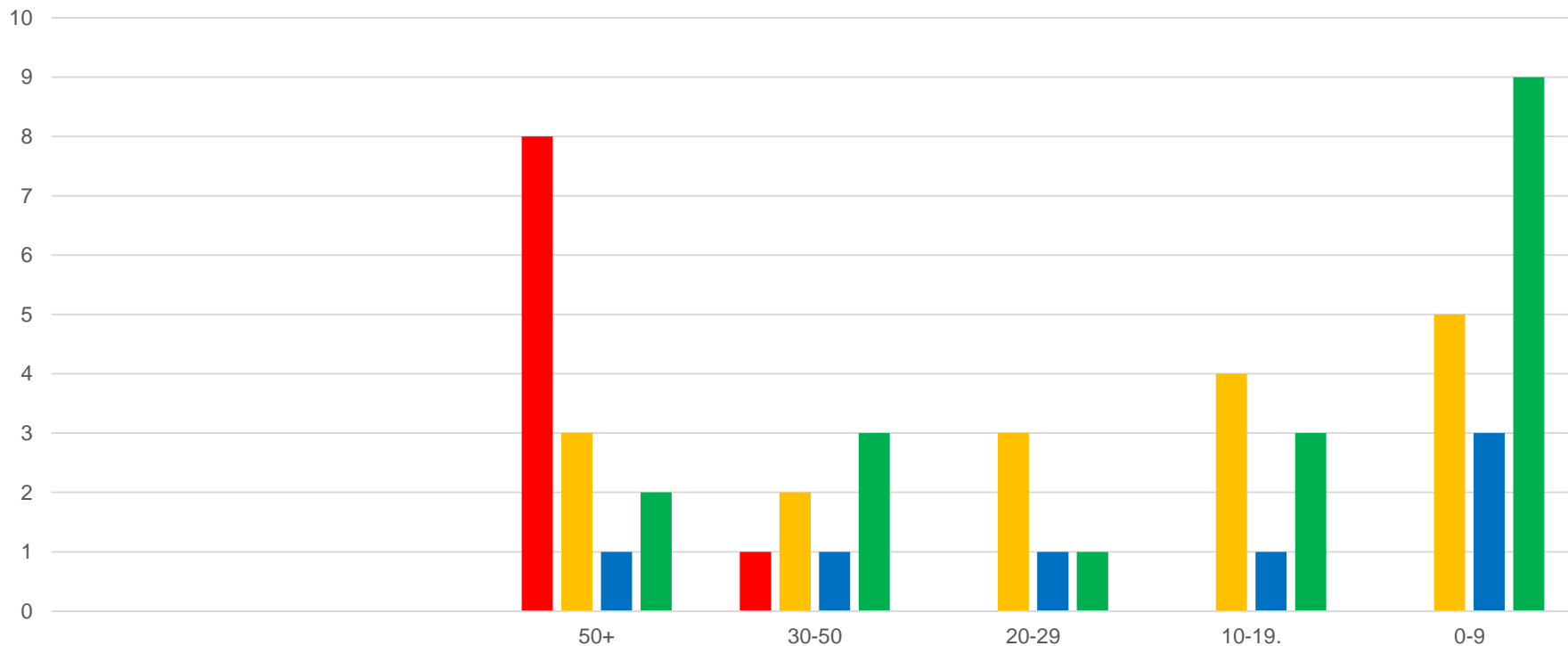
Top Challenges & Priorities

- Variation in centre/surgeon volumes
- Reduce infections/revision rates and litigation
- Consider forming a regional revision centre
- Variation in procurement – prosthesis cost/loan kits
- Variation in # NOF outcomes
- Increase use of cemented THR replacements in over 70s
- Reduce LOS
- Reduce inappropriate knee arthroscopy rates

1. Getting It Right First Time (GIRFT) Elective Orthopaedics

Table 1.7

Number of THR per surgeon



34% do less than 10 procedures a year

54% do less than 20 procedures a year.

Only 30% of STP surgeons perform greater or equal to 50

TKR 1 year revision rates post Joint Replacement per Surgeon

1. Getting It Right First Time (GIRFT) Elective Orthopaedics

Table 1.15

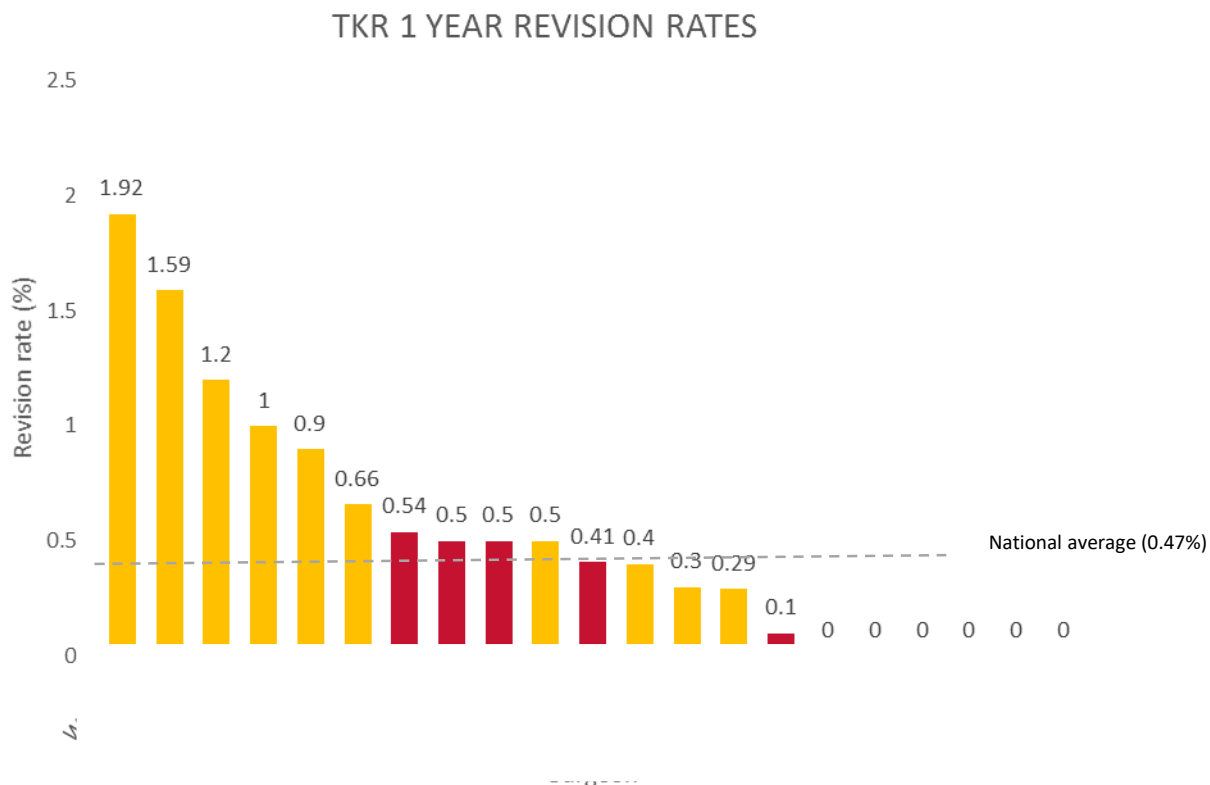
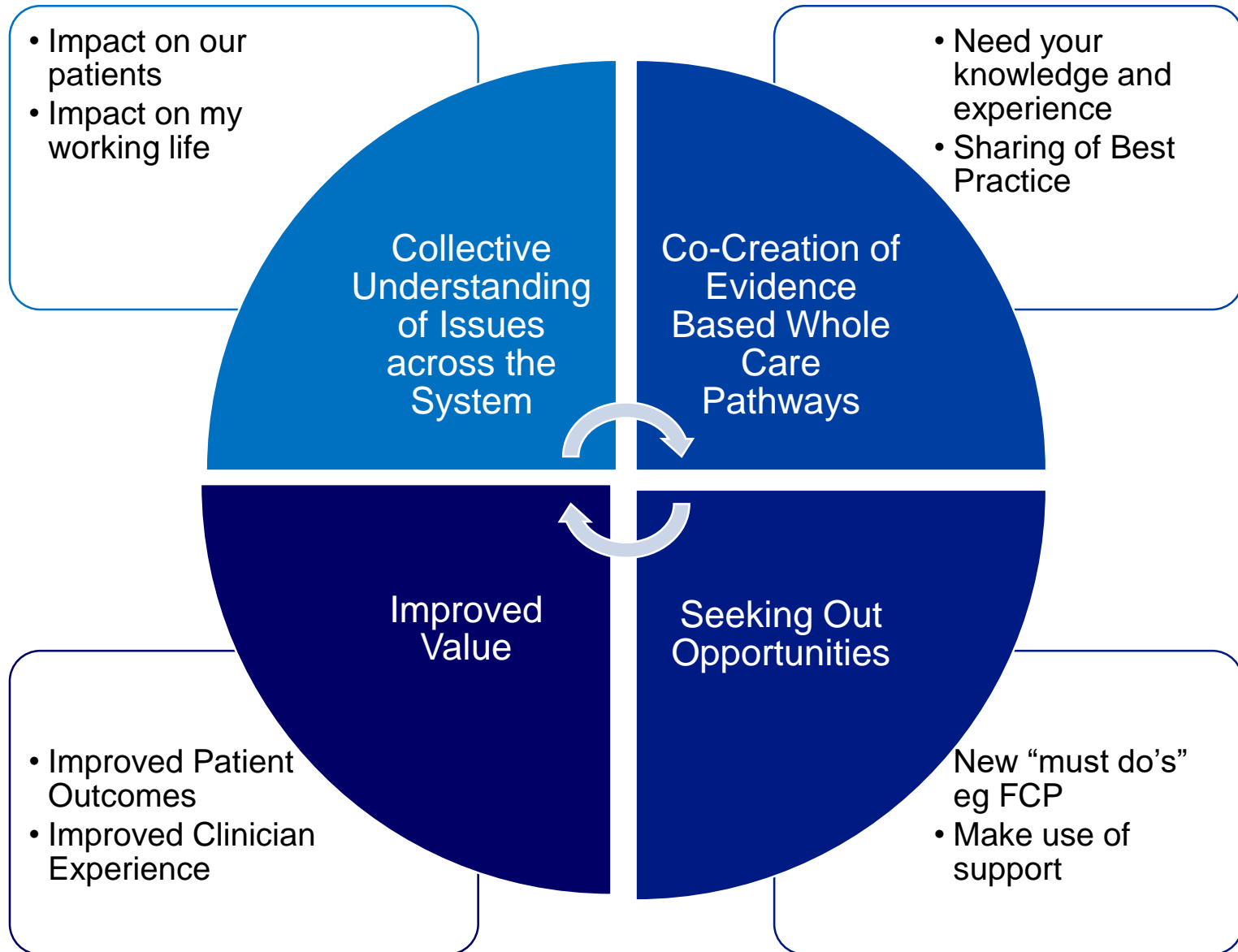


Table	Description	Source
1.15	1 year revision rates for TKR	Source: GIRFT Orthopaedics data requests obtained from each respective trust

What's the Focus and Why Me?



ISSUES	OPPORTUNITIES
<ul style="list-style-type: none"> Variation within the Complex Revision Surgery Pathway and need for STP MDT 	<ul style="list-style-type: none"> Signposting to self-management opportunities/social prescribing across the System
<ul style="list-style-type: none"> Variation in prosthesis procurement costs 	<ul style="list-style-type: none"> Develop/spread First Contact Practitioners/ESCAPE-Pain Programmes/patient information leaflets/videos and improved front end of Pathway
<ul style="list-style-type: none"> Variation in waiting times/capacity, esp. physiotherapy 	<ul style="list-style-type: none"> See patients sooner
<ul style="list-style-type: none"> Variation in patient experience/journey 	<ul style="list-style-type: none"> Agreed wider Primary Care MSK Pathway/Guidelines
<ul style="list-style-type: none"> Variation in management/referral by GP 	<ul style="list-style-type: none"> Health promotion/School sports
<ul style="list-style-type: none"> Under-resourcing of pain management services 	<ul style="list-style-type: none"> Make use of local weight management services
<ul style="list-style-type: none"> Making better use of Pharmacists/ability to access digital primary care records 	<ul style="list-style-type: none"> Shared decision making earlier in the pathway Involve patients more
<ul style="list-style-type: none"> Workforce – physiotherapy/FCPs 	<ul style="list-style-type: none"> Share best practice
<ul style="list-style-type: none"> Lack of conservative management options and investment in Primary/Community Care 	<ul style="list-style-type: none"> Improved GP knowledge of CEC Policies
<ul style="list-style-type: none"> Data – understanding and believing our data Data sharing/IT Integration 	<ul style="list-style-type: none"> Peer support Pain medication guidance
<ul style="list-style-type: none"> Variation in availability of Tier 3 weight management services 	<ul style="list-style-type: none"> Make use of exercise referral programmes and leisure centres
<ul style="list-style-type: none"> Variation in access to self-referral physio and knowledge of self-management options available 	<ul style="list-style-type: none"> Link to Local Authority Wellbeing Services Link to Tine to Talk Health (IAPT)

SO HOW DO WE MAKE A DECISION ON THE BEST WAY FORWARD?





DECISION FRAMEWORK

**A reference guide for organisations making
value-based decisions for healthcare services**

What is Best Possible Value?

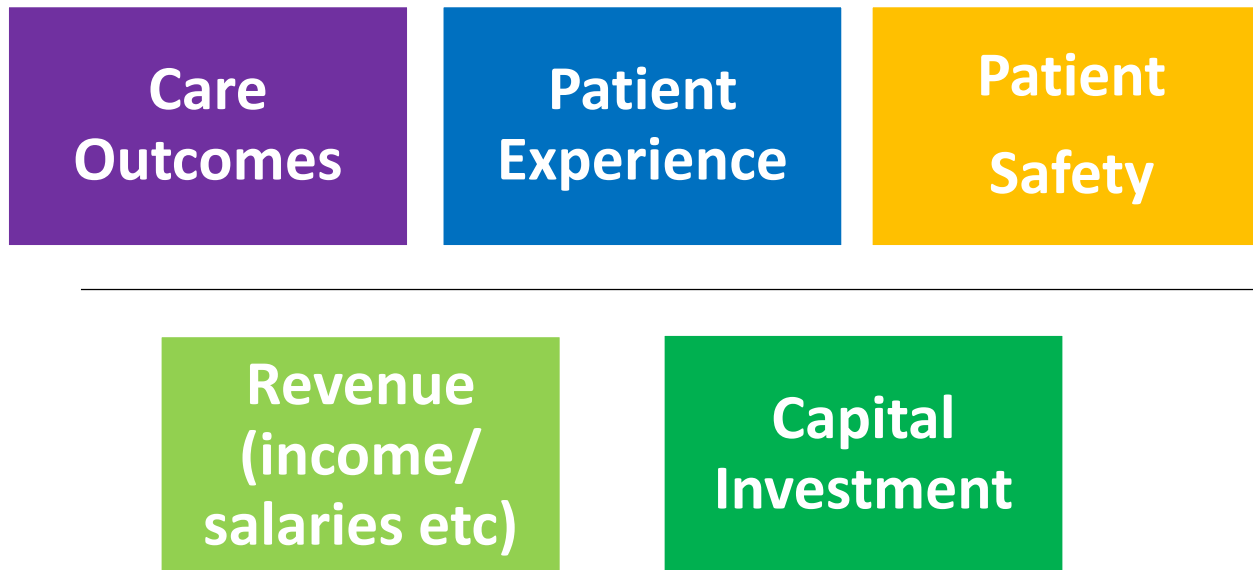


Best Possible Value (BPV) is a **national framework** that provides a process to **optimise decision making** for large groups of stakeholders (ie – across a whole healthcare system) to create:

**“The best possible outcome for patients, through
collaborative agreement of the
right decision and value optimisation”**

Why is BPV important to achieve the outcomes?

VALUE = OUTCOMES / RESOURCES



*Data driven / Evidence based on metrics

How will BPV Work For Us?



Using Best Possible Value (BPV) allows us to consider:

- **What Does Good Look Like? NICE Guidance**
- **How Can We Get Stakeholder Engagement?**
- **What is our Key Decision? (Decision Charter)**
- **What is Value and How Can We Measure It? (Value Charter)**
- **What is the Best Possible Value Solution?**

The BPV Decision Charter

Addresses 4 areas:

1. Situation
2. Complication
3. Objectives
4. Constraints

=> Decision

DECISION CHARTER – TEMPLATE 1

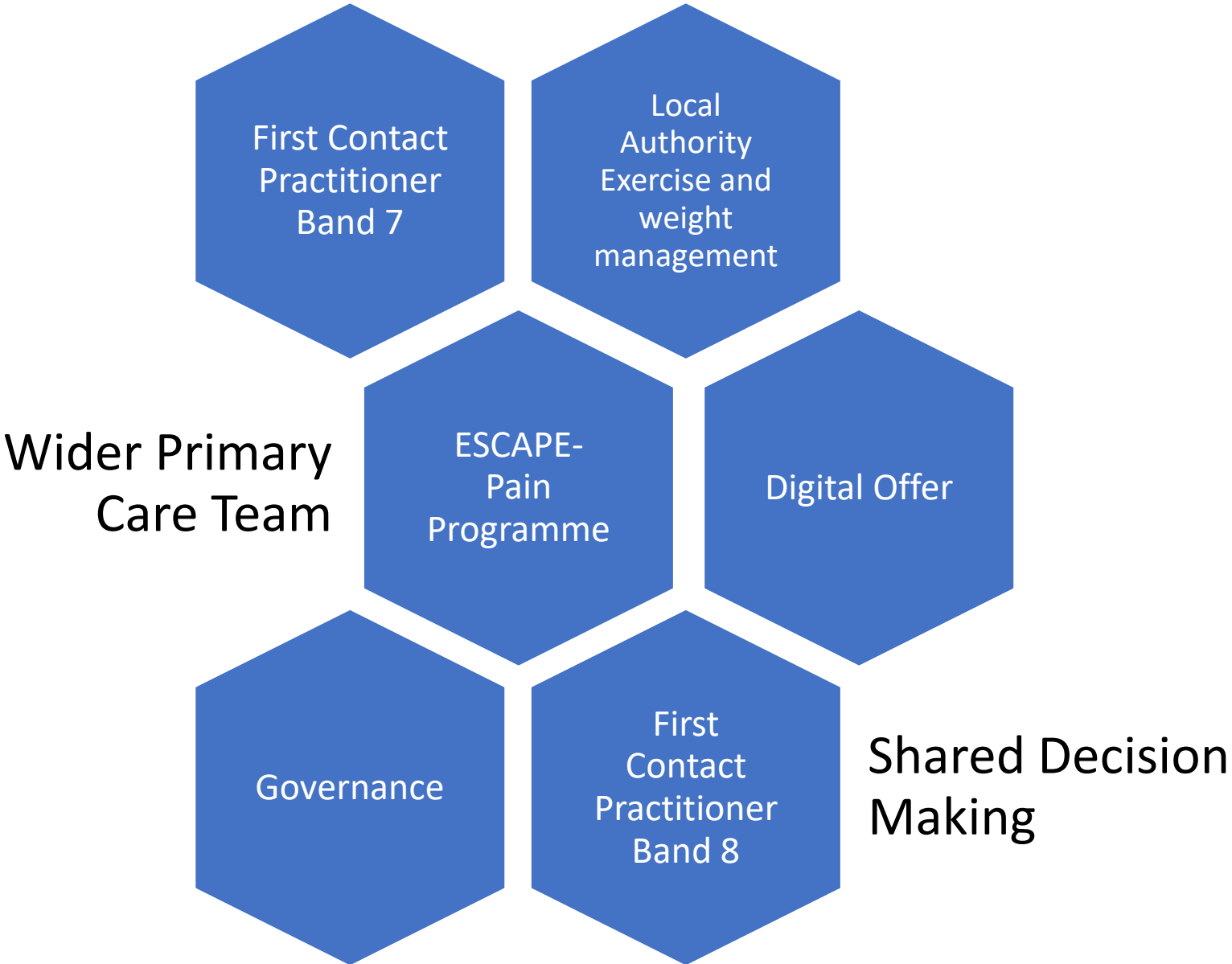
<p>SITUATION</p>	<ul style="list-style-type: none"> • Variation in patient pathways, access and knowledge • Variation in self management information and services • Variation in support for patients to make decisions • Long waiting times • Inappropriate imaging 	<ul style="list-style-type: none"> • Lack of resources in primary care and physio/community workforce • Variation in guidelines and adherence to and awareness of clinical pathways and Policies • Lack of joined up care – resulting in frustrated patients bouncing around the system • Lack of Integrated IT / patient information
<p>COMPLICATION</p>	<ul style="list-style-type: none"> • Financially unsustainable • Increasing demand for secondary care leading to increases in Referral To Treatment Time • Changes in flow to AQPs/number of organisations (underutilised capacity in some areas/impact on workforce and training) • Brexit 	<ul style="list-style-type: none"> • Inconsistent patient and clinician shared decision making, patient expectation, patient / clinician bias • Patients and clinicians overestimate benefits of surgery and underestimate harms • Lack of investment in preventative approaches eg. digital aids/patient information
<p>OBJECTIVES</p>	<ul style="list-style-type: none"> • STP wide information and conservative management (FCP/digital) pathway for clinicians and patients <ul style="list-style-type: none"> - shift to focus on ‘front end of MSK pathway’ - Non medical management of early to moderate stages of MSK conditions - Makes it easier to signpost patients to conservative management (‘guide me the right way’) • Enshrine shared decision making 	<ul style="list-style-type: none"> • Effective embedding of the clinical evidence and Clinically Effective Commissioning Clinical policies • Improve partnership working (both health and care) • Improved digital info / Patient Passport (collaborative care and support plan) • Shared generic First Contact Practitioner model / Improved understanding of role • Enhanced Patient and Public Engagement
<p>CONSTRAINTS</p>	<ul style="list-style-type: none"> • Resource for delivery • Finances • Non-uniform commissioning • workforce • Professional bias • Size and geography • Number of organisations 	<p>==</p> <h2>DECISION</h2> <p>Best value MSK initial pathway within wider Primary Care focused on empowering self- management conservative approaches and supporting where appropriate onward referral/post-operative rehabilitation</p>

SUSSEX WIDE INITIAL MSK PATHWAY MODEL

- VALUE CRITERIA AND METRICS

VALUE COMPONENT		VALUE CRITERIA	VALUE METRICS
OUTCOMES	CARE OUTCOMES	<ul style="list-style-type: none"> Improved quality of life/reduced pain/improved function/return to work. Improved use of evidence based self-management and conservative management of MSK conditions Onward referral and intervention rates. 	<ul style="list-style-type: none"> MSK-HQ pre/post Intervention(s) Elective MSK Procedure Activity Rate and conversion rates. Onward Referral Rates and where. % discharged to self-manage from FCP % Patients referred/signposted to physical activity. Number of patients seen by FCP who would otherwise have been seen by a GP.
	USER EXPERIENCE	<ul style="list-style-type: none"> Improved Shared Decision Making. Improved knowledge, skills and confidence to self-manage. Improved timely access to Primary Care MSK assessment and management. 	<ul style="list-style-type: none"> Improved patient satisfaction Improved GP satisfaction
	SAFETY / QUALITY	<ul style="list-style-type: none"> Improved surgical outcome and reduced Length Of Stay Reduce MSK related prescribing Reduce MSK related imaging Improved lifestyle factors 	<ul style="list-style-type: none"> CollaboRATE Patient Activation Measure Wait times across pathway Patient Experience Survey GP satisfaction survey
RESOURCES	REVENUE COSTS	<ul style="list-style-type: none"> FCP workforce costs 	<ul style="list-style-type: none"> Infection rates post joint replacement surgery Revision rates within a year of joint replacement surgery Length of Stay MSK Imaging rates £ prescribing related to MSK % Patients referred to smoking cessation clinic % Patients referred to weight management support
	CAPITAL COSTS	<ul style="list-style-type: none"> Use community facilities (eg- physio - gyms out of hours/Secondary Care-Out Patient Departments empty 6-9pm IT 	<ul style="list-style-type: none"> Utilise GP Practice/ community clinic space/Local Authority - leisure centre, gyms/Third Sector)

BEST POSSIBLE VALUE SOLUTIONS



MSK UCV Patient Engagement

MSK FCP Patient Engagement feedback:-

When you first recognised you had a problem what did you do to look for help first?

86% said they went to their GP first.

Googling was the second most common place people went for help (13%) and a further 5% went to A&E in the first instance.

How would you like to contact an FCP?

Answer Choices	Responses	
Via your GP Receptionist	20.77%	38
Via your GP	34.97%	64
Yourself directly (Self-referral)	87.43%	160
Other (Please give details below)	8.74%	16
Answered		183

How would you like to contact an FCP if you did this yourself?

Answer Choices	Responses	
Telephone	43.41%	79
Paper referral form	7.14%	13
Online	42.86%	78
Other (please state)	6.59%	12
Answered		182

MSK FCP Patient Engagement feedback:-

Would you like to be able to access self-management information before you contact an FCP/GP Practice?

Answer Choices	Responses	
Yes	72.93%	132
No	27.07%	49
Answered		181

If you see your FCP face to face, where would you like to see them?

Answer Choices	Responses	
Your own GP practice	45.90%	84
Another GP practice in your area	2.73%	5
At a central health hub	26.23%	48
In a community setting such as a community centre	4.92%	9
Other (please give details below)	20.22%	37
Answered		183

Would you be happy to have a consultation with your FCP online? So this might mean having a Skype/Facetime type video conversation, or asking and answering questions using your smartphone/computer.

Yes	49.43%	87
No (please give details below)	50.57%	89
Answered		176

Those who would not like to have an online consultation said the most common response was that face to face is far more personal.

Many said they would feel happy to have an online follow-up consultation, but not for the initial diagnosis in case something important was missed

AFTER THE IDENTIFICATION OF OPTIONS.....



SCORING FRAMEWORK FOR SUSSEX WIDE MSK PATHWAY MODEL OPTIONS

	Criteria	Importance	Rationale	Scoring
Outcomes	<ul style="list-style-type: none"> Improved quality of life/reduced pain/improved function/return to work. 	%	Is the option going to improve quality of life/reduce pain and improve function?	1 - NO IMPROVEMENT 2- SOME IMPROVEMENT 3 – OPTION ACHIEVES MODEST IMPROVEMENT 4- SIGNFICANT LEVEL OF IMPROVEMENT 5- OPTION WILL ACHIEVE SUSTAINABLE IMPROVEMENT
	<ul style="list-style-type: none"> Improved use of evidence based self-management and conservative management of MSK conditions 	%	Does the option increase use of evidence based self management and/or conservative management of MSK conditions	1 - NO IMPROVEMENT 2- SOME IMPROVEMENT 3 – OPTION ACHIEVES MODEST IMPROVEMENT 4- SIGNFICANT LEVEL OF IMPROVEMENT 5- OPTION WILL ACHIEVE SUSTAINABLE IMPROVEMENT
	<ul style="list-style-type: none"> Onward referral to physiotherapy and MSK clinic and surgical intervention rates. 	%	Is the option likely to achieve reduced onward referral and intervention rates.	1 - NO IMPROVEMENT 2- SOME REDUCTION 3 – OPTION ACHIEVES MODEST REDUCTION 4- SIGNFICANT LEVEL OF REDUCTION 5- OPTION WILL ACHIEVE SUSTAINABLE REDUCTION
	<ul style="list-style-type: none"> Improved Shared Decision Making. 	%	Does the option result in improved shared decision making	1 - NO IMPROVEMENT 2- SOME IMPROVEMENT 3 – OPTION ACHIEVES MODEST IMPROVEMENT 4- SIGNFICANT LEVEL OF IMPROVEMENT 5- OPTION WILL ACHIEVE SUSTAINABLE IMPROVEMENT
	<ul style="list-style-type: none"> Improved knowledge, skills and confidence to self-manage. 	%	Is the option likely to increase knowledge, skills and confidence to self manage	1 - NO IMPROVEMENT 2- SOME IMPROVEMENT 3 – OPTION ACHIEVES MODEST IMPROVEMENT 4- SIGNFICANT LEVEL OF IMPROVEMENT 5- OPTION WILL ACHIEVE SUSTAINABLE IMPROVEMENT

SCORING FRAMEWORK FOR SUSSEX WIDE MSK PATHWAY MODEL OPTIONS

Outcomes

Criteria	Importance	Rationale	Scoring
<ul style="list-style-type: none"> Improved timely access to Primary Care MSK assessment and management. 	%	Does the option improve timely access	1 - NO IMPROVEMENT 2- SOME IMPROVEMENT 3 – OPTION ACHIEVES MODEST IMPROVEMENT 4- SIGNIFICANT LEVEL OF IMPROVEMENT 5- OPTION WILL ACHIEVE SUSTAINABLE IMPROVEMENT
<ul style="list-style-type: none"> Improved patient satisfaction 	%	Will the option increase patient satisfaction	1 - NO IMPROVEMENT 2- SOME IMPROVEMENT 3 – OPTION ACHIEVES MODEST IMPROVEMENT 4- SIGNIFICANT LEVEL OF IMPROVEMENT 5- OPTION WILL ACHIEVE SUSTAINABLE IMPROVEMENT
<ul style="list-style-type: none"> Improved GP satisfaction 	%	Will the option increase GP satisfaction	1 - NO IMPROVEMENT 2- SOME IMPROVEMENT 3 – OPTION ACHIEVES MODEST IMPROVEMENT 4- SIGNIFICANT LEVEL OF IMPROVEMENT 5- OPTION WILL ACHIEVE SUSTAINABLE IMPROVEMENT
<ul style="list-style-type: none"> Improved surgical outcome and reduced Length Of Stay 	%	Is the option likely to improve surgical outcome and reduce length of stay	1 - NO IMPROVEMENT 2- SOME IMPROVEMENT 3 – OPTION ACHIEVES MODEST IMPROVEMENT 4- SIGNIFICANT LEVEL OF IMPROVEMENT 5- OPTION WILL ACHIEVE SUSTAINABLE IMPROVEMENT
<ul style="list-style-type: none"> Reduce MSK related prescribing 	%	Will the option reduce MSK related prescribing?	1 - NO IMPROVEMENT 2- SOME IMPROVEMENT 3 – OPTION ACHIEVES MODEST IMPROVEMENT 4- SIGNIFICANT LEVEL OF IMPROVEMENT 5- OPTION WILL ACHIEVE SUSTAINABLE IMPROVEMENT

SCORING FRAMEWORK FOR SUSSEX WIDE MSK PATHWAY MODEL OPTIONS

	Criteria	Importance	Rationale	Scoring
Outcomes	<ul style="list-style-type: none"> Reduce MSK related imaging 	%	Is the option going to reduce MSK related imaging	1 - NO IMPROVEMENT 2- SOME IMPROVEMENT 3 – OPTION ACHIEVES MODEST IMPROVEMENT 4- SIGNIFICANT LEVEL OF IMPROVEMENT 5- OPTION WILL ACHIEVE SUSTAINABLE IMPROVEMENT
	<ul style="list-style-type: none"> Improved lifestyle factors 	%	Will the option improve lifestyle factors eg smoking, weight loss	1 - NO IMPROVEMENT 2- SOME IMPROVEMENT 3 – OPTION ACHIEVES MODEST IMPROVEMENT 4- SIGNIFICANT LEVEL OF IMPROVEMENT 5- OPTION WILL ACHIEVE SUSTAINABLE IMPROVEMENT

SCORING FRAMEWORK FOR SUSSEX WIDE MSK PATHWAY MODEL OPTIONS

	Criteria	Importance	Rationale	Scoring
Resources	• FCP workforce costs reasonability	%	Is the option reasonable cost	1 = No 2 = Possible 3 = Probable 4 = Likely 5 = Highly likely
	• FCP workforce sustainability	%	Will the option result in or increase the likelihood of sustaining the FCP workforce.	1 = Remote chance 2 = Possible 3 = Probable 4 = Likely 5 = Highly likely
Risks	• Workforce	%	Will the quality of care delivered be negatively affected by not being able to secure appropriate workforce with relevant knowledge, skills and qualification required to deliver change.	1 = Highly likely 2 = Likely 3 = Probable 4 = Possible 5 = Not likely
	• Capacity to deliver change	%	Does the option have senior level buy in and strong leadership to deliver change?	1 = Weak case for change, delivery plan and leadership. 2 = 3 = Partially defined plan with milestones but some elements lacking 4 = 5 = Strong case for change, delivery plan and leadership

SCORING FRAMEWORK FOR SUSSEX WIDE MSK PATHWAY MODEL OPTIONS

	Criteria	Importance	Rationale	Scoring
Strategy	System strategy alignment	%	Does the option align with system strategic plans and intent?	<p>1 = The option does not align with strategic intent or planning is poor.</p> <p>3 = Plans adequately aligned between players but further clarity is required.</p> <p>5 = Strong strategic alignment and planning between players is clear.</p>
	Time to savings realisation	%	Does this option support timely delivery of savings realisation.	<p>1 – Not likely to</p> <p>2- Slightly likely to</p> <p>3- Moderate chance</p> <p>4 – Likely</p> <p>5 – Highly likely</p>

SCORING RATIONALE

TEMPLATE 10 ILLUSTRATIVE EXAMPLE



	Criteria	Importance (%)	Rationale	Scoring
OUTCOMES	Fall in stillborn rate	25%	Is the option likely to achieve the target fall in stillborn rate?	5 largest reduction offered 1 smallest reduction offered
	Fall in brain injuries rate	25%	Is the option likely to achieve the target fall in brain injuries rate?	All options scored on sliding scale between 1 and 5 proportionate to distance between them and highest/lowest scoring options
	Increase in breastfeeding	10%	Is the option likely to achieve the target rise in breastfeeding rate?	
	Improved service access	5%	Is the option likely to achieve the target improvements to access?	5 plans to achieve targets are clear, impressive, and demonstrate the means to measure improvements
	Improved care experience	5%	Is the option like to achieve the target improvements to experience?	3 plans to achieve targets are described and promising but require more detail and clarification
	Reduced harm	10%	Is the option like to achieve the target reductions to harm?	1 no improvements are described with no measurement plans
RESOURCES	Cost reasonability	10%	Are the costs per head of population clearly indicated? Is the option financially viable to all stake-holding parties?	5 there is a clear, specific answer to all questions 3 there is an answer to all questions but more detail is needed 1 none of the questions are answered satisfactorily
	Sustainability	10%	How much money will be saved? How will the saving be reinvested?	
RISK	Quality of evidence	50%	Is the evidence used to generate the option robust?	5 quantitative evidence from this site 4 quantitative evidence from national study 3 quantitative evidence from international study 2 anecdotal evidence or robust logic model 1 no evidence
	Capacity to deliver change	50%	Can the change be delivered without service disruption? Does the option have senior level buy-in and strong leadership to deliver the change?	5 strong case for change, delivery plan, leadership and risk assessment 3 partially defined plan with milestones but some elements lacking 1 weak case for change, delivery plan, leadership and risk assessment
STRATEGY	System strategy alignment	50%	Is the option aligned with local system strategic plans and intent?	5 strong strategic alignment and planning between players is clear 3 plans adequately aligned between players but further clarity required 1 the option does not align with local strategic intent or planning is poor
	Time to savings realisation	50%	When will breakeven be achieved?	5 breakeven by 2020/1 1 breakeven by 2024/5

VALUE COMPARISON

TEMPLATE 11 ILLUSTRATIVE EXAMPLE



			OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
OUTCOMES	Fall in stillborn rate	25%	4	4	2	2	2
	Fall in brain injuries rate	25%	4	5	2	3	3
	Increase in breastfeeding	10%	3	3	1	2	1
EXPERIENCE	Improved service access	5%	4	4	3	3	2
	Improved care experience	5%	4	4	2	3	3
SAFETY	Reduced harm	10%	3	5	3	2	1
RESOURCES	Cost reasonability	10%	4	3	3	5	2
	Sustainability	10%	3	3	2	3	1
VALUE		100%	3.7	4.1	2.2	2.8	2.0

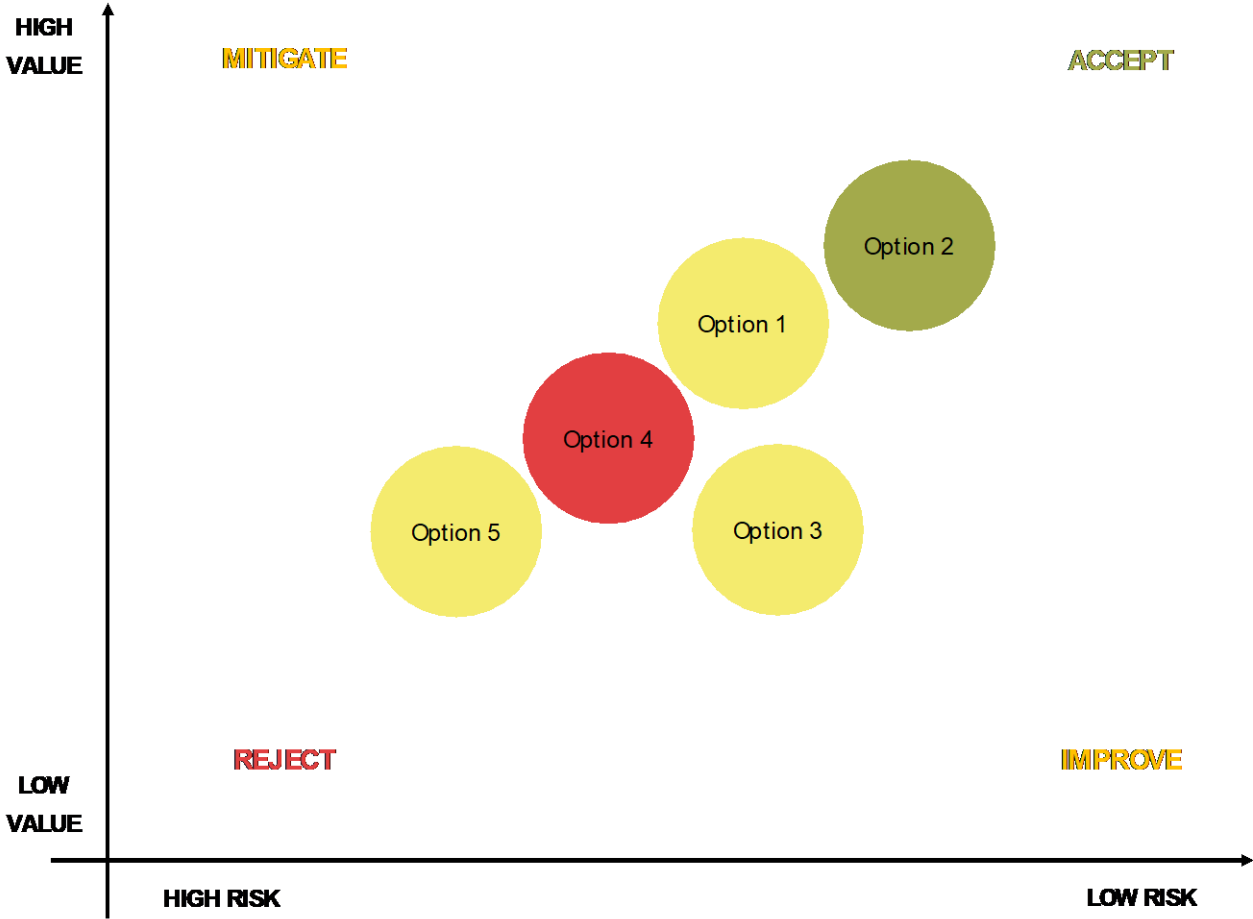
RISK	Quality of evidence	50%	4	5	3	2	1
	Capacity to deliver change	50%	3	4	4	3	2
RISK		100%	3.5	4.5	3.5	2.5	1.5

STRATEGIC FACTORS	System strategy alignment	50%	3	4	3	1	1
	Time to savings realisation	50%	2	3	3	1	3
STRATEGIC FACTORS		100%	2.5	3.5	3.0	1.0	2.0

WE WILL THEN GET OUR RESULT AND DECISION

VALUE PRIORITIES

TEMPLATE 12 ILLUSTRATIVE EXAMPLE



Strategic factors

- High
- Medium
- Low

NEXT STEPS

- **Engagement, Co-design and Service Modelling (May 19 – September 19)**
- **Governance Processes initiated/Sign off and endorsement of Business Cases &/or Proposals (Oct 19 – December 19)**
- **Pre mobilization planning/service implementation (January 19 – March 2020)**
- **Operational phase commences with methods/resources in place to ensure ongoing monitoring and evaluation of the long term outputs (April – June 2020)**



Thank you

