Transformation of Services and Care Pathway Redesign in the NHS: Further Reforms in Health Policy

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Agenda

- Objective
- Approach
- Results
- Conclusions
Objective
Can health policies around transformation of services & care pathway redesign achieve savings?

- Nicholson challenge - £20 billion by 2015

- Efficiency savings through Quality, Innovation, Productivity & Prevention (QIPP)

- Reducing demand

- Redesigning care pathways - more appropriate treatment setting

- ....however, there exists a prospective payment system: Payment by Results (PbR)
Approach
A five phase approach was implemented to gain insight into further reforms in health policy.

Key aspects considered in these steps were:

- In-depth secondary research and analysis to inform understanding of current reforms
- Understanding of healthcare and payer environment at the national, regional and local level – is further centralization ‘rhetoric or reality’?
- Development of hypotheses on every aspect of the reforms: transformation of services; care pathway redesign
- Development of specific hypotheses
- Input from AP experts and Key Opinion Leaders
- Development of appropriate discussion guide that covers the key questions
- Discussions with the right mix of PCT payers at regional and local level and key opinion leaders at provider level
- Discussions conducted in-house
- Qualitative analysis including interpretation of scores and triangulation of findings with thought leaders
- Analysis conducted in-house
- PbR ‘perverse’ incentives impede progress
- Lack of collaboration between providers hampers innovative approaches to transformational change and care pathway redesign
- Success can be achieved by moving away from paying for inputs, and moving towards paying for outcomes, or value delivered
Survey of PCT Clusters & review of Independent Government office findings into policy changes

- Manufacturers of innovative technologies need to understand impacts of healthcare reforms; major trends in terms of policy initiatives, including service transformation and care pathway redesign

- There is clinical consensus around the ‘right treatment at the right time, for the right patient’

- Service change is difficult to introduce and to measure, barriers to services transformation exist and need to be fully understood

- We drew on the National Audit Office report on the future financial sustainability of the NHS

- We undertook web-based surveys of primary care trust clusters and NHS providers (NHS trusts and NHS foundation trusts)
Patient Pathway: Pre- and Post-April 2013
NHS health policy reforms are already impacting care pathways.

The pathways pre-reforms were simple and worked.

Funding
Monitoring
Training

Funding
Monitoring
Training

NHS

Pre-April 2013

Practice team

Immunisation team

Practice driven reminders

Practice driven reminders

Practice driven reminders

Practice driven
opportunist
immmunisations

Practice team

• Hib/MenC
• MMR
• PCV Prevenar 13®

Practice team

• DTaP/IPV(polio)/Hib
• PCV Prevenar 13®
• Rotarix®

Health Visitor → Patient
Practice team

• DTaP/IPV(polio)/Hib
• PCV Prevenar 13®
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Health Visitor → Patient
Practice team

• DTaP/IPV(polio)/Hib
• MenC
• PCV Prevenar 13®

Health Visitor → Patient
Practice team

• Hep B

Midwife → Mother

Start of Patient Journey

Baby born

Before birth

2 months

3 months

4 months

Between 12-13 months

Secondary care

Primary Care

Funding
Monitoring
Training
Post April 2013 the landscape is more complex and will affect all care pathways.

Before birth
- Baby born
- Practice driven reminders
- CHIS
- Central issue system
- Register via GP Practice

2 months
- Health Visitor → Patient
  - Practice team
  - DTaP/IPV(polio)/Hib
  - PCV Prevenar 13®
  - Rotarix®

3 months
- Health Visitor → Patient
  - Practice team
  - DTaP/IPV(polio)Hib
  - MenC
  - Rotarix®

4 months
- Health Visitor → Patient
  - Practice team
  - DTaP/IPV(polio)/Hib
  - MenC
  - PCV Prevenar 13®

Between 12-13 months
- Practice → Patient
  - Practice team
  - Hib/MenC
  - MMR
  - PCV Prevenar 13®

Secondary care
- Midwife → Mother
- Start of Patient Journey
- Hep B

Primary Care

Funding → Monitoring → Training
Results
Anxiety around the sustainability of healthcare - transformation rather than transaction is key (1)

- There is broad consensus that changing how health services are provided is key to a financially sustainable NHS.

- Such changes will include integrating care, where multiple providers work together to provide a coordinated service for patients, and expanding community-based care.

- Evidence indicates that the NHS has taken limited action to date to transform services. In 2011-12 47% of PCT clusters reinvested less than a quarter of their cash releasing savings in transforming services.
  - There are a number of challenges to delivering service transformation.
  - Changes take time to implement and may initially cost, rather than save, money. In 2011-12, the proportion of cash-releasing savings reinvested in transforming services varied and there is no evidence of a shift in staff from the acute to the community sector.

- Financial incentives do not always encourage NHS providers to undertake service transformation. The PbR framework can create perverse incentives now that the NHS is seeking to reduce hospital activity; and in community settings, 90 per cent of care is reimbursed under block contracts, which do not provide an incentive to increase activity.
Anxiety around the sustainability of healthcare - transformation rather than transaction is key (2)

- The NHS is making increased use of demand management measures to reduce the growth in hospital activity, but it is not clear whether the slowdown in growth is sustainable.

- Reducing demand and redesigning care pathways to make sure patients are treated in the most appropriate setting are key ways of generating efficiency savings. The growth in hospital activity was 1.2 per cent in 2011-12, compared with 3.7 per cent in 2010-11.

- The aim is to control demand without inappropriately restricting patients’ access to care, but the Department has no way of routinely gaining assurance that this is being achieved.

- Through our survey, primary care trusts reported they had introduced a variety of measures to manage demand, in most cases for clinical reasons. Some stakeholder bodies have raised concerns, however, that access is being restricted.

- The Department has made clear that blanket bans on particular procedures are not permitted. However, an investigation is now being undertaken into the decommissioning of certain elective surgical procedures (Cataract & orthopaedic etc).
Payment reform is a cornerstone to enabling service transformation

- The reality is that, in England, the current payment systems work directly against the delivery of integrated care.

- Existing payment systems tend to pay for care activities within organizations rather than rewarding the efforts to integrate care across them.

- Instead of paying for outcomes or integrated care paths, payment systems usually pay for individual activities and other input characteristics (such as beds used or the presence of professionals).

- Most now accept that this approach actually stimulates high volumes of these activities and input characteristics, whether or not they add value to the system or for the patient.
Other barriers to service transformation were uncovered, including lack of enforcement measures

- Lack of measures to invest first e.g. In community services

- Organisational barriers between health and social care including information sharing and differing financial priorities

- Organisational barriers between acute and community services

- Lack of influence over acute providers

- Staff across patient care pathways do not have the right skills

- Lack of evidence to convince stakeholders of the benefits of service transformation

- Some transformations would be better enforced at a regional or national level
4 Major trends in shaping service transformation

**Payers taking a more proactive role**
- Governments, public sector bodies and insurers – are becoming ‘engaged payers’ by focusing on value, contracting more selectively, reshaping patient behaviour and moving care upstream to focus more on prevention

**Providers need to rethink their approach**
- It is becoming clear that major transformational change can no longer be delayed
- Some hospitals have the opportunity to transform themselves into ‘health systems’, providing new forms of much more extensive and integrated care and taking more risk and accountability for outcomes from payers. others need equally radical approaches to reshape their operating models

**Patients need to become partners**
- There is an imperative to engage patients in new ways so that they become active partners in their care, rather than passive recipients. This requires new systems and ways of working

**Sustainable change and better value**
- These are increasingly being seen as a direct result of new approaches to integration. a survey of PCT clusters revealed that 90% of payers, providers and professionals believed integration would produce better patient outcomes, while three-quarters were confident that it would cut costs
‘Engaged Payers’ will shape system change

• The emergence of the ‘engaged payer’ – the role of this new breed of healthcare commissioner in shaping system change, driving payment reform and influencing behaviour

• The dilemmas facing providers in a changing environment – to transact or transform, to grow or to evolve, hospital or health system, passive partner or active change-agent
Conclusions
Payment reform & service integration are pivotal to overcome the barriers to transformation of services.

### Prerequisites for an integrated system

The definition of this varies between systems, but at its heart the strategy aims to offer coordinated care across the whole patient journey:

- A clearly defined population
- The ability to stratify risk reliably and develop registries
- Accountability for outcomes, supported by aligned contracts and incentives
- Systematic clinical care
- Staff and systems to support coordination
- Shared records & quality governance arrangements between participants; payment mechanisms that support these arrangements
- The development of a workforce with new skills including the ability to manage multiple morbidity including dementia and work in multidisciplinary teams

"The payer no longer sits back, just paying bills. [They are] involved in continuous quality improvement now, helping providers improve, and in researching best practices. They’re more and more interested in improving outcomes and the care itself.” CCG Chair
Thank you

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