Getting it right

NHS Right Care is about to take centre stage, supporting commissioner efforts to deliver efficiency savings. Seamus Ward reports

A lot has been said recently about value in the NHS – by one definition a catch-all term for getting the best services for the least amount of money and a driving force behind service reconfiguration as the NHS. The focus has naturally fallen on providers, but commissioners can also play a huge part in obtaining value.

In the summer, NHS England chief finance officer Paul Baumann told the HFMA Commissioning Finance annual conference that two elements would deliver the anticipated £22bn efficiency programme over the next five years. The first – operational efficiency – will make up the bulk of the savings, particularly in the early years, and will focus on traditional areas such as staffing, procurement and medicines costs.

While commissioners will have a role in delivering greater operational efficiency, they will be more directly involved in the second element – allocative efficiency. At the heart of this is value – getting the best care, better value for money, motivating patients to greater self-care and ill health prevention.

Mr Baumann announced that support would come in the form of the NHS Right Care programme, which will be rolled out across all clinical commissioning groups. 'The biggest single weapon in our armoury, in my judgement, is the Right Care programme, which has been around for some years in evolving form, but is a largely hidden treasure whose time appears to have come,' he told the conference.

Right Care produces useful generic analytical information, but the programme as a whole is about much more, he said. It is a holistic improvement mechanism that facilitates the eradication of waste and ineffective spending and the achievement of best value for every pound spent.

'Without exception, those who have adopted it in its full form have seen concrete and sustainable clinical and financial benefits, the latter typically between 3% and 5% per annum,' he added.

> **"The Right Care programme, which has been around for some years in evolving form, is a largely hidden treasure whose time appears to have come"**
> Paul Baumann

Right Care national director Matthew Cripps says the programme is a perfect fit for commissioners. 'The Right Care approach is trying to optimise how the system manager manages improvement to produce optimal performance. The real system manager is the commissioner, so this is the right place to be for our facilitative role.'

Delivery opportunity

He adds that Right Care is also a huge opportunity for NHS providers, who could adopt the approach to get better value in their delivery of services.

'The Right Care approach has not evolved from commissioning, but from industrial production and business processes,' he says. 'We've adapted these processes, which are more closely related to what NHS providers do, and got them to work for commissioners.'

Professor Cripps says the programme will facilitate savings and will succeed when CCGs 'embed the approach and show the leadership to see it through'. He adds: 'It will enable them to deliver their share of the £22bn of savings required.'

It shifts the focus from traditional cost-cutting to reorganising services so they are better, both clinically and financially. Most importantly, improved services will

meet the needs and expectations of patients and the population.

He gives an example of a health economy that needs to save £15m. 'At the moment, what tends to happen is some of this will be achieved through high-priority healthcare improvement, some of it as transactional salami slicing and the rest by everyone taking their share of the balance.

'Say £8m is due to positive changes that improve the population healthcare and £7m is delivered to achieve the target through the other interventions. The Right Care approach changes that so more of the £15m will be about healthcare improvement. It helps them focus on areas where there are the greatest gains to be made – areas where they are spending more than they ought to.'

Currently, 20 CCGs have adopted the Right Care approach comprehensively, with maybe as many again known to be using it on a more ad hoc basis. The intention is to roll out support in tranches of 50 CCGs from January 2016. All CCGs will have the opportunity to have support to implement Right Care within two years. However, with the pressures on NHS budgets, Professor Cripps says the roll-out could be accelerated.

CCGs will be given free 'chair-side' support by experts known as Right Care delivery partners. Commissioning support units will be offered a development programme, so they are ready to help their CCG clients from the off. An accreditation framework is planned, to enable CSUs to deliver support in line with the Right Care approach, such as service review 'deep dives'.

There will be three levels of accreditation – bronze, silver and gold. Bronze organisations will offer the basic service, while the silver award will be for organisations delivering Right Care to the same standard as the national Right Care team. The gold standard will be for innovators and those going beyond the Right Care approach.

Professor Cripps says the improvements made by the gold organisations will subsequently be expected of the bodies with silver accreditation. The gold standard will then be reserved for those demonstrating further innovation. In this way, Right Care should be the subject of continuous improvement.

The Right Care approach is based on three questions – where to look, what to change and how to change. The first two are data-driven, taking information from sources such as the atlases of variation and *Commissioning for value* packs, produced in partnership with Public Health England. They include programme budget spend, health outcomes and information on health variations. The latest *Atlas of variation* is to be published this month.

Analysis can be based on a specially devised CCG spend and outcome tool, which will show a CCG's position on spend and outcome relative to its peers.

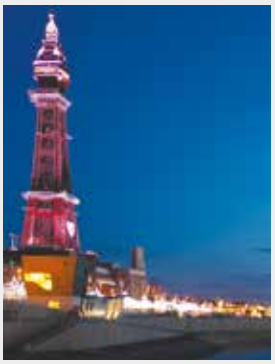
'A CCG might see it is overspending on

Blackpool lights the way

Sometimes the best ideas are the simplest. In the case of Blackpool and Fylde and Wyre clinical commissioning groups, the first of Right Care's three stages, 'where to look', identified unscheduled care as a key area for improvement.

Commissioning for value packs, atlases of variation and other comparator tools were used at this stage. The tools showed few patients accounted for a substantial proportion of the budget. Some of these patients have multiple long-term conditions and may also be elderly and frail.

The 'what to change' stage included an analysis of the local ambulance service database. This showed the top 100 999 callers had called a total of 1,100 times in three months. The CCGs decided to identify and address what was causing this to reduce pressure on unscheduled care services. An advanced paramedic called the top 100 callers, plus a few vulnerable patients who had presented with self-harm



or homelessness, focusing on their issues, not the frequency of their calls.

A brief pilot demonstrated that empathy and coaching rather than enforcement had the potential to reduce the number of 999 calls. In many cases calls were related to emotional, financial or family problems rather than physical health.

The team sought to 'de-medicalise' each patient's needs by referring them to more appropriate support services, such as a mental health helpline. Unscheduled care contacts dropped as a result of addressing human, emotional and social needs.

In the first 15 months among the cohort, 999 calls fell 89%, A&E attendances 93%. Admissions were down 82% and there was a 98% reduction in incidents of self-harm. Other services benefited too – there was a 44% reduction in calls from the cohort to the police.

Overall, the CCGs have made savings of more than £2.7m in 15 months in this isolated group – the pilot cost £70,000.

Blackpool CCG has embedded the model into primary care, offering health coaching to vulnerable and high service users. Chief operating officer David Bonson said: 'This innovative approach to tackling frequent callers has delivered benefits to patients and the system.

'The combination of Right Care and adopting coaching techniques to change the question from "What's the matter with you?" to "What matters to you?" has reduced demand on highly pressured parts of the system and empowered patients to meet their unfulfilled needs.'

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The atlases of variation are an integral part of the Right Care assessment

diabetes care for poorer outcomes than their demographic peers. If they at least copy the best in class for their demographic peers, they will have better care for less money,' Professor Cripps says. 'Variation data raises awareness of where there are most opportunities to improve healthcare for the population.'

Having answered the 'where to look' question, CCGs can conduct deep dives into the data to discover what to change. The third element of the approach can then address areas such as pathway redesign. Clinicians and managers should be involved in all stages.

Professor Cripps says the Right Care approach is an exercise in reducing the reform design focus to individual care pathways before then looking across the whole system. This gets the highest value from engagement by the clinical disciplines.

He explains: 'For example, cardiologists can most readily engage in a heart disease pathway or a diabetes pathway that cardiology can enhance, rather than in, say, a frail elderly system design. So when trying to get cardiologists to engage in designing the optimal way of doing things, we focus on pathways.'

He adds: 'Having said that, when you design an optimal heart disease pathway you discover that a good percentage of the steps are generic across all the pathways – supported patient self-management is generally the same, for example.

'Also, when a frail elderly person has heart disease, they receive the best care by virtue of the heart disease pathway having been optimised. So, the system-wide improvements in a local health economy naturally follow as a next phase in the continuous improvement.'

In support of this, the commissioning for value programme is prototyping a long-term conditions pack, showing individual pathway and system-wide improvement opportunities together.

This means that, with so many of the changes common to all pathway redesign, health economies can use this pathway approach as a springboard to spreading the benefits across their systems quickly. Blackpool (see case study, previous page) is an example of this – a simple idea that has had a significant impact on the wider system, he says.

'The reason it is so effective is that a key concept in the design of the Right Care approach was to be attractive to every perspective in the commissioning part of the system. If everyone around the governing body table and the senior management team agree on where to look, you are a long way down the road to being effective. If finance wants to look at respiratory services because that's where you spend the most, and clinicians believe it is where you can make significant gains in the population's healthcare, then everyone agrees to look at respiratory.'

This agreement can be a powerful lever when the health economy moves on to make changes. There may be objections and reasons given not to make changes – for example, if they are not in a provider's interests. But Professor Cripps insists the objective of improving the healthcare of the population must take priority and is supported by the evidence and consensus generated by the Right Care approach.

Mr Baumann said CCGs that have fully embraced and embedded the Right Care approach have seen clinical and financial benefits, the latter being savings of between 3% and 5% of income. The qualifying phrase 'fully embedded' is important.

Professor Cripps says the benefits are clear and consistent. 'We know that the benefits are replicable because a number of CCGs have already copied the approach and been able to achieve [results] similar to the early adopters. In those that haven't achieved these same benefits there is a clear reason why – for example, engagement or use of delivery levers is not sufficiently developed. So it's not the approach, it's always a local characteristic that we can help to resolve.'

Collaboration between finance and clinical professionals is a key element of the Right Care approach, and of course critical to success of the NHS *Five-year forward view*. Financial leadership will be important as the approach is rolled out, and each discipline will have a role, with, perhaps, clinicians at the fore in designing pathways, for example, while finance staff may take the lead when asking if a new pathway is viable.

Partnership link

Given this collaboration, Right Care is working closely with the future-focused finance best possible value and close partnering work streams. Professor Cripps says: 'Integral to delivering a sustainable NHS is getting everyone in a local health system working together on the same areas of improvement. The "where to look" phase of the Right Care approach is designed to do just this.

'Understanding each other's perspective is key to ensuring a common language in improvement discussions and the work of the close partnering work stream of future-focused finance is making great progress in this area. This workstream is fundamentally about developing our ability to engage and influence others, which is not just limited to clinicians but also patients and the public.'

He adds: 'Further to this, the best possible value work stream is about providing specific methodologies for putting value at the centre of every decision that we make to deliver the best outcomes for patients given the resources available. The principles of the Right Care approach have been included in its outputs.

'Thanks to this integrated thinking, now is an exciting time and opportunity for finance to lead the way, alongside clinical colleagues, and ensure improvement efforts deliver sustainable and optimal population healthcare.'

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