NHS England

Improving Value in Specialised Services

Menu of Opportunities

Introduction

Welcome to our Menu of Opportunities.

The aim of this document is to provide an overview of schemes aimed at improving value in specialised services.

The menu is broken down into three overarching themes and sub themes which have been taken from the NHS 10 point efficiency plan.

Each improving value scheme has it's own chapter which provides a summary of the opportunity, potential benefits & savings, useful resources including case studies where available, key performance indicators and contact details for more information.

This document is aimed at commissioners and providers of both specialised services and other parts of the patient pathway including acute commissioners and providers.

Overarching Themes

Get Best Value out of Medicines and Pharmacy

Reduce Avoidable Demand and Meet Demand more Appropriately

Reduce Unwarranted Variation in Clinical Quality and Efficiency

Theme rationale

Get Best Value out of Medicines and Pharmacy

In 2018 the NHS drugs bill grew by over 7%, with particular growth in hospital-driven prescribing. This was faster than the growth in the overall NHS budget. In some cases, newer medicines displace other hospital costs or older categories of treatment. However within this fast growing pharmaceutical expenditure there are also opportunities for efficiency.

Reduce Avoidable Demand and Meet Demand more Appropriately

One of the greatest opportunities for increasing efficiencies in the NHS is the reduction of unwarranted variation in care. Across the NHS there are large variations in the number of people seeing GPs, being referred to hospital and receiving operations that are not explained by clinical need. In a financially constrained system, unnecessary care given to one patient results in necessary care being denied to another.

Reduce Unwarranted Variation in Clinical Quality and Efficiency

The NHS has been locked into a cycle where the extra funding needed to pay for hospital services could not be used to invest in extra services that could moderate growth in this demand. The NHS is starting to break out of this cycle both by increasing hospital productivity and – as the new care models are starting to demonstrate – using existing resources more effectively to reduce rates of emergency admissions and lengths of stay.

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Get Best Value out of Medicines and Pharmacy

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Immunoglobulin–Dosing Regimens for Immune Thrombocytopenic Purpura (ITP)

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Immunoglobulin – Dosing Regimens for Immune Thrombocytopenic Purpura (ITP)

Name of Scheme	Immunoglobulin–Dosing Regimens for Immune Thrombocytopenic Purpura (ITP)
Theme	Get Best Value out of Medicines and Pharmacy
Menu of Opportunities sub themes	• Deliver medicines at home. • Reducing waste in high cost drugs. • Reduce unwanted variation in prescribing practice. • Multi-Disciplinary team decision making to ensure medicine optimisation.
Useful Sources of Information	• Clinical Guidelines on Immunoglobulin ITP can be found here. • The National Immunoglobulin Database can be found here here. • Optimising the use of Immunoglobulin in treating ITP. Case study can be found in slide 10.

Summary

Immunoglobulin (Ig) is a high cost, excluded from tariff drug. Annual expenditure across England is ~£190m and increasing by ~10% per year. The project aimed to ensure appropriate and cost-effective use of Ig for ITP. Immune thrombocytopenic purpura (ITP) is a disorder that can lead to easy or excessive bruising and bleeding. The bleeding results from unusually low levels of platelets. ITP affects children and adults.

Clinical Guidelines recommend a dose of 1g/kg immunoglobulin in the treatment of acute ITP. An audit of the national database showed that in 2015/16, for use of immunoglobulin in ITP, where weight of the patient was recorded: 30% of doses were at the recommended 1g/kg dose or less, 55% at 2g/kg and; 15% at more than 2g/kg.

Across all regions in England, the total estimated savings for prescribing the recommended dose for ITP was £5.6m for 2016/17 based on 80% of patients receiving 1g/kg. In the first quarter of 2017/18, the national database reported 66% of patients received 1g/kg or less Ig, this equates to £2.5m savings, based on 2016/17 activity.

The provider packs for ITP dosing and savings calculations by regions and hubs have been published and included in the implementation pack for hubs to use in discussions with provider outliers.

Improving Value Menu of Opportunity Guide

Immunoglobulin – Dosing Regimens for Immune Thrombocytopenic Purpura (ITP)

Who should consider this opportunity?

- This is an existing NHSE improving value scheme which all providers, NHSE hub commissioners and pharmacists should be implementing at a local level.
- The aim is to ensure evidence based use of high cost drugs to maximise efficiency & value from limited resources & compliance with clinical guidelines.
- Where regions/hubs find that there is variation in immunoglobulin dosage prescribed for ITP, they should consider this scheme

Example case studies

A case study from Leeds Teaching Hospital Trust shows how the trust implemented prescribing Immunoglobulin at the recommended dose in ITP and the cost savings achieved.

The case study gives an in depth explanation on the background and what was done to Optimise Immunoglobulin use in treating ITP. It also gives information about key barriers and issues faced by those involved. In addition, the case study explains the key aspects of the decision making process and the results that ensued. Lastly, this case study contains a checklist of strategies that would help others to implement this initiative.

Please contact sarahdenman@nhs.net for further information.

Solutions

The Aim

To ensure appropriate and cost-effective use of immunoglobulin by:

- Ensuring adherence to eligibility criteria and identification of efficacy outcomes to be recorded on the national database.
- Investigating the use of a prior approval system; initial investigation will focus on the use of the existing database to fulfil this role.
- Ensuring outcomes are recorded on the national database.
- Maximising the use of optimal dosing for individual indications, thus reducing overall cost.

We will know that changes and improvements have been achieved if the following conditions are met:

- Reduced use of Immunoglobulin at doses of >1g/kg body weight in ITP.
- Reduction in overall spend on Immunoglobulin for ITP.

What changes will be made that will result in an improvement?

- Review of national database for ITP prescribing and dosage completed to identify non-adherence to clinical guidelines.
- Review of national database in 2017/18 completed & showed body weight recorded for 96% patients prescribed immunoglobulin.
- Analysis was completed which demonstrated potential savings of prescribing immunoglobulin for ITP at the recommended dose. 1g/kg.

Improving Value Menu of Opportunity Guide

Immunoglobulin – Dosing Regimens for Immune Thrombocytopenic Purpura (ITP)

Key Performance Indicators (KPIs)

Quality

- Reduce over-treatment of patients on immunoglobulin therapy without health benefit & reduce side-effects by raising awareness of due process for use of Ig and using assessment panels to review usage.

Efficiency

- Ensure evidence-based use of this treatment by adherence to eligibility criteria and identifying efficacy outcomes to be recorded on the national database.

Key Enablers

- Circular and letter sent to all regions/hubs to raise the issue of variation in dosage with providers.
- Communication with clinicians through the Clinical Reference Group members to raise awareness of clinical guidelines & adherence to recommended dosage.
- Implementation Pack with tools and resources has been developed including hub level savings calculations.

Finances

How will the saving be achieved?

- Identify outliers for dosage of Ig in ITP by reviewing National Immunoglobulin Database.
- Use algorithm for treatment for appropriate dosage in ITP treatment.

How will the saving be calculated?

- Providers have access to the National Immunoglobulin Database which produces a dashboard of agreed indicators.

Costs

- There were no additional costs associated with this scheme.

Commissioning Considerations

Defining the service

- Data is essential in developing this type of scheme in order to build the evidence base and case for change and also in tracking savings during implementation.

Ensuring delivery and implementation

- The key to the success of this scheme is that it was clinically led from the start.
- It is also important to agree a consistent way of monitoring benefits realisation including weight & dose recording and associated savings.

NHS England

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Antifungal Stewardship

Improving Value Menu of Opportunity Guide
Antifungal Stewardship

Name of Scheme	Antifungal Stewardship
Theme	Get Best Value out of Medicines and Pharmacy
Menu of Opportunities sub themes	• Multi-Disciplinary team decision making to ensure medicine optimisation. • Reduce unwarranted variation in clinical quality and efficiency.
Useful Sources of Information	• British Society for Medical Mycology best practice recommendations for the diagnosis of serious fungal Diseases can be found here. • Worldwide Emergence of Resistance to Antifungal Drugs Challenges Human Health and Food Security (Mathew C Fisher et al. 2018) can be found here.

Summary

The overall aim of this project is to achieve improved value from NHS England's spend on antifungal medicines – this includes preserving the future effectiveness of antimicrobials (prevent resistance) and to improve patient outcomes, including reducing adverse effects. Specifically, the three key objectives are to; improve Antifungal Stewardship across the NHS in England, achieve greater standardisation in the use of antifungals across the NHS in England and optimise use of generic products wherever clinically appropriate to ensure best value.

Improving Value Menu of Opportunity Guide

Antifungal Stewardship

Who should consider this opportunity?

This scheme is relevant to providers, commissioners and clinicians who are concerned with the prevention and treatment of fungal infections. The key patient groups where there are particular risks to fungal infections are those patients who have compromised immunity. In particular patients with cancer or patients having a solid organ transplant.

Example case studies

There are no specific case studies available at present. However, there is a much broader programme of medicines optimisation across the NHS which encompasses antifungal stewardship. The principle of stewardship to ensure improved clinical outcomes is well understood and widely supported.

Solutions

The Aim

The overall aim of this project is to achieve improved value from NHS England's spend on antifungals – this will include improved patient safety through reduced adverse effects and standardisation of clinical practice.

We will know that changes and improvements have been achieved if the following conditions are met:

- When antifungals stewardship has been achieved we and best practice guidance has been implemented.
- Production of an implementation and evaluation resource pack for commissioning teams to support implementation of change.
- The use of the Blueteq system to support antifungal prescribing.

What changes will be made that will result in an improvement?

The purpose of the project is to develop more standardised guidance on antifungal stewardship.

Improving Value Menu of Opportunity Guide
Antifungal Stewardship

Key Performance Indicators (KPIs)

- Defined daily dosage could support the quality of clinical outcomes.
- Oral to Intravenous ratios.
- Review of the guidelines against the general principles.
- Use of diagnostics and possible turnaround time for diagnostic test.

Quality
- Use of diagnostics and possible turnaround time for diagnostic tests.
- Defined daily dosage could support the quality of clinical outcomes.

Efficiency
- Overall expenditure of antifungals.

Key Enablers

- Clinical Guidelines will offer the opportunity for commissioners to have discussions with providers.
- Blueteq forms will be used with one antifungal to enable change to more clinically effective antifungal stewardship.
- Use of a diagnostic testing process which will enable providers to reduce the use of antifungals that are given for prophylaxis (preventative use).
- A provider wide system of ensuring that antifungal stewardship is central to all clinical decisions where fungal infections are a risk.
- Implementing a risk stratification tool to support the appropriate use of antifungal drugs.
- A CQUIN could be offered to support the uptake of best practice clinical guidelines in terms of antifungal stewardship.

Finances

How will the saving be achieved?
Clinical guidelines will support the appropriate use of antifungals this will also reduce inappropriate use of antifungals.

How will the saving be calculated?
Savings will be calculated based on the spend on antifungals.

Costs
In order to implement antifungal stewardship the cost of a specialist pharmacist for 1PA / week may be required for larger providers.

Commissioning Considerations

Defining the service
This scheme is about taking the excellent work undertaken by all providers in England in managing antibacterial drugs and applying that to antifungal drugs thereby putting antifungals on the same platform as antibacterial drugs.

Ensuring delivery and implementation
A specialised commissioning improving value implementation pack is available to local hub supply managers for ensuring delivery of the project.

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Cost Effective ARV Treatment (ART) Prescribing

Improving Value Menu of Opportunity Guide

Cost Effective Antiretroviral Treatment (ART) Prescribing

Name of Scheme	Cost Effective Antiretroviral Treatment (ART) Prescribing
Theme	Get Best Value out of Medicines and Pharmacy
Menu of Opportunities sub themes	• Coordinated switching of patients to best value medicines. • Reducing waste in high cost drugs. • Reduce unwarranted variation in prescribing practice.
Useful Sources of Information	Specialised Human Immunodeficiency Virus Services Service Specification can be found here.

Summary

The NHS has developed world class treatment for people living with HIV, meaning people now have near normal life expectancy as they maintain viral suppression. However, the impact of people being on lifelong treatment, new HIV diagnoses and the ambition to have all people with HIV on treatment, poses a continued cost pressure to the NHS.

It is therefore essential that we look at new ways of improving value and maximising cost efficiency of treatments whilst maintaining patient outcomes. This scheme was developed by clinicians and patient groups and identified a 'basket' of alternative, clinically appropriate and more cost efficient treatment regimens. A patient information leaflet, along with guidance for clinicians was developed to support clinicians to discuss potential switches with patients.

Estimated savings from switch initiatives are £22m in 2017/18 and £13.7m by the end of the 2018/19 financial year. This represents a total saving of 8.3% of the total spend on HIV ARTs.

Improving Value Menu of Opportunity Guide

Cost Effective Antiretroviral Treatment (ART) Prescribing

Who should consider this opportunity?

- This is an existing NHS England (NHSE) improving value scheme which all HIV providers, NHSE hub commissioners and pharmacists should be implementing at a local level.
- Although this scheme focuses on HIV drugs, the concept of developing a basket of best value drug regimens could be applied to other areas.
- In particular, any provider/commissioner of a service that includes prescribing of high cost drugs for long term conditions should consider this scheme.

Example case studies

This scheme was based on work that was already underway in NHSE London region as well as experience in some HIV providers in the south.

A similar approach has also been used in other services such as Specialised Bleeding Disorders, where patients were switched to clinically appropriate more cost efficient clotting factor products.

Please contact heather.weaver@nhs.net or rocoster@nhs.net for more information about how this scheme was implemented in London.

Solutions

The Aim

The aim of the scheme is to ensure patients with HIV are prescribed the most clinically appropriate ART whilst maximising cost efficiency and ensuring the best use of limited financial resources in the prescribing of ARTs.

The scheme identifies a range of switches from branded to generic products which give clinicians a "basket" of options for discussion with individual patients.

We will know that changes and improvements have been achieved if the following conditions are met:

Overall reduction in expenditure of branded ART products compared to generic products and cost savings achieved.

What changes will be made that will result in an improvement?

- Clinicians, pharmacists and patient groups developed and agreed a basket of alternative regimens using generic products which was shared with clinicians.
- Analysis was completed which demonstrated the potential savings of switching from branded to generic products.
- Resources including patient leaflets and guidance for clinicians were developed to support clinician/patient discussion.
- A monitoring template was developed to track numbers of drug regimen switches and identify savings.

Improving Value Menu of Opportunity Guide

Cost Effective Antiretroviral Treatment (ART) Prescribing

Key Performance Indicators (KPIs)

Quality
Reduced variability in regimens prescribed and average patient cost by monitoring of generic drugs uptake against percentage switch targets and reporting of savings achieved.

Efficiency
- Savings from switching from branded to generic products where clinically appropriate.
- Transferring of knowledge from specialist HIV pharmacists to regional pharmacists.

Key enablers

- The scheme was developed nationally by clinicians and patient representatives.
- Communication with clinicians and wider patient groups through Clinical Reference Group members so everyone was aware of the challenge we were trying to address and signed up to the solution
- Patient leaflets were developed so patients understood the scheme along with guidance/FAQs for clinicians. This ensured patients were involved in decisions about their treatment options.
- Implementation Pack with tools and resources has been developed, including FAQs for patients & clinicians, monitoring forms, savings calculations.

Finances

How will the saving be achieved?
- Reduction in branded ARTs prescribed and increase in use of generic products.

How will the saving be calculated?
- Quarterly monitoring of drug expenditure and patient numbers using data submitted by all HIV service providers.
- Monitoring of generic drugs uptake against % switch targets and savings achieved.

Costs
A part time Pharmacist was employed for 12 months to lead the scheme and work with local pharmacists. Thereafter, there were no additional costs associated with this scheme.

Commissioning considerations

Defining the service
Data is essential in developing this type of scheme in order to build the evidence base and case for change and also in tracking savings and switches within each provider trust during implementation.

Ensuring delivery and implementation
Key to the success of this scheme is that it was clinically and patient led from the start. This then supported ongoing engagement from key local stakeholders including HIV providers and patient groups. It is also important to agree a consistent way of monitoring benefits realisation including drug regimen switches and associated savings.

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Virtual Biologics Clinics

Improving Value Menu of Opportunity Guide

Virtual Biologics Clinics (VBC)

Name of Scheme	Virtual Biologics Clinics (VBC)
Theme	Get Best Value out of Medicines and Pharmacy
Menu of Opportunities sub themes	• Coordinated switching of patients the best value medicines • Multidisciplinary team decision-making to ensure medicines optimisation • Reduce waste in high cost drugs • Reduce unwarranted variation in clinical quality and efficiency
Useful Sources of Information	• NHS England`s commissioning framework for biological medicines can be found here. • NICE guidance for Manchester Royal Infirmary Virtual Biologics Clinic can be found here.

Summary

A Virtual Biologics Clinic is an effective approach to overseeing the management of patients to commence on, be maintained on and switch between biologics - using a small multi-professional team, to achieve equity of access and consistency in patient care and ensure best value use of these medicines.

Improving Value Menu of Opportunity Guide

Virtual Biologics Clinics (VBC)

Who should consider this opportunity?

- Clinical teams who want to improve the existing pathway for their biologic services or integrate best practice and national guidelines into prescribing decisions.
- Commissioners who have identified high/increasing drug spend on specific biologic and poor compliance with associated clinical pathways.
- Where there is poor compliance with adherence to existing biologic medication.

Example case studies

Manchester Royal Infirmary: The rheumatology team at Manchester Royal Infirmary undertook a quality improvement approach to changing the biologics service. After mapping the 'typical patient journey', for an individual starting on a biologic therapy, they identified several problems with their biologics service including unreliable systems to facilitate efficient prescribing of high-cost drugs, inefficient use of appointments, delays in initiating therapies, missed translational research opportunities, haphazard data collection, and a variation in clinical practice. Subsequently, using an improvement methodology approach and PSDA cycles, they established a Virtual Biologic Clinic to review all patients recommended for a rheumatology biologic to ensure compliance with the regional Greater Manchester Medicines Management Group (GMMMG) biologic prescribing pathway and to integrate research, thereby containing prescribing costs. Initially, there was no additional administrative funding and as the clinics became established the team could identify capacity regained as a result of improved administrative efficiencies and reduced bureaucracy. The rheumatology virtual biologic clinic is now established 'business as usual' and other specialties are developing similar clinics.

Solutions

Aim

Virtual Biologic Clinics offer an opportunity to reduce variation by ensuring all patients prescribed a biologic therapy receive the same clinical approach, access to specialist Multidisciplinary Team review, appropriate education through a more effectively delivered approach. In addition, they facilitate adherence to medication, recruitment into research trails (with associated financial opportunities) and opportunities to identify and collect data for further service improvement and savings.

We will know that changes and improvements have been achieved if the following conditions are met:

- Waiting times between diagnosis for suitability and commencement of biologic medication will reduce.
- Fewer patients will be prescribed biologics inappropriately.
- The percentage of patients prescribed biologics will reduce, simultaneous with improved clinical outcomes for those patients receiving the biologic.
- Greater numbers of relevant patients will be recruited to research and clinical trials.

What changes will be made that will result in an improvement?

All appropriate patients prescribed biologic medicine are reviewed through a specific biologic which includes Virtual Biologic Clinic which includes a Specialist Consultant, Nurse and Pharmacist, in line with the evidence base and best practice guidelines for that biologic. The Virtual Biologic Clinic would be integral to a pathway approach, including follow up support to maximise adherence, compliance and patient benefit.

Improving Value Menu of Opportunity Guide

Virtual Biologics Clinics (VBC)

Key Performance Indicators (KPIs)

Quality

- Number of new patients referred to VBC subsequently prescribed biologic.
- Number of existing patients ceasing biologic.
- Patient waiting time (days) between decision to prescribe and patient receiving biologic medication for patients reviewed by VBC.
- Number of patients compliant with biologic requirement following access to the VBC pathway.
- Number of patients reporting successful self management following access to VBC pathway.

Efficiency

- Number of appropriate patients reviewed in VBC recruited to clinical trail and research per quarter/year.
- Cost of prescribing biologic after VBC introduced per year.

Key Enablers

- Existence of service specification or best practice pathway relevant to the biologic.
- Engagement of clinical networks to support engagement of all required Clinicians, and develop the biologic prescribing pathway.
- Opportunities to improve participation in research trials.
- Teams willingness to participate in service improvement/quality projects locally.
- NHS Improvement. Commissioning Framework for Biological Medicines.

Finances

How will the saving be achieved?

Recurrent savings will be achieved through;

- Improved safe prescribing; reducing the number of new patients prescribed a biologic inappropriately and, where clinically evidenced, by reducing or ceasing with the biologic for existing patients.
- The avoidance of future costs associated with inappropriate prescribing of biological medicines – helping to contain cost growth.

How will the saving be calculated?

- Savings will be calculated through analysing NHS trust drug prescribing data - spend on specific biologic drug.

Costs

- There were no additional costs associated with this scheme.

Commissioning Considerations

Defining the service

- Understand the existing pathway and how to measure impact of new prescribing pathway / virtual biologic clinic on:
- Treatment delays.
- Service efficiencies – quantifying additional capacity regained and for which professionals.
- Compliance with best practice pathway.

Ensuring delivery and implementation

- Relevant service specification or pathway.

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Switching patients on maintenance immunoglobulin to rituximab for inflammatory myositis

Improving Value Menu of Opportunity Guide

Switching patients on maintenance immunoglobulin to rituximab for inflammatory myositis

Name of Scheme	Switching patients on maintenance immunoglobulin to rituximab for inflammatory myositis
Theme	Get Best Value out of Medicines and Pharmacy
Menu of Opportunities sub themes	• Coordinated switch of patients to best value medicines • Reduce waste in high cost drugs • Ensure high cost medicines are use for defined cohorts of patients who will benefit most
Useful Sources of Information	NHSE`s Commissioning Policy for switching patients on maintenance immunoglobulin to rituximab for inflammatory myositis can be found here.

Summary

Patients with resistant inflammatory myositis may be receiving maintenance treatment with intravenous immunoglobulin (IVIg) at specialised centres because their disease was inadequately controlled with conventional disease modifying anti-rheumatic drugs (cDMARDs) e.g. methotrexate, mycophenolate, azathioprine, ciclosporin and/or cyclophosphamide.
The NHS England clinical commissioning policy for the use of rituximab in treating dermatomyositis and polymyositis (adults), reference 16036/P, July 2016, positions rituximab ahead of IVIg because this will be cost-saving and the recent availability of biosimilar rituximab has increased the potential for savings even further.

To encourage clinicians to consider switching patients who are on a maintenance treatment with IVIg and have not previously received rituximab to receive a course of rituximab to see if it provides the same level of disease control. IVIg is a blood product and can, at times, be in scarce supply. Optimising the use of rituximab where appropriate will therefore help to protect supply for those patients whose need is greatest.

Cost of treatment using intravenous immunoglobulin per patient, per year is approximately £70,720 compared with rituximab biosimilar which is £3,780 per year. Potential saving per patient, per annum is £66,940.

Improving Value Menu of Opportunity Guide

Switching patients on maintenance immunoglobulin to rituximab for inflammatory myositis

Who should consider this opportunity?

- This is an existing NHSE improving value scheme which all providers, NHSE hub commissioners and pharmacists should be implementing at a local level.
- In particular, any provider/commissioner of a service that includes prescribing of high cost drugs for long term conditions, should consider this scheme.
- Providers who are looking to decrease day care capacity.

Example case studies

There is a much broader programme of medicines optimisation across the NHS which encompasses switching from the use of branded drugs or originator drugs to generics or biosimilars, dose banding and stewardship. This is supported in many trusts by a CQUIN for 2017/18 and 2018/19. While this scheme is not specifically part of that CQUIN the principle of switching where possible and appropriate to ensure best use of financial resources is well understood and widely supported.

Solutions

The Aim

- The objective is to ensure evidence based commissioning with the aim of improving outcomes for adults with active dermatomyositis or polymyositis who have autoantibodies relevant to myositis.
- To support clinicians to consider switching from maintenance IVIg to rituximab for patients with resistant inflammatory myositis for whom this would be appropriate without any impact on clinical outcomes. This will lead to a reduction in spend on IVIg for this cohort of patients.

We will know that changes and improvements have been achieved if the following conditions are met:

- Patients' myositis has not deteriorated.
- Reduction in number of patients with inflammatory myositis on maintenance Immunoglobulin infusions.
- Increase in volumes of rituximab purchased against baseline from 2016/17 volumes purchased.
- Reduction in spend on immunoglobulin for patients with inflammatory myositis.

What changes will be made that will result in an improvement?

- Commissioners will identify myositis patients on maintenance immunoglobulin dose and engage with providers to initiate switching plan from IVIg to rituximab.
- It is important to note, IVIg is a blood product and can at times be in scarce supply. Optimising the use of rituximab where appropriate will therefore help to protect supply for those patients whose need is greatest.

Improving Value Menu of Opportunity Guide

Switching patients on maintenance immunoglobulin to rituximab for inflammatory myositis

Key Performance Indicators (KPIs)

- A switching plan, including weaning off of IVIg developed by the treating clinician for each appropriate patient.
- Number of IVIg infusions given for patients with inflammatory myositis.
- Patient will be entered onto the Myositis Disease Activity Assessment Visual Analogue Scales (MYOACT) database, as per clinical commissioning policy, so treatment outcome using validated measures can be captured.

Quality: Patients will not need to attend a day case unit for Intra venous treatment on a 4 weekly basis but for 2 infusions every 6 months or less, so fewer hospital visits.

Efficiency: Reduction in the number of attendances per patient per annum from a minimum of 26 days for IVIg versus 4 days for rituximab.

Key Enablers

- The scheme was developed nationally by clinicians and commissioners.
- An example care pathway for IVIG to rituximab (biosimilar) switch has been developed by the Specialised Rheumatology CRG for use by clinicians.
- Implementation Pack with tools and resources has been developed, including FAQs for patients & clinicians, monitoring forms, savings calculations.
- Clinical Commissioning Policy: Rituximab for the treatment of dermatomyositis and polymyositis (adults), published in July 2016

Finances

How will the saving be achieved?
By reduction in hospital day case attendance for infusion from 26 days for immunoglobulin to 4 day for rituximab.

How will the saving be calculated?
Cost of IVIg for an 80kg patient receiving 4 weekly courses of 2g/kg costs approximately £70,720 (average 80kg person to receive 2g/kg of Flebogamma at £680/20g x 13 courses). The total cost for 2 courses of rituximab biosimilar is approximately £3,780 per annum. For this calculation an average cost of £450 per infusion has been used.

Costs
There were no additional costs associated with this scheme.

Commissioning Considerations

Defining the service
Data is essential in developing this type of scheme to; build the evidence base, case for change, in tracking savings and switches within each provider trust during implementation.

Ensuring delivery and implementation
- Linked pharmacist in trusts, could have a role in reviewing prescriptions and supporting the identification of potential switch patients.
- It is also important to agree a consistent way of monitoring benefits realisation including drug regimen switches and associated savings.

NHS England

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Prescribing Generic & Biosimilar Products

Improving Value Menu of Opportunity Guide
Prescribing Generic & Biosimilar Products

Name of Scheme	Prescribing Generic & Biosimilar Products
Theme	Get Best Value out of Medicines and Pharmacy
Menu of Opportunities sub themes	• Coordinated switching of patients to best value medicines. • Reduce waste in high cost drugs. • Ensure high cost medicines are use for defined cohorts of patients who will benefit most. • Reduce variation in prescribing practice.
Useful Sources of Information	NHS England Biosimilar Medicines Framework can be found here. NICE Medicines Optimisation Quality Standard [QS120] can be found here.

Summary

Medication is a crucial element of almost every type of care, and is the most common form of healthcare intervention. However, ineffective use of medicines is a recognised problem that has an impact on the economy, society, healthcare system and patients.

The Medicines Optimisation CRG has developed and implemented schemes to improve value from high cost medicines, e.g. reducing waste by increasing uptake of a standardised chemotherapy doses and expediting implementation of biosimilar products.

Biological medicines are currently the largest cost and cost growth areas in the NHS medicines budget. Using a new commissioning framework, NHS England aims to drive a step change in the uptake of biosimilar medicines and make sure patients are offered the choice of switching to a new product by their specialist hospital doctor. The NHS is bringing a new generation of biosimilar medicines to the fore for patients, giving greater access to important treatments for thousands of hospital patients with serious conditions and providing increased value for the NHS.

The current CQUIN programme for 2018/19 facilitates fast switching by incentivising provider trusts which switch patients to generic drugs & biosimilar products. For example, Trigger 1:Faster adoption of prioritised best value medicines and treatment regimens as they become available. Further details of examples of NHS Trust/s that have implemented the 2018/19 Medicines Optimisation CQUIN are given on the next slide.

Improving Value Menu of Opportunity Guide

Prescribing Generic & Biosimilar Products

Who should consider this opportunity?

- The concept of prescribing generic medication & biosimilar products when available is a well established practice in the NHS.
- NHS England hub commissioners and pharmacists should be implementing this approach at a local level.
- In particular, any provider/commissioner of a service that includes prescribing of high cost drugs for long term conditions, should consider this approach.

Example case studies

There are no specific case studies available at present. However, there is a much broader programme of medicines optimisation across the NHS which encompasses switching from the use of branded drugs, or originator drugs, to generics or biosimilar, dose banding and stewardship. This is supported in many trusts by a CQUIN for 2017/18 and 2018/19. The principle of switching where possible and appropriate to ensure best use of financial resources is well understood and widely supported.

Solutions

The Aim

To influence prescribers and their decision making processes to ensure evidence-based, safe, cost effective prescribing ensuring optimal clinical outcomes for patients.

Specific Objectives

- Adoption of changes in practice to ensure implementation of evidence based prescribing in line with NICE guidance where available.
- Improving patient safety and outcomes from the use of medication.
- Improving quality indicators and reducing variation across providers.
- Sharing the evidence base and updating prescribers knowledge.
- Allowing peer challenge and debate leading to self-reflection, ultimately achieving a change in culture and outcomes.

We will know that changes and improvements have been achieved if the following conditions are met:

- Overall reduction in expenditure of branded products compared to generic drugs and biosimilar products and cost savings achieved.
- Monitoring of prescribing practice to ensure patients are receiving clinically appropriate treatment in line with NICE Medicines Optimisation Quality Standards and NHSE Biosimilar Medicines Framework.

What changes will be made that will result in an improvement?

- Region/Hub teams will review current prescribing & spend on high cost branded drugs & identify generic & biosimilar alternatives.
- Commissioners will engage with providers to promote implementation of CQUIN for best value products, including biosimilars and generics, see next slide.

Improving Value Menu of Opportunity Guide
Prescribing Generic & Biosimilar Products

Key Performance Indicators (KPIs)

Quality
Reduced variability in generic drugs & biosimilar products prescribed and average patient cost by monitoring of uptake and reporting of savings achieved.

Efficiency
Savings from switching from branded to generic drugs & biosimilar products where clinically appropriate.

Key Enablers

A CQUIN was developed in 2017/18 which outlined the following improvement:

- Adoption of best value generic/ biologic products in 90% new patients within one quarter of guidance being made available.
- Adoption of best value generic/ biologic products in 80% of applicable existing patients within one year of being made available (except if standard treatment course is < 6 months).
- Reviewing and switching of applicable existing patients to appropriate regimen treatments in line with NHS England agreed policy/ consensus guidelines, e.g. HIV, MS, (except if standard treatment course is < 6 months).

Targets for switching applicable patients will be agreed locally as and when the policy/guidelines are published and taking into account current guidelines where there is further opportunity for optimising use of medicines.

Finances

How will the saving be achieved?
Reduction in branded drugs prescribed and increase in use of generic & biosimilar products.

How will the saving be calculated?
Monthly monitoring of drug expenditure and patient numbers using data submitted by all providers. Monitoring of generic drugs & biosimilar uptake against % switch target in the CQUIN and savings achieved.

Costs
There may be costs associated with establishing current baselines for high cost drug use for providers.

Commissioning Considerations

Defining the service
Data is essential in developing this type of scheme in order to build the evidence base and case for change for generics and biosimilar products in specific conditions. Also in tracking savings and switches within providers during implementation.

Ensuring delivery and implementation

- Key to the success of this CQUIN scheme is clinical & commissioner engagement from the start. This will then support ongoing engagement from key local stakeholders including specialist pharmacists and patient groups.
- It is also important to agree a consistent way of monitoring benefits realisation including drug regimen switches and associated savings.

NHS England

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Obeticholic Acid for treating primary Biliary Cholangitis

Improving Value Menu of Opportunity Guide

Obeticholic Acid for treating primary Biliary Cholangitis (OBCA)

Name of Scheme	Obeticholic Acid for treating primary Biliary Cholangitis (OBCA)
Theme	Get Best Value out of Medicines and Pharmacy
Menu of Opportunities sub themes	• Reducing waste in high cost drugs. • Multidisciplinary team decision-making to ensure medicines optimisation. • Ensuring high cost medicines are used for defined cohorts of patients who will benefit most.
Useful Sources of Information	• NHS England`s Commissioning Intentions for Blueteq can be found here. • NICE Guidance for Obeticholic acid for treating primary biliary cholangitis can be found here.

Summary

This scheme is an example of how, by utilising and combining clinical evidence and NICE guidance through an Multidisciplinary Team (MDT) approach, it is possible to ensure that high cost medicines, specifically Obeticholic Acid, are used for the defined cohort of patients who will benefit most and maximise patient safety. Such an approach improves value by reducing harm caused through inappropriate prescribing.

Improving Value Menu of Opportunity Guide

Obeticholic Acid for treating primary Biliary Cholangitis

Who should consider this opportunity?

- Hubs and regions that have identified a need to improve value from medicines and pharmacy.
- Specialised commissioners and Clinicians who have concern around local variation in clinical quality and efficiency of OBCA prescribing.
- Areas with higher than expected population currently prescribed OBCA compared with estimated numbers derived from the NICE appraisal.
- HPB centres wishing to improve or develop their specialist MDT.
- Clinicians /Networks wishing to reduce variation in levels of data submitted to UK primary Biliary Cholangitis registry.

Example case studies

This scheme has not been implemented system wide so there are no specific case studies.

Solutions

Obeticholic acid is recommended as an option for managing symptom control and slowing down the disease process with primary biliary cholangitis for a specific cohort of patients i.e. the population for whom the main drug of choice for treating this condition – ursodeoxycholic acid - is not delivering an adequate response (between 20 and 70%) It is recommended only if the company provides it with the discount agreed in the patient access scheme.

The Aim

To maximise value and prevent inappropriate prescribing of Obeticholic Acid. Ensuring prescribing is in line with NHS England's criteria for commissioning this drug as outlined in Specialised Services Circular 1746. Numbers of patients receiving the drug will be consistent with the NICE TA by restricting it to those that will benefit most thereby reducing the harm of inappropriate prescribing (and the associated financial costs).

We will know that changes and improvements have been achieved if the following conditions are met:

OBCA is prescribed via Blueteq in line with commissioning guidance and estimated numbers derived from the NICE appraisal, inappropriate use is avoided and associated costs are contained. Blueteq is a web-based tool that supports improving value by ensuring treatments are being offered to the cohorts of patients most likely to benefit and that clinical resources are utilised in line with commissioning policy and evidence base.

What changes will be made that will result in an improvement?

Obeticholic acid will only be funded for patients registered via the Blueteq system i.e. where specific criteria have been met including a review by an appropriately constructed MDT within a specialised hepatobiliary centre. 'MDT' should meet a range of criteria including meeting at least once a month and comprising a 24/7 hepatology service supporting 2 WTE hepatologists and the agreement to submit data to the Primary Biliary Cholangitis registry.

Improving Value Menu of Opportunity Guide

Obeticholic Acid for treating primary Biliary Cholangitis

Key Performance Indicators (KPIs)

Quality
Number of patients funded for OBCA with completed Blueteq form.

Efficiency
- Compliance with commissioning guidance; reduction in cost of inappropriate prescribing.
- Ensuring PAS scheme discount - number of prescriptions for OBCA with PAS discount.

Key Enablers

- Engagement and discussion; confirm that Trusts understand the need to approve obeticholic acid at MDT and are registering obeticholic acid on the Blueteq system and appropriate data registry.
- Purchasing review; ensure that Trusts are purchasing obeticholic acid at the agreed discounted price.
- Utilise available intelligence; the CRG and professional bodies have provided advice on which providers fulfil these criteria and discussed the management of this drug with stakeholders.

Finances

How will the saving be achieved?
Through reduction in drug spend: Obeticholic acid will only be funded for patients registered via the Blueteq system and where an appropriately constructed MDT has approved its use within specialised hepatobiliary centres.

How will the saving be calculated?
Invoicing Data and Blueteq Data.

Costs
There are no associated costs with this scheme.

Commissioning Considerations

Ensuring delivery and implementation
- NHS providers will need to demonstrate specific criteria through the use of the Blueteq the system. The Blueteq initiation form was updated August 2017.
- Patients could be a candidate for transplant so established pathways to liver transplant and liver cancer networks should be in place to optimise uptake and management of these patients and use of this drug.
- Commissioners need to ensure that they are paying this discounted price for this drug as agreed in the patient access scheme.

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Dose Standardisation in Chemotherapy

Improving Value Menu of Opportunity Guide

Dose Standardisation in Chemotherapy

Name of Scheme	Dose Standardisation in Chemotherapy
Theme	Get Best Value out of Medicines and Pharmacy.
Menu of Opportunities sub themes	• Reduce waste in high cost drugs • Multidisciplinary team decision-making to ensure medicines optimisation • Reducing unwanted variation in clinical quality and efficiency
Useful Sources of Information	• NHS England`s Dose Banding Table and Service Specification for Chemotherapy can be found here. • SACT Systemic Anti-Cancer Therapy Dataset can be found here. • Information on Dose banding CQUIN can be found (CQUIN CA2) here. • The Carter Review on the standardisation of procedures in hospitals can be found here. • NHS England`s CQUIN tool on Dose Standardisation can be found here.

Summary

Chemotherapy Dose Standardisation is an opportunity for Clinical Pharmacy services to change the delivery of high cost chemotherapy drugs for their patients by using a nationally agreed set of standardised dose banding tables and a defined set of standard product presentations for each chemotherapy drug. Through this approach, they can optimise patient safety and minimise avoidable waste – with a positive impact on their multidisciplinary team, pharmacy service efficiency and capacity. Dose banding is described as a “system whereby doses of intravenous cytotoxic drugs calculated on an individualised basis that are within defined ranges, or bands, are rounded up or down to predetermined standard doses”.

Improving Value Menu of Opportunity Guide

Dose Standardisation in Chemotherapy

Who should consider this opportunity?

- Pharmacy services seeking opportunities to improve pathway efficiencies or service improvement work within adult chemotherapy medicines management in line with Carter Review recommendations.
- Pharmacy services that have identified high levels of avoidable waste in their chemotherapy pathway.
- Specialised Commissioners working in areas with high or increasing tendering costs for chemotherapy medication.
- Areas with trusts incurring higher than anticipated drug costs for chemotherapy, compared with other similar Trusts/populations.

Sheffield Teaching Hospitals NHS Foundation Trust
Following dose banding there was a significant decrease in the monthly expenditure with the chemotherapy dose banded drugs This occurred on a background of an increasing workload for the unit meaning that the reduced expenditure could not be related to a drastic decrease in prescriptions . Milly.Finch@sth.nhs.uk

Northumbria Healthcare NHS Trust.
This service successfully achieved chemotherapy dose banding via an improvement methodology project approach. They worked on understanding their pathway, waste points in the pathway, agreeing where waste was avoidable and unavoidable. Through small PDSA cycles they made changes to enable implementation through consensus. Steve.Williamson@northumbria-healthcare.nhs.uk

Leeds Teaching Hospitals NHS FT
Purchased chemotherapies from the regional contract requiring discussions between pharmacy and the healthcare team to agree changes to administration and delivery of chemotherapy regimens. These were then embedded into the electronic prescribing templates. Some of the practices of the aseptic department were also changed to match those of the outsourced providers, in order that all products given to patients, regardless of origin, were presented in the same way. Over £125,000 savings made in the first six months. julie.mansell@nhs.net

Solutions

The Aim
To support delivery of standardised IV chemotherapy drug doses to optimise patient safety and minimise avoidable waste of chemotherapy drugs.

We will know that changes and improvements have been achieved if the following conditions are met:

- 90% of Systemic intravenous Anti-Cancer Therapy Data set (SACT) administrations are being delivered using nationally agreed dose banded drug tables and through standard products.
- When all NHS England providers of chemotherapy are utilising standardised products definitions for the bulk-purchasing of “off the shelf” products.
- Demonstrable financial benefits associated with savings from reduced avoidable chemotherapy drug waste.
- Reduction in costs through tendering process associated with efficiencies of prescribing due to dose banding and standard products.

What changes will be made that will result in an improvement?

- Providers will use the national dose banding tables and product specifications for the agreed list of 50 IV Chemotherapy medications – reported via SACT returns
- Providers will use the waste calculation tool to identify avoidable waste, and the measurement toolkit, to identify opportunities to reduce avoidable waste and improve capacity within their pharmacy services.

Improving Value Menu of Opportunity Guide
Dose Standardisation in Chemotherapy

Key Performance Indicators (KPIs)

Quality

- Number of chemotherapy drug doses administered via dose banded drugs/standardised products.
- Number of provider contracts using standardised products.
- Number of different presentation descriptions using standardised products.
- Number of chemotherapy drug dosage errors.
- Number of complaints relating to delays in all chemotherapy administration using standardised products.
- Amount of intravenous chemotherapy drugs wasted - in process – following implementation of standardised products.
- Time taken to complete the process of preparation/ dispensing of chemotherapy drug using standardised products.

Efficiency

- Improved efficiency of resource allocation; standardised products used across every provider in England.
- Reduction in drug costs through improved administration of chemotherapy via standardised products adopted by providers.
- Less waste and reduced cost due to reduction in variation of chemotherapy drug prescription doses.

Key Enablers

- Utilising national tools and resources to support delivery.
- National dose banding tables. This can be accessed by clicking here.
- Standardised product specifications which can be found here.
- Ensuring engagement waste measurement toolkit - supporting people to make change and measure impact/benefit.
- Waste metric - to understand and calculate waste and monitor progress with dose banding over time
- CQUIN CA2 – which can be accessed here.
- The Carter review; Alignment with the overarching requirements around improving patient safety, and improving Pharmacy workforce capacity for direct patient contact and medicines optimisation.
- National plans for move to e –prescribing.

Finances

How will the saving be achieved?

Through reductions in chemotherapy drugs costs paid by NHS England, delivered through reductions in wastage and through efficiencies gained from purchasing of standard chemotherapy products

How will the saving be calculated?

- Reduction in tendering costs for chemotherapy
- Reduction in amount of drug purchased - mds
- Reduction in avoidable waste – waste metric; SACT and MDS data

Costs

There are no associated costs with this scheme.

Commissioning Considerations

Defining the service

Use of measurement toolkit to facilitate understanding the existing pathway, opportunities for change and agreement of an implementation plan and submission data to measure avoidable waste

Ensuring delivery and implementation

- Incentivisation through use of CQUIN, enabled by the CQUIN monitoring tool.
- Engagement with CMU around opportunities through local tendering

NHS England

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Reducing Wastage in Oral Chemotherapy

Improving Value Menu of Opportunity Guide

Reducing Wastage in Oral Chemotherapy

Name of Scheme	Reducing Wastage in Oral Chemotherapy
Theme	Get Best Value out of Medicines and Pharmacy
Menu of Opportunities sub themes	• Reduce waste in high cost drugs • Deliver medicine at home
Useful Sources of Information	National Guidance on Oral Chemotherapy can be found here. NHS England`s National Specification for Adult Chemotherapy can be found here.

Summary

There has been a significant increase in the proportion of chemotherapy that is prescribed as oral chemotherapy. There is a greater risk of drug wastage with oral chemotherapy as tablets are prescribed for extended periods of time and are taken out of hospital by patients. This risk is greater for patients with metastatic cancer who have short doses of chemotherapy but complex clinic needs whereby their dosage may change. The Christie NHS Foundation Trust implemented a scheme whereby a clinician can write three monthly scripts for higher cost oral chemotherapy drugs; however patients are only supplied with one month supply at a time. A nurse or a pharmacist phones the patient to review medicine intake and ensure that the patient is still taking their medicine and requires a further supply before the next months stock is sent to the patient. Patients who have ceased therapy or do not need a further supply of drugs are quickly identified before drugs are dispensed.

Improving Value Menu of Opportunity Guide

Reducing Wastage in Oral Chemotherapy

Who should consider this opportunity?
All trust who prescribe oral chemotherapy should consider this scheme: especially where there is evidence to show that best practice in oral chemotherapy prescribing has not been implemented.

Example case studies
During the course of 2013 the Pharmacy team at the Christie were becoming increasingly concerned about medicines wastage of high cost oral chemotherapeutic agents, dispensed to patients on long-term oral chemotherapy regimens. The pharmacy team were keen to introduce a solution to this problem which not only reduced wastage but also put into practice the key elements of Medicines Optimisation

The redesigned pathway has resulted in the hospital being able to issue patients with prescriptions of up to 3 months duration – but the drugs being issued in monthly instalments. This has resulted in patients never holding more than one month's supply of drugs – the total value of which is often in excess of £6000. The prescribing scheme has achieved all its objectives and has resulted in recurrent savings, for commissioners of over £200,000.

A further unintended, but welcome, consequence of the scheme has been the greater buy-in from patients around the management of their medicines. Patients have a great deal of confidence in the scheme and the staff running it.

Solutions

The Aim
This initiative seeks to minimise wastage for patients who are prescribed oral chemotherapy for more than one month at a time.

We will know that changes and improvements have been achieved if the following conditions are met:

- Reduction in wastage of high cost oral chemotherapy drugs.
- Lower ratio of follow up appointments.
- Reduced cost per cycle of chemotherapy.
- Better support for patients receiving chemotherapy via telephone reviews
- Different options for delivery models e.g. potential for homecare delivery.
- Improved patient adherence to oral chemotherapy.

What changes will be made that will result in an improvement?

- Minimise wastage of oral chemotherapy by making changes to prescribing behaviours and review processes.
- To ensure that appropriate supplies are made at the right time for patients and that the patients are reviewed appropriately, without the possibility of being given more than needed (when the patient does not need the prescription).
- Review the model of delivery for patients using oral chemotherapy, for example expanding the role of homecare delivery models or outsourcing of outpatient dispensing services.

Improving Value Menu of Opportunity Guide

Reducing Wastage in Oral Chemotherapy

Key Performance Indicators (KPIs)

Quality
- Improved patients adherence to oral chemotherapy.

Efficiency
- Reduce wastage of oral Chemotherapy
- Reduced cost per cycle of Chemotherapy.

Key Enablers

- Information regarding current activity (volumes of drugs used) and unit price.
- National policy for oral chemotherapy.
- Information regarding the Christie's NHS Foundation Trust implementation of the scheme (e.g. business case/ progress report etc.).
- NHS England`s National Specification for Oral Chemotherapy prescribing.

Finances

How will the saving be achieved?
- Understand current expenditure on high cost oral chemotherapy drugs (based on current volumes and unit prices)
- Estimate changes in volumes required, based on % reduction in wastage from the Christie's experience
- Calculate future expenditure based on future volumes of drugs usage and unit price.

How will the saving be calculated?
- Understand current expenditure on high cost oral chemotherapy drugs (based on current volumes and unit prices).
- Estimate changes in volumes required, based on % reduction in wastage from the Christie's experience.
- Calculate future expenditure based on future volumes of drugs usage and unit price.

Commissioning Considerations

Ensuring delivery and implementation
- Drugs included in the initiative (eg sunitinib, everolimus or axitinib) are confirmed based on patient eligibility.
- National policy developed
- National policy embedded in national practice
- Providers change their practices including change in prescribing practice; change in outpatient clinic templates and change to review process (e.g. setting up telephone review clinic)
- Providers to review their delivery model for homecare delivery/ outsourcing of dispensing services
- Where required providers contract with outsourced homecare delivery providers
- Embed changes in the provider contracts

NHS England

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Multiple Sclerosis Disease Modifying Therapies

Improving Value Menu of Opportunity Guide

Multiple Sclerosis Disease Modifying Therapies (MS)

Name of Scheme	Multiple Sclerosis Disease Modifying Therapies (MS)
Theme	Get Best Value out of Medicines and Pharmacy
Menu of Opportunities sub themes	• Ensure high cost medicines are used for defined cohorts of patients who will benefit most
Useful Sources of Information	• NHSE Clinical Commissioning Policy: Disease Modifying Therapies for Patients with Multiple Sclerosis Can be found here. • NICE Clinical Guidance 127: Natalizumab for the treatment of adults with highly active relapsing–remitting MS can be found here. • NICE Clinical Guidance 254: Fingolimod for the treatment highly active relapsing–remitting MS can be found here.

Summary

This scheme aims to ensure full implementation of the NICE Guidance & NHSE Clinical Commissioning Policy around MS disease modifying therapies by using an electronic prior approval system (Blueteq) to ensure evidence based starting and stopping criteria for MS drugs are being adhered to.

Improving Value Menu of Opportunity Guide
Multiple Sclerosis Disease Modifying Therapies

Who should consider this opportunity?

- This is an existing NHSE scheme and commissioners and Providers of MS services should have reached the implementation stage.

- This scheme could also be considered for other disease areas where there is clear evidence based starting and stopping criteria for high cost drugs. And where there is an opportunity to reduce inappropriate prescribing outside of this evidence base. Lead Commissioners as it would lead to a reduction in the prescription of inappropriate drugs that has no clinical benefits.

Example case studies

There are many examples in NHSE where an electronic prior approval system has been used and successfully addressed variations in prescribing.

Solutions

The Aim
The aim of the scheme is to ensure patients with MS are on the correct treatment in line with NICE Guidance & NHSE Clinical Commissioning Policy for MS disease modifying therapies. This can be done by using an electronic prior approval system (Blueteq) for all patients starting treatment and at annual reviews.

We will know that changes and improvements have been achieved if the following conditions are met:

- Monitoring of Blueteq reports to ensure patients are receiving the most clinically appropriate treatment in line with NICE guidelines and NHSE clinical commissioning policy
- Reduction in variation of prescribing.
- Identification and management of outliers in terms of prescribing and spend
- Map invoice spend to Blueteq approval for new patients.
- Hub teams review Blueteq approvals for spend for continuation of DMT.

What changes will be made that will result in an improvement?
Clinicians and patient groups through the Neurosciences Clinical Reference Group helped develop the electronic prior approval form which included starting and stopping criteria for clinicians to complete for individual patients to ensure prescribing in line with national policy. A treatment algorithm has also been developed to further support clinicians and consistent prescribing.

Improving Value Menu of Opportunity Guide

Multiple Sclerosis Disease Modifying Therapies

Key Performance Indicators (KPIs)

Quality

- Whole system reduction in prescribing of inappropriate drugs that have no clinical benefits will be measured via drugs dataset and review of Blueteq approvals.
- Appropriate prescribing of MS drugs for patients with ongoing treatment which would lead to greater clinical efficacy will be measured via drugs minimum dataset and review of Blueteq approvals.

Efficiency

- Reduction of outpatient follow up appointments.
- Improved patient flow and a reduction of emergency admissions associate with cost.

Key Enablers

- This scheme was developed through NHSE the Neurosciences Clinical Reference Group (CRG) which includes patients and clinicians so had buy in from the start.
- Electronic forms were developed by the CRG and were tested to ensure they were clear and no room for different interpretations.
- NHSE Circular for commissioners and letter for providers was developed describing the case for change and actions needed for implementation.
- The prescribing algorithm also went out for 2 week stakeholder consultation and feedback informed further development.

Finances

How will the saving be achieved?

- Reduction in the number of MS drugs being prescribed outside of NICE guidance and NHSE clinical commissioning policy.

How will the saving be calculated?

- MS drugs are a pass through payment so reductions in spend per patient should be easily identifiable by mapping invoice spend against Blueteq report.

Costs

There are no associated costs with this scheme.

Commissioning Considerations

Ensuring delivery and implementation

- Updated Blueteq Forms implemented (February 2017).
- Agreement of draft treatment algorithm (February 2017).
- Agreement of treatment algorithm (consultation (July 2017).
- Published algorithm (August 2017).
- Implementation of algorithm into contracts (February 2018).

Reduce Avoidable Demand and Meet Demand more Appropriately

NHS England

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Enhanced Supportive Care

Improving Value Menu of Opportunity Guide

Enhanced Supportive Care (ESC)

Name of Scheme	Enhanced Supportive Care (ESC)
Theme	Reducing Avoidable Demand and Meet Demand more Appropriately
Menu of Opportunities sub themes	• Reduce unwarranted variation in clinical quality and efficiency. • Ensure compliance with latest evidence, national clinical policy, specifications and guidance. • Reduce waste in high cost drugs. • Multi-disciplinary team decision-making to ensure medicines optimisation.
Links to useful Sources and Information	• NHS England`s Five Year Forward View on Cancer can be found here. • NHS England`s Cancer Strategy can be found here. • NHS England`s Guidance for Cancer Alliances and the National Cancer Vanguard can be found here.

Summary

Enhanced Supportive Care is about bringing the skills and expertise within palliative care upstream, and making them accessible to patients with cancer at/from the point of diagnosis of incurable disease. The proactive and supportive approach of ESC on the effects of cancer, and effects of the treatment of cancer improves patient experience and quality of life across a range of metrics including reducing symptom burden, experience of chemotherapy and unplanned admissions to acute care.

Improving Value Menu of Opportunity Guide

Enhanced Supportive Care (ESC)

Who should consider this opportunity?

Clinicians wishing to improve pathway for patients diagnosed with incurable cancer disease, from that point in their pathway.

Trusts with a growing rate of unplanned admissions to acute care for people with incurable cancer for management of symptoms/problems that could have been avoided if a proactive support system had been in place.

Organisations with a worsening QOL for cancer patients, identified through clinical patient experience scores (IPOS) in feedback/ clinical assessment.

Example case studies

The Christies NHS Foundation Trust

The Christie Hospital; developed ESC and rolled it out across all cancer disease groups and currently are progressing ESC II, offering 7/7 walk in clinics for all cancer patients. This ESC has resulted in over £1.4 million savings in unplanned admissions across 3 years and projected savings from ESC II of £4.2 million. Richard.Berman@christie.nhs.uk

Nottingham Hospital

Commenced ESC with stage IV lung cancer patients 2016/17 resulting in a change to the commissioned pathway for these pts, and integration ESC within cancer alliance work. Vincent.crosby@nuh.nhs.uk

Barking Havering and Redbridge

Developed a predominantly nurse led model of ESC resulting in improved patient experience through reducing the instances where these individuals would have been admitted to acute care, and by enabling pts who declined chemotherapy to be better supported at home. Pauline.Staley@bhrhospitals.nhs.uk

Solutions

The Aim

There is growing evidence that providing patients with better access to supportive care can improve their experience of care, prevent escalation of symptoms, and even lengthen survival. Enhanced Supportive Care aims to optimise management, treatment and support for people diagnosed with incurable cancer, from the point of diagnosis, thereby maximising patient QOL, minimising symptoms associated with cancer, and the treatment of cancer and also help optimise the timing of final chemotherapy administration.

We will know that changes and improvements have been achieved if the following conditions are met:

- All patients with a diagnosis of incurable cancer are offered ESC through a model that comprises the 6 pillars of ESC **(see next slide).**
- Fewer patients with incurable cancer will be admitted to acute care for symptom related issues.
- More patients are supported through the chemotherapy process to enable them to complete these, or, where a decision has been made by the patient not to undertake chemotherapy, they are supported accordingly.

What changes will be made that will result in an improvement?

- All patients will be offered ESC at the point of diagnosis of incurable disease; ESC services will be in place to:
- To support patients proactively and prevent development of symptom necessitating admission to acute care, chemotherapy related complications and partially completed courses of chemotherapy.
- Screen patients using a validated patient experience score to optimise timely and effective symptom management and support.
- ESC services will be delivered by an ESC MDT comprising suitably skilled experts in supportive care, optimising evidenced based approaches and technologies across **the 6 pillars of ESC (see next slide).**

Improving Value Menu of Opportunity Guide

Enhanced Supportive Care

Key Performance Indicators (KPIs)

Quality

- Improved patient experience of care – as measured through a change in IPOS or other validated QOL patient experience measure: directly related to ESC intervention/support.
- Increase in the percentage of the cancer disease group being offered ESC at the point of diagnosis with incurable disease

Efficiency

- Improved use of chemotherapy – fewer partially completed courses due to improved support for patients
- Reduction in growth of unplanned acute admissions – compared with non ESC cancer groups/ the growth in total cancer population being managed
- Reduction in inappropriate A&E visits, GP appointments due to access to ESC team.

Key Enablers

- The National Cancer Strategy 2010 /16 and Achieving World Class Cancer Outcomes; A strategy for England 2015/20 both identify ESC as an essential component of good cancer care
- ESC enables and aligns with Personal Health Budget, Patient Activation and SDM which are all aspirations of the 5 Year Forward.
- Cancer Alliances – are opportunities for strategic alignment of ESC within STP geographies.
- The national CQUIN CA1 - offers a template that can be adapted for local use, and a CQUIN monitoring tool, to support data collection.

Finances

How will the saving be achieved?

- Lower overall healthcare costs through earlier intervention. This is done through reductions in chemotherapy drugs costs, a reduction in use of chemotherapy at end of life, fewer emergency hospital admissions/slower growth in rise of unplanned admissions.
- Reduction in LOS and fewer intensive care hospital days for patients with advanced progressing cancer.

How will the saving be calculated?

- Improved management of cost pressures around growth in unplanned admissions and chemotherapy drug spend.
- Slower increase in growth of unplanned admissions compared with non ESC disease groups.
- Reduction in chemotherapy waste costs.

Costs

There were no additional costs associated with this scheme.

Commissioning Considerations

A successful and sustainable ESC model must include all six pillars that underpin ESC

- Earlier involvement of supportive care services
- Supportive care teams that work together
- A more positive approach to supportive care
- Cutting edge and evidence-based practice in supportive and palliative care.
- Technology to improve communication
- Best practice in chemotherapy care.

Ensuring delivery and implementation

- Support with data collection and management – to collect and analyse IPOS data in various clinical settings and stages within the ESC pathway.
- ESC MDTs require space for ESC clinics, in addition to supporting colleagues in their specific MDT, acute oncology clinics and chemotherapy delivery unit

NHS England

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Shared Decision Making

Improving Value Menu of Opportunity Guide

Shared Decision Making (SDM)

Name of Scheme	Shared Decision Making (SDM)
Theme	Reduce Avoidable Demand and Meet Demand more Appropriately.
Menu of Opportunities sub themes	• Reduce Unwarranted variation in Clinical Quality and Efficiency • Ensure compliance with Latest Evidence, National Clinical Policy, Specifications and Guidance
Useful Sources of Information	• NICE Shared Decision Making collaborative can be found here. • Embedding Shared Decision Making can be found here. • NICE guidance on shared decision making can be found here. • The National CQUIN for Shared Decision Making can be found here. • Advancing Quality Alliance (AQuA) Case Study on Shared Decision Making can be found here.

Summary

Shared Decision Making (SDM) is about ensuring that ALL relevant treatment options irrespective of the clinical team's preferences, are discussed with individual patients, to enable the patient choices and decisions to be aligned with their overall needs, values and clinical ability to benefit.

The Health and Social Care Act 2012 s23(1)(13H) & s25(1)(14U)): Statutory duties of CCGs and NHS England to promote patient choice and the duty to promote involvement of patients and carers in decisions about prevention and diagnosis of their illness, and in their treatment and care.

Improving Value Menu of Opportunity Guide
Shared Decision Making

Who should consider this opportunity?

Everyone: This is an existing key NHS priority as indicated in the Five year forward view that supports person centred care.

CCGs and providers: there is a duty to deliver person centred care and a contractual requirement for providers to deliver against regulation 9, outlined in the NHS Standard Contract (Full Version) Service Conditions SC10.

Commissioners, primary care and providers: involved in supporting patients with services on a pathway where treatment becomes more intensive as their condition progresses, but where local patient satisfaction/outcomes is not corresponding with this.
CCGs and NHS England who are seeking to actively promote patient choice and demonstrably involve patients and carers in decisions around diagnosis and management of their illness, and in their treatment and care – and to measure the impact of this on patient, service and systems.

Example case studies

Advancing Quality Alliance (AQuA) worked with 32 national teams to share and embed a culture of shared decision making. They developed training resources, patient engagement leaflets, decision grids, recording mechanisms and case studies. Aqua has produced a few case studies.

Solutions

The Aim
Shared decision making is “a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient’s informed preferences.
It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients’ informed preferences” (NICE 2015).

We will know that changes and improvements have been achieved if the following conditions are met:

- There is a reduction in the demand for successive treatments where these have been associated with poorer patient outcomes, satisfaction and high service costs. In pathways where Shared Decision Making has been implemented.
- There are improved patient compliance with Shared Decision Making related conditions, i.e. treatments selected, due to an optimised engagement and shared decision making process, resulting in improved patient outcomes.
- Fewer complaints / Improved patient satisfaction due to improved engagement and optimised treatment selection.

What changes will be made that will result in an improvement?

- Clinical teams will demonstrate specific Shared Decision Making related competency and skills to engage patients in a shared decision making process.
- Clinical teams will discuss the full range of treatment options available and emphasise to patients their ability to benefit from all of these options as part of the decision making process.

Improving Value Menu of Opportunity Guide

Shared Decision Making

Key Performance Indicators (KPIs)

Quality

- Better quality discussion of risks and options for patients when making decisions /reduced decision conflict for patients.
- Measured through patient questionnaires/local audit/ review of complaints.

Efficiency

Reduction in demand for successive treatments in high cost pathways associated with poorer outcomes and satisfaction where Shared Decision Making has been implemented e.g. Osteoarthritis (OA) hip, Knee, back pain, cardiac devices. Measured through:

- Additional clinic capacity gained for appropriate patients.
- improved use of appropriate AHP specific therapies, self management programmes and health promotion services.
- Reduction in growth of demand for specific high cost services e.g. knee surgery for OA hip surgery for OA, and cardiac devices.

Finances

How will the saving be achieved?

In specific services where SDM has been implemented:

- Reduction in number of clinic and Out Patient Appointments per patient.
- Reduction in growth in demand for some high cost treatments e.g. cardiac devices / OA knee surgery.

How will the saving be calculated?

- Provider activity data.
- Ratio of NP to follow up appointments costs.

Costs

- Training for clinical teams in effective SDM.

Key Enablers

- RightCare Renal Casebook: Transferrable learning around how SDM can significantly inform patient decisions, outcomes (including financial) and their impact on individuals, families and the health care system .
- RightCare Decision Aids which can be found **here.**
- Shared Decision Making National CQUIN: The structure and approach of this national CQUIN may offer a framework for devising a local CQUIN, especially to incentivise training and use of Patient Decision Aids. Please find the National CQUIN **here.**

Commissioning Considerations

Defining the service

- Prioritise areas for implementation and consider a realistic pace of change.
- Ensure services are supported by providers and the voluntary sector. Plan how to monitor and measure impact in order to highlight benefit as early as possible.

Ensuring delivery and implementation

- Plan and resource for a change management programme; Organisations need a committed clinical champion to lead local implementation supported by committed management support. Where possible, use existing governance structures as opposed to setting up new processes.
- Consider patient involvement in every key process and decision; use existing patient networks, expert patient programmes and advocates as change agents.
- Engender support from stakeholders across the whole pathway, not just those healthcare staff . Regular engagement and updates are vital in ensuring everyone is aware of progress and in communicating benefits and outcomes.
- Cultural change will have the greatest impact where engagement with providers supports the development of training programmes for patient facing decision making. Contractual levers can support this.

NHS England

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Avoiding Term Admissions into Neonatal Critical Care Unit (ATAIN)

Improving Value Menu of Opportunity Guide

Avoiding Term Admissions into Neonatal Critical Care Unit (ATAIN)

Name of Scheme	Avoiding Term Admissions into Neonatal Critical Care Unit (ATAIN)
Theme	Reduce Avoidable Demand and Meet Demand more Appropriately
Menu of Opportunities sub themes	• Optimisation use of specialised bed base • Ensure compliance with latest evidence, national clinical policy, specifications and guidance
Useful Sources of Information	• NHS Improvement document on ATAIN can be found here. • British Association of Perinatal Medicine Framework for Neonatal Transitional Care can be found here. • British Association for Perinatal Medicine Framework for Practice can be found here. • Nice Guidance on Jaundice in new-born babies under 28 days can be found here.

Summary

Improving the safety of maternity services is a key priority for the NHS and reducing admission of full-term babies to neonatal care is an indicator in the NHS Outcomes Framework for 2016 to 2017. The number of unexpected admissions of term babies is seen as a proxy indicator that harm may have been caused at some point along the maternity or neonatal pathway.

In 2013 in England, there were 80,251 admissions to neonatal units of which almost 60% (48,000) were babies born at term (≥37 weeks), of which, the NHS Improvement say, 30% are avoidable. The main purpose of this scheme is to prevent avoidable admission of term babies to Neonatal Critical Care Units (NICU). This scheme will focus on 4 key clinical areas which are believed to be driving part of these avoidable term admissions - hypoglycaemia, jaundice, respiratory conditions and asphyxia (hypoxic-ischaemic encephalopathy).

Improving Value Menu of Opportunity Guide

Avoiding Term Admissions into Neonatal Critical Care Unit (ATAIN)

Who should consider this opportunity?

This is an existing scheme.

- Commissioners as it would lead to a reduced variation in care and reduction in avoidable term admission into NICU & associated costs.
- Providers looking to provide the required care for babies aligned with national guidance.
- Providers adopting this scheme could see an Improvement in survival rates and a reduction in mortality.

Example case studies

This scheme has been implemented in the South Region for a number of years. Average term admissions as a % of all live births into NICU, for South Region in Q3 2017/18, was reported at 4.9%. For South East Coast, term admissions into NICU were reported as 4.1%. The South East ODN has also produced an ATAIN Pack with guidance and year end dashboard for term admissions for providers.

Please contact vanessa.attrell@nhs.net Network Manager, South East Coast Neonatal ODN, for more information about how this scheme was implemented in South Region.

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Solutions

The Aim

A central aim of this scheme is to reduce avoidable admissions to neonatal care and prevent harm leading to separation of mother and baby.

We will know that changes and improvements have been achieved if the following conditions are met:

- Reduction in avoidable admissions for term babies to NICU and associated cost savings.
- There should also be a reduction in transfers due to lack of cot capacity.
- Increase in keeping mothers and babies together.

What changes will be made that will result in an improvement?

- Whole system approach and collaboration between maternity and neonatal teams in providing care and support for mothers and babies in avoiding admission to NICU.
- The prevention of term admissions needs to take place within maternity pathway and reviewing the admission criteria of neonatal units.
- Transitional care units will be an alternative pathway for a percentage of avoidable admissions and these will need to be established in some areas where there is no current provision.
- Closer collaboration between maternity and neo-natal critical care.

Improving Value Menu of Opportunity Guide

Avoiding Term Admissions into Neonatal Critical Care Unit (ATAIN)

Key Performance Indicators (KPIs)

Quality

- Local maternity and neonatal teams will identify main reasons for term admissions into NICU and identify local improvement priorities to improve the safety of care and keep mothers and babies together whenever it is safe to do so.
- Families experience will improve as hospital stay by mothers and babies will be minimised, avoiding unnecessary interventions for babies and reducing exposure to infections.

Efficiency

- Babies will be admitted to an appropriate clinical setting based on their health status, for example, transitional care. This enables babies to be with their mothers and maximise the opportunity for bonding and breastfeeding to be established with long term health benefits.

Finances

How will the saving be achieved?

It is estimated that 30% term admissions associated with hypoglycaemia are avoidable and this represents a cost saving of approximately £3m per annum for hypoglycaemia admissions alone**.**

How will the saving be calculated?

Using the latest data on term admissions a savings analysis will be conducted to identity potentially savings at national and regional level.

Costs

There are no additional costs associated with this scheme as this is a core function of ODNs which NHSE already fund.

Key Enablers

- Data analysis and savings calculations at national & regional level.
- Launch events to support the development of the project.
- ATAIN Implementation Pack to assist regions and hubs to implement the project.
- Resources and case studies from units with experience of implementation of ATAIN to aid further learning.

Commissioning Considerations

Defining the service

The programme has been led by clinical experts from a range of organisations, including NHS Improvement, Royal College of Midwives, British Association of Perinatal Medicine and patient representatives from Bliss.

National data term admissions into NICU are available for 2014/17.

Ensuring delivery and implementation

- An implementation pack with tools & resource s is available to support regional implementation.
- NHS Improvement, through a Patient Safety Alert have encouraged neonatal units to address avoidable admissions and developed a resource pack to support implementation.
- Tariff development – national work is underway to develop national tariff for neonatal care which will be available in 2019.
- Plans for including Transition Care Units within specialised commissioning will support implementation of this scheme.

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Clinical Utilisation Review (CUR)

Improving Value Menu of Opportunity Guide

Clinical Utilisation Review (CUR)

Name of Scheme	Clinical Utilisation Review (CUR)
Theme	Reduce Avoidable Demand and Meet Demand more Appropriately
Menu of Opportunities sub themes	• Optimisation use of specialised bed base and primary, secondary and tertiary prevention • Reduce unwanted variation in clinical quality and efficiency • Implement optimal pathway of care • Shared decision-making
Links to useful Sources and Information	• The key documents related to CUR can be found here. • NHS England`s CUR CQUIN Document can be found here. • National CUR Review Framework here. • CUR National Team Members- ✓ Hilary Heywood, National Programme Director - h.heywood@nhs.net

Summary

Clinical Utilisation Review is a process that enables clinicians to make impartial and objective evidence-based assessments of whether patients are receiving the right levels of care in the right settings at the right time based on clinical needs. CUR improves patient flow across the health continuum, identifying patients who should never have been admitted and demonstrating whether or not patients are clinically appropriate for the level of care they are receiving. CUR supports organisations to tackle delayed transfers of care, stranded patients and will help NHS Trusts achieve the required 25% reduction in stays longer than 3 weeks. Successful healthcare organisations worldwide have embraced this approach to improve patient outcomes and satisfaction. As a result, the appropriate CUR tools can play a significant role in supporting the emerging new models of care and is an essential function of successful Integrated Care Systems.

Improving Value Menu of Opportunity Guide

Clinical Utilisation Review (CUR)

Who should consider this opportunity?
Commissioners and all NHS providers may wish to consider CUR:-

- To understand and address the barriers to patient flow across their health and care system
- To support the development of Integrated Care Systems and New Models of Care
- To address challenges with delayed transfers of care, inappropriate admissions, stranded patients, length of stay and winter pressures
- To support clinicians, managers and commissioners understand and manage, the utilisation of beds in real time, using evidence-based data
- To identify opportunities for service improvement that improve productivity, efficiency and patient outcomes

Case Studies

Norfolk and Norwich University NHS Foundation Trust aligned their CUR data holistically to inform other key Trust requirements, including recording of Delayed Transfers Of Care and Situation Reports. CUR data is now active in all clinical settings, resulting in savings in both clinical and administrative time of 1.0 whole time equivalent administrator.

Implementation of CUR at **South Tees NHS Foundation Trust** has provided demonstrable impact in the reduction of delays for continued stay patients, and improvement to patient flow. Through use of granular level data, CUR presents a compelling case for change for its use in an acute hospital setting. Non-qualified patient levels have improved by 35% in a 12-month period presenting tangible savings/increased capacity.

Solutions

The Aim

To ensure that patients are being treated in the right care setting (right care, right time, right place), determined through the use of evidence-based CUR assessments. CUR fully supports organisations to improve patient care, supporting organisations to deliver the required 25% reduction in over 3-week length of stays, as announced by Simon Stevens (June 2018).

We will know that changes and improvements have been achieved if the following conditions are met:

- A reduction in the percentage of patients identified as not meeting the criteria for an admission or continued stay and reduction in the top 5 reasons for delay (internal and external)
- CUR data supports changes in clinical practice and service improvement, for example production of business cases for service re-design / commissioning of services across a health and social care footprint
- The delivery of higher quality care is supported by improving the transfer of patients to the most appropriate level of care
- Service efficiency is improved by reducing length of stay, stranded patients and delayed transfer of care.
- CUR data provides a more granular evidence base for operational and strategic management, aligned to key performance indicators that underpin contracts and service specifications
- CUR data informs system-wide commissioning plans based on real-time demand and capacity requirements.

What changes will be made that will result in an improvement?

- An accredited CUR* system will be embedded and used on a daily basis across a trust to manage patient flow.
- Appropriate staff are aware of and have been trained in using CUR software.
- Real time data is routinely used at an operational level to inform decisions in patient flow to support greater efficiency and identify service redesign opportunities .* Ref CUR National Framework.
- CUR data is used to inform strategic decisions that impact patient flow across a health and social care system, e.g. winter planning.

Improving Value Menu of Opportunity Guide

Clinical Utilisation Review (CUR)

Key Performance Indicators (KPIs)

Quality

- Improve management information, e.g. providing the evidence for key performance indicators that underpin contracts and service specifications.
- Improved patient experience of care through receiving the right care at the right time in the right place.
- Improved patient safety and patient satisfaction.
- Reduced length of stay, inappropriate admissions, delayed discharges.

Efficiency

- Reduction in inappropriate admissions, stranded patients and delayed discharges
- Reduction in Length of Stay - admission spell, or within a specific part of the pathway/bed (e.g. specialist bed).
- Reduction in not-met / non qualified rate for continued stay patients.
- Reduction in unwarranted clinical variation.

Finances

How will the saving be achieved?

- Reduction in costs associated with fewer delays in the system and patients accessing right care at the right time/place e.g. , improved patient safety, shorter LOS, better clinical outcomes, reduction in unnecessary treatment costs.
- Fewer inappropriate admissions and a reduction in readmissions.
- Reduction in avoidable discharge delays.

How will the saving be calculated?

- Trust data/CUR data

Cost

- Requires investment in CUR software: software license costs, installation and training (clinical and non-clinical), programme management support to ensure an early and sustained return on investment.
- Providers need to procure a CUR supplier from the NHS England national CUR Framework.
- CUR requires executive ownership and an executive sponsor, ideally a clinical lead.
- Clinical and Business Intelligence support will be required to ensure that CUR data drives service improvement and organisational change.

Key Enablers

- National CUR framework and supporting documentation.
- National CUR Team .
- National CUR Learning Network sharing best practice and lessons learnt.
- CUR CQUIN – the national GE1 CQUIN provides a framework model for how this approach can incentivise the process
- CUR extranet.
- CUR newsletters and case studies.

Commissioning Considerations

Defining the service

CUR has been applied to specialist services, supported by CQUIN. However CUR offers greater value when applied across a health system (acute, community and mental health services. CUR tools can play a significant role in supporting the emerging new models of care and is an essential function of successful Integrated Care Systems.

Ensuring delivery and implementation

- CUR is a medium to long-term transformation programme. Commissioners and Trusts should avoid focussing on single year blocks when planning and measuring impact /service redesign.
- CUR requires clinical leadership and Executive ownership and should not sit in isolation and should be embedded as part of organisational transformation.
- CUR is not an IM&T solution but a clinical decision support / transformation change tool.

NHS England

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Adult Critical Care Delayed Discharges

Improving Value Menu of Opportunity Guide

Adult Critical Care Delayed discharges

Name of Scheme	Adult Critical Care Delayed Discharges
Theme	Reduce Avoidable Demand and Meet Demand more Appropriately
Menu of Opportunities sub themes	• Optimisation use of specialised bed base and primary, secondary and tertiary prevention • Reduce unwanted variation in clinical quality and efficiency • Implement optimal pathway of care
Useful Sources of Information	National Adult Critical Care Service Specification can be found here.

Summary

The national standard for discharge from critical care clearly states that this should be within 4 hours of the decision to discharge being made and during daylight hours. It is estimated that 50% of all discharges to ward level care are delayed and of this 10% are delays of 24 hours or more. Providers were initially incentivised to reduce delays through a CQUIN, and this scheme then aimed to embed this into business as usual by using contractual levers to only pay for delayed discharges at an excess bed rate.

Improving Value Menu of Opportunity Guide

Adult Critical Care Delayed Discharges

Who should consider this opportunity?

- Commissioners should consider this as delayed discharges mean patients are not being cared for in the appropriate setting.
- Providers should consider this as it would lead to an overall reduction in cancelled electives.

Example case studies

This scheme has not been implemented system wide so there are no specific case studies. There are however plenty of examples at an individual trust level where delayed discharges are at a low level and this data is available through ICNARC and through critical care networks.

Solutions

The Aim

The general aim of this scheme is to ensure patients are being cared for in the appropriate setting and are being discharged in a timely manner. This will be achieved by maximising the use of contractual levers to only pay for delayed discharges greater than 24hrs at an excess bed rate and to extend this to delays >4 hours <24 hours in the following year.

We will know that changes and improvements have been achieved if the following conditions are met:

- Intensive Care National Audit & Research Centre (ICNARC) data will show reductions in delayed discharges.
- Savings will be released as move to excess bed rate.
- Decrease number of cancelled elective surgery.
- Improve patient flow through critical care.
- Improve patient experience.
- Timely admission of emergencies to critical care.
- Lower occupancy rates within adult critical care.
- Lower cost for commissioners.

What changes will be made that will result in an improvement?

Contracts will reflect move to payment at an excess bed rate.

Improving Value Menu of Opportunity Guide

Adult Critical Care Delayed discharges

Key Performance Indicators (KPIs)

Quality

- Good quality of care for patients is maintained as discharges are planned with appropriate handover to ward based care.
- Quality standards around discharge during daylight hours are achieved for all patients.
- Improved patient experience as a result of better discharge planning/step down.

Efficiency

- Reduction of cancelled electives as a result of reduced occupancy.
- Maintaining flow through the hospital as access to critical care beds will be available.
- Generating critical care capacity to deliver predictable occupancy and timely admission and reduced costs to commissioners.

Key Enablers

- CQUIN was available to providers in 2016/17 and 2017/18 to incentivise this change.
- The move to pay at an excess bed rate was included in the 2017 Commissioning Intentions.
- The standard of discharge within 4 hours is a national standard recognised by both providers and commissioners.

Finances

How will the saving be achieved?

Contractual change of moving payment for delayed discharges to an excess bed rate as opposed to paying at ICC bed rate.

How will the saving be calculated?

By calculating the price differential between paying for delayed discharges at an ICC bed rate compared to an excess bed rate.

Costs

There are no additional costs associated with this scheme.

Commissioning Considerations

Ensuring delivery and implementation

- No investment required if change in price is mandated and agreed in contracts.
- CQUIN has also previously been offered to incentivise this change.

Reduce Unwarranted Variation in Clinical Quality and Efficiency

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Patient Activation: Activation Systems for patients with Long Term Conditions

Improving Value Menu of Opportunity Guide

Patient Activation: Activation systems for patients with Long Term Conditions (LTC)

Name of Scheme	Patient Activation: Activation systems for patients with LTC
Theme	Reduce Unwarranted Variation in Clinical Quality and Efficiency
Menu of Opportunities sub themes	• Implement optimal pathway of care • Multidisciplinary team decision-making to ensure medicines optimisation
Links to useful Sources	Patient Activation information can be found here. Evidence base and supplementary information can be found here.

Summary

Evidence demonstrates that patients with long term conditions with higher levels of activation (the knowledge, skills and capacity to manage their own condition) have better outcomes including reduced frequency of exacerbations and associated high cost interventions. There is also evidence that understanding where people are in their activation is helpful in providing them with tailored interventions to support them more effectively.

The “Patient Activation Measure" (PAM) survey can be used to assess patients’, knowledge, skills, confidence and competence in self-management of their health and care. The PAM score should be used to tailor an approach with appropriate interventions to support patients to increase their levels of knowledge, skills and confidence. The implementation of a patient activation system is designed to realise significant benefits to individuals and the healthcare system.

Improving Value Menu of Opportunity Guide

Patient Activation: Activation systems for patients with Long Term Conditions (LTC)

Who should consider this opportunity?

Providers and Commissioners:

- Wishing to develop engagement with patients to optimise management of LTC and their personalising care agenda.
- Where there is evidence of increasing avoidable unplanned admissions within LTC, associated with poor patient compliance/adherence with treatment and care pathways.

Clinicians wishing to improve & optimise their existing LTC pathways of care.

Example case studies

Over 90 sites are now using the PAM tool to measure levels of patient activation locally to manage their approach to supporting patients with long-term conditions more effectively. These include key NHS change programmes (including new care model Vanguards, integrated personal commissioning sites, test beds and Integration Care Pioneers), CCGs, local authorities and third sector organisations. Information on their progress can be found here.

Solutions

The Aim

Supporting patient activation helps to increase patient motivation and capacity to carry out behaviours that maintain better health through tailoring an approach to the individual, dependant on their level of activation and supporting them with appropriate interventions to improve their level of knowledge, skills and confidence.

We will know that changes and improvements have been achieved if the following conditions are met:

There are improved patient outcomes and experience of care in relevant patient cohorts. Tailoring interventions to support individuals to develop the confidence and understanding to allow them to participate more fully in their health and care. This enables individuals to improve their own health related behaviours, resulting in:

- Better outcomes
- Better experience of care
- Fewer episodes of unplanned or emergency care
- A financial benefit for the overall healthcare system

What changes will be made that will result in an improvement?

Measuring patient activation is the first step – what happens after is key. There are a number of activities that can be organised to support patient activation, these can include; health coaching, self management training, peer support and social prescribing.

Patient Activation systems will be implemented in specific Long Term Conditions pathways to capture patient's knowledge and skills, and include population segmentation, interventions to improve engagement, and measuring performance across the healthcare system.

Data from this will be used to

a) stratify the patient groups to help diagnose problems and determine appropriate care plans;

b) Work with patients to raise motivation, skills in self-management, etc.

c) Tailor interventions provided to individuals that help to increase their knowledge, skills and confidence.

Improving Value Menu of Opportunity Guide

Patient Activation: activation systems for patients with LTC

Key Performance Indicators (KPIs)

Quality

Patient experience reporting in relevant patient groups:

- Number of patients who receive tailored intervention to increase their activation.
- Improved satisfaction rates.
- Improved adherence/compliance with treatments.
- Number of patients confident to self manage.
- Improved experience of care.
- Fewer patient complaints.

Efficiency

- Reduction in hospital admissions.
- Reduction in number of A & E attendances .
- Reduction in drug spend (associated with optimisation/compliance and less waste).

Finances

How will the saving be achieved?

Through reduction in acute unplanned admissions and A & E attendances.

Through optimising use of medicines and treatment costs.

How will the saving be calculated?

- Hospital Episode Statistics (HES) data
- Blueteq drug data – if relevant

Costs

- Team building costs.
- An important cost may be commissioning interventions that support activation if they are not already available.
- Patient Activation licence costs need to be included in any future scheme that is being developed

Key Enablers

- CQUIN. PSS GE2 have been used by NHS England to incentivise uptake of Patient Activation – this approach can be replicated locally. Information about the CQUIN can be found here.
- A taxonomy of patient activation interventions is available here and here.
- There are a number of activities that can be organised to support patient activation, these can include; health coaching, self-management training, peer support and social prescribing.

Commissioning Considerations

Patient groups who stand to benefit include those with persistent conditions for which:

- There is a care regime of known effectiveness which is complex
- Symptomatic abreaction to poor adherence is distal (so that patients will realise that poor adherence is responsible for deteriorating health)
- Symptomatic consequences of poor adherence may – if poor adherence is not recognised – lead to misdiagnosis and mistaken prescription
- The severity of the condition does not itself preclude self-care.

Ensuring delivery and implementation

Team Capacity Building; Staff training in the administration of the instrument element is required. The outcome here should be patient activation preparedness of the team: it would be helpful to specify what this will comprise more precisely.

Mechanisms for gathering, presenting and analysing activation information should be considered.

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Improving Spinal Surgery Pathway

Improving Value Menu of Opportunity Guide

Improving Spinal Surgery Pathway

Name of Scheme	Improving Spinal Surgery Pathway
Theme	Reduce Unwarranted Variation in Clinical Quality and Efficiency
Menu of Opportunities sub themes	• Implement optimal pathway of care
Useful Sources of Information	The Spinal Surgery Service Specification can be found here.

Summary

Spinal surgery is growing at a higher rate than average. It is estimated that approximately £200m is spent per annum on adult specialised spinal surgery and that there are approximately 10,000 adult patients each year that have elective spinal surgery within England. Neurosurgery (of which Spinal Surgery is a significant part) is one of six services that will account for 50% of spend growth in specialised services over the next 5 years. It is estimated that more than 50% of this growth will be spinal surgery. Due to the limited number of spinal centres (35) it is becoming increasingly difficult to absorb the increases in demand within the current system. This results in increasing waiting times for patients, and delivery challenges such as workforce and capacity issues.

The pathway directs all patients with lower back pain and radicular pain to triage and treat practitioners. The practitioners are responsible for initial treatment and will organise/refer additional treatment. Referral to secondary care can only be made by the triage and treat practitioners.

Improving Value Menu of Opportunity Guide
Improving Spinal Surgery Pathway

Who should consider this opportunity?

- Directors of Commissioning Teams/ CCGs/ NHS England should decide whether to adopt this project as it could lead to savings from reductions in unnecessary activity and low value treatments.
- Providers should consider this scheme as this scheme could lead to a reduction in treatment delays which would lead to an improvement throughout the service they provided.

Example case studies

In Middlesbrough, the pathway was adopted and succeeding in saving money and delivering better, more efficient services to the patient population.

The pathway has been independently analysed by Teesside University. The report concluded that the pathway reduced unnecessary investigations and interventions and also provided rapid access to core therapies, booked referral slots for MRIs, nerve root blocks, surgical opinion and pain management. The pathway improved patient outcomes and reduce disability and chronicity of back pain.

The savings are estimated at £1 per patient population e.g. a service serving a notional catchment of 500,000 people would save £0.5M per year.

Solutions

The Aim

The project aims to ensure swift, efficient services for patients presenting with low back pain and radicular pain. The expected benefits are clinical for patients and cost savings for commissioners. Providers should be more able to meet waiting list targets potentially avoiding out of hours elective treatment, which often costs more to provide than the income received from national tariffs.

We will know that changes and improvements have been achieved if the following conditions are met:

- Improvement in clinical outcomes for patients on this pathway.
- Integrated care pathways via establishment of networks.
- Savings from reduced specialised activity and focussing specialised interventions on those patients who will benefit most (reducing low value interventions).
- Patients are treated with effective interventions, in the right place at the right time.

What changes will be made that will result in an improvement?

Benefit targets will be agreed in each geography following the initial stocktake and agreed local transformation plan.

Improving Value Menu of Opportunity Guide

Improving Spinal Surgery Pathway

Key Performance Indicators (KPIs)

Quality

- Patients should be assessed and treated more promptly. This enables early treatment with expert care; minimising the risk of complications and reducing the tome a patient experiences pain.

Efficiency

- Reduction in waiting time for out patient and (where needed) in patient treatment.
- Higher conversion rates from out patient to in patient treatment.

Key Enablers

- **SDIP:** Recommendation for hubs to use SDIPs Service Development and Improvement Plans to facilitate provider support of spinal networks.
- **Co-commissioning agenda:** Recommendation for this project to be included in co-commissioning agenda discussions to gain support from CCGs.

Finances

How will the saving be achieved?

There are estimated to be a significant opportunity to commissioners of approximately £50m through the national implementation of this project. The majority of this will fall to CCG Commissioners.

How will the saving be calculated?

The Improving Value SharePoint site has published a savings calculator into which Regions can enter their CCG populations. This gives and estimate of the potential savings. Further guidance will be developed through the Project.

Cost

The estimated Yearly Cost of Pathway - (Includes non-recurring costs) is £176,425.58.

Commissioning Considerations

Ensuring delivery and implementation

- Facilitate the development of approximately 15 regional spinal networks ("the networks") to ensure national UK coverage. Each network to comprise of a Specialist Spinal Centre and partner hospitals who deliver local spinal services.
- Facilitate the national roll out of the lower back pain and radicular pain pathway ("the pathway").

NHS England

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A Coordinated Network for Specialised Rheumatology

Improving Value Menu of Opportunity Guide

A Coordinated Network for Specialised Rheumatology

Name of Scheme	A Coordinated Network for Specialised Rheumatology
Theme	Reduce Unwarranted Variation in Clinical Quality and Efficiency
Menu of Opportunities sub themes	• Implement Optimal Pathway of Care • Ensure compliance with Latest Evidence, National Clinical Policy, Specifications and Guidance
Useful Sources of Information	• NHS England`s commissioning policy for Sildenafil and Bosentan can be found here. • NHS England`s Clinical Commissioning policy for Rituximab can be found here. • NHS England`s Standard Contract for specialised rheumatology services can be found here.

Summary

Systemic autoimmune rheumatic diseases (e.g. systemic vasculitis, systemic lupus erythematosus, scleroderma, myositis, and Sjogren's syndrome) are rare, multisystem, non-genetic conditions that have high morbidity and mortality rates. They share overlapping clinical and serological features, affect multiple organ systems, and therefore require coordinated multidisciplinary care. However, currently, there is no coordinated process within each region that ensures comprehensive governance of the management of rare multisystem autoimmune rheumatic diseases or supports a cohesive drive to improve outcomes.

As a result, there is likely to be significant variation in standards of care and outcome depending on where patients are treated. Therefore, the development of a Coordinated Network for Specialised Rheumatology will be a catalyst to eliminate this variation. It will also be the essential framework that is required to ensure appropriate specialised access to the high-cost drugs that are commissioned by NHS England for use in these conditions. The network will also support the audit of use of these high cost drugs.

Improving Value Menu of Opportunity Guide

A Coordinated Network for Specialised Rheumatology

Who should consider this opportunity?

- Commissioners looking to reduce long term, unplanned care cost and commissioned activity (i.e. day case activity) should consider implementing this scheme.
- Providers should consider adopting this scheme as it could lead to an enhanced local governance of rare complex disease, reduce delay in the detection of organ threatening disease and enable all provider teams to have a common purpose and a focused care pathway regardless of their specialised status.

Example case studies

This scheme has not been implemented system wide so there are no specific case studies.

Solutions

The Aim

Develop a Coordinated Networks for Specialised Rheumatology services in order to provide governance and standardised care.

We will know that changes and improvements have been achieved if the following conditions are met:

- Earlier intervention for severe disease with clear pathways of specialised centre involvement, which is likely to improve outcome and reduce costs associated with organ failure.
- Patient satisfaction will be improved by reduced attendances enabled by coordinated care, and the reassurance that their care is being provided as part of a specialised network.
- Embedding formal guidelines and pathways across the whole network, which will enable earlier intervention and reduced risk of progression to organ failure (e.g. renal, lung, vision)

What changes will be made that will result in an improvement?

- Improve the care of people living with rare multisystem autoimmune rheumatic diseases by utilising a positive community of clinicians within a governance structure and framework of networked service delivery.
- Ensure that strategic planning of specialised services within the Regional and Sub Regional Teams is informed both by expert clinical advice and, through the CRG, the views of patients and carers, putting this voice at the heart of our strategy.
- Become the regional/local node for delivery of the Specialised Rheumatology Clinical Reference Group's service level strategy, enabling a mechanism across each region to secure adoption of best practice, including British Society for Rheumatology national guidelines and selected A3 Change Proposals.
- Enable coordinated management of complex autoimmune disease by involving all the key interdependent specialties, with centres with sufficient volume and expertise providing multispecialty-coordinated clinics as a regional resource.
- Create a common purpose shared by every Rheumatology team in each Senate Region, enabled by an agreed region-specific work plan and the use of standard management protocols including thresholds for referral for specialised advice.

Improving Value Menu of Opportunity Guide
A Coordinated Network for Specialised Rheumatology

Key Performance Indicators (KPIs)

The benefits will be monitored via quarterly audits, which align to the CQUIN data requirements.

Quality
- Patient satisfaction will be improved by reduced attendances enabled by coordinated care, and the reassurance that their care is being provided as part of a specialised network. Improved education, social and psychological support delivered through specialised centres will improve economic activity, and improve adherence and outcomes.

Efficiency
- Embedding formal guidelines and pathways across the whole network, which will enable earlier intervention, structured internal organ screening and reduced risk of progression to organ failure (e.g. renal, lung, vision)

Key Enablers

- Coordinated Network CQUIN for Specialised Rheumatology will support early implementation.
- Establishing a clear baseline and KPI's, developed by CRG/AT oversight group.
- Monthly Progress Reports to the sponsoring Task and Finish Group;
- Monthly summary Progress Reports to the National Improving Value Team.

Finances

How will the saving be achieved?
Improved clinical care arising directly from the Network is likely to lead to direct savings via a 15-20% reduction in each of the following:
- Reduced direct costs, via network implementation and governance of high cost drug Policies.
- Reduced long term care costs e.g. progression to end stage disease through enabling a focus on earlier detection and quality across the whole care pathway.
- Number of patients with lupus and vasculitis who progress to end-stage renal replacement therapy (each single avoided case saves £30,000 per year, estimated minimum 12 cases avoided amounts to £360,000).

How will the saving be calculated?
The savings for this scheme will be calculated using data on 90% of patients on high cost drugs being submitted to relevant registry.

Cost
Providers may need to consider costs of clinician time when setting up multidisciplinary team networks.

Commissioning Considerations

The Coordinated Network will be discussed with the commercial team, but no significant commercial considerations are expected.

Defining the service
This approach fully aligns with UK Rare Disease Strategy, NHS Outcome Framework and NHS England's Strategy.

Ensuring delivery and implementation
- Each unit will identify a single clinician responsible for leading the network strategy in their hospital.
- Based on local resources and expertise, to enable access and egress at the right time, each unit will adopt agreed principles for sharing care with Specialised Centres and pre-defined thresholds for referral.
- Each region will identify training and mentoring opportunities (e.g. within specialised centres) as a regional resource.

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Radiotherapy Prostate Fractionations

Improving Value Menu of Opportunity Guide

Radiotherapy Prostate Fractionations

Name of Scheme	Radiotherapy Prostate Fractionations
Theme	Reduce Unwarranted Variation in Clinical Quality and Efficiency
Menu of Opportunities sub themes	• Implement optimal pathway of care
Links to useful Sources	• NHSE Clinical Commissioning Policy can be found here.

Summary

The Prostate Fractionation scheme was generated from the emerging results of the Cancer Research UK CHHiP trial (Conventional or hypo-fractionated high-dose intensity-modulated radiotherapy for prostate cancer) into the treatment of prostate cancer using radiotherapy. The trial was published in June of 2017. Media interest in the story was welcomed and the benefits of the trial were celebrated on national media.

The Clinical Commissioning Policy has been developed in response to the publication and peer review of a large, multi-centred radiotherapy CHHiP trial which has been published during 2016, and aims to secure improvement in services for patients by enabling the delivery of radiotherapy treatment with a low overall total radiation dose (measured in "Grays") and in fewer attendances, or "fractions".
The policy sets out that a course of radiotherapy treatment for localised prostate cancer should now involve the delivery of 60 Grays in 20 fractions rather than 74 Grays delivered in 37 fractions, as is normally the case.

Improving Value Menu of Opportunity Guide

Radiotherapy Prostate Fractionations

Who should consider this opportunity?

Many radiotherapy providers have already implemented this scheme. This scheme should also be considered by providers who have not yet implemented radiotherapy prostate fractionations.

Case Study

This scheme has not been implemented system wide so there are no specific case studies.

Solutions

The Aim

The policy describes both patient pathway arrangements and clinical eligibility criteria. Specifically the policy identifies that hyper-fractionated radiotherapy should be considered for the following three patient cohorts:

- The risk localised prostate cancer which is suitable for treatment with external beam radiotherapy rather than active surveillance brachytherapy or radical prostatectomy.
- Intermediate risk localised prostate cancer which is suitable for treatment with external beam radiotherapy rather than radical prostatectomy or brachytherapy
- High-risk localised prostate cancer where the target volume is limited to the prostate and seminal physical.

We will know that changes and improvements have been achieved if the following conditions are met:

Radiotherapy treatments are reported to a nationally mandated dataset (RTDS) which is maintained by Public Health England (PHE). Data contained within RTDS identifies that approximately 13,000 patients receive radical prostate radiotherapy every year in England (RTDS, 2015). Of those patients currently receiving radical prostate external beam radiotherapy, it is considered that at least 70% are suitable for hypo-fractionated external beam radiotherapy, in accordance with the clinical eligibility criteria. Therefore, the policy also includes a reporting benchmark of 70%.

What changes will be made that will result in an improvement?

Providers will invite patients to receive the 20 treatments of 60 Grays which will result in more capacity within radiotherapy units which in turn will mean patients with other cancers will be treated more quickly.

Improving Value Menu of Opportunity Guide

Radiotherapy Prostate Fractionations

Key Performance Indicators (KPIs)

Quality
The quality of the service will be measured from Patient Related Outcome Measurements and patient satisfaction**.**

Efficiency
We will be paying for fewer fractionations for the cohort of Patients who has prostate cancer and this will release capacity for the provider to treat other patients.

Key Enablers

The key enabler is the Clinical Commissioning Policy titled hyper- fractionated external beam radiotherapy in the treatment of localised prostate cancer.

Finances

How will the saving be achieved?
We will be paying for fewer fractionations for the cohort of patients. This will release capacity for the provider to treat other patients.

How will the saving be calculated?
Savings will be calculated from the number of freed up slots of radiotherapy in each provider.

Costs
There were no additional costs associated with this scheme.

Commissioning considerations

Defining the service
Providers will submit their activity and confirm compliance with the new policy (Hyper fractionated external beam radiotherapy in the treatment of localised prostate cancer).

Ensuring delivery and implementation
Providers have all been set compliance targets for the number of patients expected to receive the lower number and lower dose of fractionations.

NHS England

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Where to Look Packs

Improving Value Menu of Opportunity Guide

Where to Look Packs

Name of Scheme	Where to Look Packs
Theme	Reduce Unwarranted Variation in Clinical Quality and Efficiency
Menu of Opportunities sub themes	• Implement Optimal Pathway of Care
Links to useful Sources and Information	• The RightCare similar 10 explorer tool can be found here

Summary

Our 'Where to Look' Packs are developed for use by specialised commissioning teams, and colleagues within Clinical Commissioning Groups (CCGs) and Sustainability & Transformation Partnerships (STPs). The packs aim to support local, regional, and national identification of potential opportunities for Improving Value in specialised services. The programme of work will incorporate the development of information to cover both Sustainability & Transformation Partnerships and Specialised Commissioning Hub footprints.

The 'Where to Look' Packs use the RightCare similar 10 CCG methodology to highlight unwarranted variation, and will focus on Top 20 Spend Areas (as highlighted in 2016/17).

Improving Value Menu of Opportunity Guide

Where to Look Packs

Who should consider this opportunity?

The intention of these packs is not to provide a definitive view of an optimal pathway, but to help commissioners explore potential opportunities by presenting key indicators relating to a given service area. As the data is not always clear-cut, local interpretation may be required before forming a judgement.

Packs will require discussion and interpretation by multi-disciplinary teams including clinical colleagues. Further analysis including drilling down into "provider" level detail and triangulation with other intelligence sources before firm conclusions can be reached

Example case studies

The Neurosciences Where to Look Pack Highlights that, when compared to demographic peers, the following specialised commissioning hubs are spending more: London, West Midlands, North East, North West. Yorkshire & Humber, and the South West,

Analysis of Total Spend Per Patient Treated in the Specialised Blood Disorders Pack highlights that CCG Populations in London, and Yorkshire & Humber appear to be spending significantly more than their demographic peers.

Solutions

The Aim
These packs have been created to align with the highest spend service areas within NHS England's specialised commissioning portfolio (covering services that account for approximately 75% of the specialised commissioning budget). By providing the most up to date data available, the packs aim to support identification of IV schemes.

The intention of these packs is not to provide a definitive view, but to help individuals explore potential opportunities. It is likely that the packs will raise more questions than they will provide answers; however they should inform commissioning teams as to which service areas hold the greatest potential for value improvement.

It is envisaged that the packs will assist with:

- Identifying potential priority service areas in your locality
- Stimulate engagement with clinicians and other local stakeholders to further explore the priority opportunities using local data
- Discussion of next steps for improvement

Broadly, the packs will help commissioners answer the question "Does this service area present an opportunity for significant improvement in value?"

When reviewing each pack, commissioners should have three broad questions in mind:

- In this service area, are we spending more on this population when compared to our demographic peers?
- Is the higher spend due to higher than expected levels of activity (when compared with our demographic peers), or higher than expected healthcare costs or both?
- Are we getting higher or lower levels of quality and outcome?

The packs have been developed, where possible, through consultation with the responsible commissioner and Clinical Reference Group chair for each service area. The objectives of this are to identify and agree the specifics of each pack, including what indicators should be included, and what activity cohorts should be included.