Response to NHS Chief Executive’s Open Call for Evidence and Ideas

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Innovation in the NHS – Call for Evidence

Prepared By WG Consulting (Healthcare) Limited
for Sir Ian Carruthers OBE
31st August 2011
Introduction

In this submission WG Consulting (WG) will provide an example of a proven innovation that has been adopted and proven to work by commissioning organisations in two separate localities producing excellent outcomes and real cost savings but the diffusion of which to the wider NHS has proven extremely difficult.

WG will provide some analysis of the barriers that have made diffusion so limited to date and make some recommendations for future actions that will aid diffusion in the future by overcoming these barriers where possible.

Referral Management Programme

WG Consulting, working in partnership with three established PBC collaboratives has succeeded in achieving very significant reductions in the value of elective referrals to acute hospital.

The first site, with a population of over 200,000 patients started in September 2009 and has shown full year NHS savings amounting to almost £600,000. In two other collaboratives (30 practices, population 224,000), the project began in September 2010 and has achieved a saving of £400,758 in just six months, reduced the referral rate by 14%. The highest referring practices in the collaboratives had the most impressive transformation of referral behaviour, with 36% of the practices having reduced the referral rate by more than 20%, and 27% of those reducing by more than 30%, one by as much 36%!

This reduction has been achieved by working closely with individual GP practices to change clinical behaviour – in effect reviewing and managing the referral before it leaves the practice.

This has been achieved with no any fixed cost investment in staff, IT hardware or software or by commissioning any new out-of-hospital services.

The project has been proven to be readily reproduced in any health economy, collaborative or consortium where there is adequate clinical engagement.

It can be adapted to fit with local initiatives and to use existing resources. WG Consulting costs are adjusted to take account of this. Because the intervention works to change clinical behaviour in practice the benefits are expected to be lasting.

The intervention is easy to set up, adaptable and can be easily de-commissioned if no visible progress is made.

This approach is supported by recently published best practice - The Kings Fund Report “Referral Management Lessons for Success” http://www.kingsfund.org.uk/publications/referral_management.html.
Programme delivery to date

Following on from a successful pilot project in NHS Buckinghamshire that demonstrated an 11% reduction of referrals, WG Consulting was asked by Solihull Care Trust to also help them achieve a reduction in their elective referrals. WG Consulting designed a tailored intervention programme that built on the resources available in the local health economy and that was based on the NHS Buckinghamshire experience. This did not include a referral management centre, clinical assessment or triage services or extensive alternative care services. What was in place was committed clinical leadership in the collaborative together with real time data to allow the project to demonstrate its effectiveness at practice level. Solihull Care Trust comprises of 30 practices covering a population of 224,000, and is made up of two collaboratives – Solis in the north, and Sirius in the south. Sirius supports patients in a mainly leafy suburban area, with the majority of the practices (21). Solis supports patients in a mainly urban area with typical issues of large ethnic mix, smaller practices, higher rates of health inequality and social deprivation. The project was carried out in collaboration with the main local secondary care provider, The Heart of England NHS Foundation Trust, which receives 85% of all referrals, as well as with other local providers. WG Consulting established and ratified a live referrals data feed with the Heart of England NHS FT to support the project.

The intervention can be described as a sustained, co-ordinated, clinically-led campaign to change clinical behaviour in each practice. Intervention and support was tailored to each practice depending on their performance. Components included:

- Practice visits – structured, prepared and including clinical and management teams at the practice
- Practice dashboard - regular, easy-to-read graphics showing the practice performance and trend. Available via collaborative intranet sites
- Senior GP involvement – the practice team included a local, senior GP to carry out a clinical review of referrals
- Structured follow up – to track whether agreed actions have been taken
- Education sessions – promoting engagement between GPs and acute clinicians
- Development of standard procedures and best practice for managing referrals
- Bespoke analysis – in some practices it was necessary to review referrals at the level of the individual GP

All of this work took place in real time. There was no need for written plans, elaborate performance metrics or complex incentive schemes. Progress could be seen (or not) in the weekly data and action taken accordingly.

The six month results were remarkable, reducing the referrals rate by 14%. Across the collaborative, this represented a total referrals reduction of 2303. The average cost of each referral was £174 thus Solihull Care Trust was able to save the NHS over £400,758. The cost of
intervention was £38 per referral, or £87,723 for the six months, giving a net NHS saving of £136 per referral, or £313,035 for the six months after costs.

If this Referrals Management Programme was then rolled out across a PCT Cluster, for example The Arden Cluster, this would represent a saving of over £3.6m in year. In addition, under the recently announced changes to the QOF from April 2011 participating practices in the Cluster could collectively earn in excess of £1m in GMS QOF QP 6-11 payments.

In addition, the Referrals Management Programme provides a mechanism to ensure GP engagement and delivery of truly lasting, optimal referrals management and clinical decision making. The GP friendly programme drives savings of NHS budgets through the reduction of inappropriate elective outpatient referrals and unplanned admissions. The proven approach helps to free up resources to re-invest in redesigned services, deliver best practice yet facilitate GPs to generate additional income for their practices.

Despite contacting every Clinical Commissioning Group, SHA and PCT outlining the potential impact of the Referrals Management Programme for their locality, there has been to date no diffusion, even though the intervention is sound, meets a real, published need that saves money in year, earns GPs QOF payments and supports care being delivered closer to home.

Attempts at diffusion

WG Consulting tried to propagate this proven example of best practice after identifying through PCT board meetings a genuine need, indeed a stated priority for many, to reduce costs, reduce inappropriate referrals and deliver care closer to home. Initially each PCT targeted and then following the announcement of the pathfinders, phase by phase, each CCG was contacted. In addition, each SHA was contacted, and currently all PCT Clusters are being contacted as their structures formalise. It is the intention of WG Consulting to also contact the SpHAs and CSUs. Each contact was by personal email to key decision makers such as the lead GP, CEO, Finance Director or Director of Performance or Quality. The potential savings were calculated for each individual, as were the potential QOF payments. On each letter it was made clear that WG Consulting is a Department of Health approved supplier of commissioning services under the FESC Framework.

In addition to contacting individuals, WG Consulting also contacted The NHS Alliance, The Life Sciences Innovation Delivery Board and The National Association of Primary Care. All were very receptive of the programme, supporting it broadly. The NHS Alliance also suggested offering a discounted rate on the WG Consulting fees of 5% which was agreed.

Barriers to diffusion

With a couple of exceptions, most people did not reply. Follow up calls were attempted, messages were left. For those where that could be reached by telephone, there was interest in the solution, and
controlling referrals and reducing costs were certainly on agendas. There was a general scepticism about the results but they are real and replicable.

WG is in preliminary discussions with just one CCG as a result of this activity. The responders are a pioneering CCG – they have some excellent examples of service redesign and investing savings back into innovation for their patients. It is probably not surprising that they were interested.

What was surprising was the apparent lack of interest from all of the other people contacted. WG Consulting has considered the possible factors that might act as a barrier to uptake. These are shown in the table below together with our assessment of each factor.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Barrier to uptake?</th>
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<tr>
<td>Existing referrals reduction initiatives underway and producing excellent results</td>
<td>Very weak - There is a wealth of evidence to indicate that levels of variation in GP generated referrals are significant and that there is considerable room for improvement. WG targeted in the first place those health economies with a known issue of excess referrals.</td>
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<td>More compelling priorities than reducing referrals and saving money</td>
<td>Weak – many emerging commissioning organisations have pressing priorities in the terms of organisational development however all of those contacted reported a strong and consistent requirement to reduce costs</td>
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<td>Unclear as to who should be responsible for, and lead, such programmes</td>
<td>Variable – this was highly variable from one health economy to another. In some areas new or emerging GP commissioning groups fully accepted the responsibility for addressing referral variation while in other areas PCTs felt this to be an essential part of performance management of GPs and providers and secondary to GP commissioning roles.</td>
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<td>Structural changes in NHS detract from day to day operational priorities</td>
<td>Significant - WG also came across health economies where middle tier leadership had been severely denuded or there was a hiatus in strategy for demand management initiatives. This was a significant barrier which we believe will resolve once the Health Bill is passed.</td>
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<tr>
<td>Unsolicited approaches from private sector screened by NHS administrators. Approaches from private sector ignored or distrusted by NHS executives</td>
<td>Significant – we believe that a number of individuals working in commissioning roles have serious concerns about their own future and see private sector providers as a threat. WG was pushing in each case to present to clinicians with commissioning responsibility but was unable to secure this once an individual had taken a view about the offering</td>
</tr>
<tr>
<td>Inability/unwillingness to make</td>
<td>Very significant – WG is very confident in the efficacy of this offering and has offered to risk share with the commissioner the</td>
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initial investment | return on investment. The real time nature of the data allows us to demonstrate efficacy as the project runs, without the need for evaluation. This is unusual in the NHS and we may be facing a generalised lack of confidence among commissioners that initiatives will pay for themselves. Despite this we were often talking to commissioners who were prohibited from spending any money on initiatives, particularly where offered by external companies, regardless of return.

WG Consulting would value the opportunity to explore further with the Department of Health the construct of the programme, its proven benefits and the possible reasons behind the lack of adoption in the hope that more CCGs can benefit from reduced inappropriate referrals and increased NHS savings.

Suggested actions to improve innovation, adoption and diffusion in the NHS

WG Consulting has given significant thought about possible ways forward. These are set out in this section.

There are a number of long terms systemic and cultural changes which could bring significant benefits. These are mostly to do with the way that we train and manage those working in commissioning. The NHS has a poor track record of investing in commissioning skills and a long history of organisational changes, both of which militate against developing a stable platform of competent and confident individuals who feel able to innovate and to take risks. Others with more skill and insight will have much to say about how to address these weaknesses.

For the immediate future we offer the following suggestions, based on our experiences with the referral management scheme and on our wider experience as an NHS commissioning support organisation.

1. **A central steer** - The bodies responsible for overseeing commissioning by CCGs should actively encourage unsolicited examples from the NHS or private industry that are proven examples of best practice, and support adoption and diffusion through specific programmes. This should extend to partnering initiatives with the life sciences industry aiming at addressing issues such as referrals management to free up resources to be used elsewhere for approved innovations such as devices or pharmaceuticals.

2. **Policies on partnership** – emerging commissioning organisations need to take a view on how they will engage with private sector and life sciences companies. We need to remove arbitrary requirements to use competitive tender when fruitful and valuable partnerships are
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formed. These should form part of initial assessment of competency and the road map to authorisation.

3. **Learn from the private sector** - on campaigning, changing behaviours and monitoring impacts – the pharmaceutical industry is expert at this

4. **Training** - embed innovation and partnerships as topics in training for emerging commissioners.

5. **Make funding available** – although local funding streams for innovation exist or appear to exist, knowledge about and access to these funds is highly variable from one health economy to another. A greater level of trust over management of these funds is probably appropriate for local emerging commissioners if we are to foster a culture of innovation

6. **Use data to demonstrate outcomes** – demonstration of outcomes and benefits in NHS projects remains extremely weak for a number of reasons. Data exists and key fields such as the NHS number allow data sets to be linked in a way that powerfully demonstrates whether an intervention, a change in a care pathway or new treatment has provided patients outcomes and a return on investment. New commissioners need to be trained to buy innovations that build this into the delivery to link rewards to achievement.

We have included a separate annex on this topic, an area in which WG is working already with pharma companies and with NHS bodies to demonstrate.

**Conclusion**

The challenges to innovation are significant, but there are excellent people in both the NHS and Pharmaceutical Industry - both sides with superb ideas but little time, incentive and support to explore them. Some fantastic programmes are developed on an ad-hoc and as needed basis, yet the benefits are rarely realised nationally. Perhaps working more closely together, at all levels, and learning to trust each other on specific campaigns would help propagate best practice further.

WG Consulting can support the NHS in managing through the changes needed to optimize innovation adoption – the heritage of the company is based on helping the UK based pharmaceutical companies find and implement win: win product positioning. At the core of this is longevity of proven experience in managing sustainable clinical behavioural change in support of best practice and evidence. From this experience, WG Consulting is confident that the typical UK based pharmaceutical company is keen to partner with the NHS in a structured, mutually beneficial way, to ensure optimal use of proven, endorsed, clinically and financially beneficial innovation. WG Consulting is happy to broker innovation projects for mutual benefit. WG Consulting works on a daily basis with the NHS and the Life Sciences Industry.
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WG Consulting applauds the NHS focus on innovation and welcomes the opportunity to further explore case studies and examples for change, supporting the NHS in achieving the innovation aims.

For clarification or further discussion, please contact:

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Annex

Demonstrating value – the role of data in adoption and diffusion of NICE supported medicines

Based on extensive experience, WG Consulting is currently writing a discussion paper which explores this area in detail. Although the points generated from the discussion are preliminary, WG Consulting hopes the Department of Health find them of interest and would welcome the opportunity to explore them further.

WG Consulting has recognised through daily interactions that the NHS tends to view medicines and new technologies as a cost item leading to decisions that give undue weight to cost-control to the detriment of patient care and sound financial management in the medium to long term. WG Consulting believes that the solution will entail a shift in perception of those charged with managing the introduction of new therapies and the optimisation of existing ones. There are a number of practical methods of demonstrating the value of medicines. It is worth pointing out that the ideas for discussion are not meant as an alternative to the initiative on value based medicines but as a compliment.

Why are approved medicines not widely and rapidly adopted?

Low up-take of new medicines is a recognised issue for the NHS in comparison to other developed health economies. There is a good deal of evidence to demonstrate this. Quite rightly the threshold for entry of new technologies is high and NHS organisations bring to bear a full kit of critical tools on new and reformulated medicines.

WG Consulting has identified serious system weaknesses that prevent value prediction and realization:

1. No agreed methodology to handle non-cash releasing costs or for taking account of future benefits
2. No mechanism for realizing savings in social care budgets
3. Little understanding of consequent changes in treatment as a result of a more effective medicine
4. Inability to track benefits at level of patient receiving the medication
5. Poor understanding of benefits of improved compliance and concordance
How can NHS supported medicines adoption be improved?

The UK pharmaceutical industry has been doing a lot of good work for years, transparently setting out costs and benefits. Some companies have gone further, over and above health economic analysis, to service impact modelling as a determinant for NHS optimal and preferred product positioning and pricing.

WG Consulting has developed a programme called Maximizing Medicines Value (MMV) which goes beyond all that is typically done by a pharmaceutical company to try to meet the needs of the NHS better.

MMV could help CCGs and inter-related stakeholders better understand what happens when pathway or service is changed – holistically – and what needs to be in place to support sustainability. MMV would be good way for a company to demonstrate to the NHS a deep understanding of the whole care process affected by the new product, and all considerations prior to when a change in care pathway is requested/required.

WG Consulting could help broker relationships between the NHS and innovative, partnering companies from Pharmaceutical Industry to drive these projects, and be involved in designing and developing the models and arrangements for joint working.

The whole premise for MMV is based upon what was learned from the WG Consulting Referrals Management Programme implementations, and likewise, using real data to affect clinical behavioural change also provides a solid foundation to introduce new products, reducing the risk to the NHS and to the pharmaceutical company.

MMV collects and uses a longitudinal data set at patient level across all care interfaces and treatments including pharmaceuticals not just for one or two patients but for large cohorts in given population. It uses a patient's NHS number to link data sets and immediately converts to pseudonymised data which allows partners in the project to use the dataset to best effect. A designated clinical group and representative stakeholders drive behavioural change based on findings, supported by strong project management.

Conclusions can then be used intelligently to improve care and maximise benefits of innovation introduction so Maximizing Medicines Value:

1. Changing Clinical Behaviour - publications of guidelines insufficient - well presented local data propagated by CCGs likely to be more successful but minor revolution in knowledge management will be necessary
2. Optimal Medicines Procurement - where a number of similar medications exist in class, there is little benefit gained from switching in response to small price differentials. Medicine should be being procured for a population using a competitive process – the ability of the supplier to maximise the benefit of the medicine, releasing resources and creativity from Pharmaceutical Industry - contracts let in this way can build in high quality data collection as a matter of routine
3. Annualised Tariffs for Care - currently CCGs will have strong incentive to control costs of care, especially acute, with little skill, knowledge or means to do it. Skill and knowledge is
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with the provider who has perverse incentive to maximise cost of care as income. Better data will pass some freedom back to provider in exchange for better outcomes and a share of released resource

4. Sharing Risk - once patients medicated, with better management they could have fewer hospital admissions, evidenced by data set so wider pathway impact costs considered

Although the benefits could be long lasting, the risks need to be managed carefully, but for those that do it, partnership is truly possible with a Maximizing Medicines Value Project. Following the project, there is a risk that the huge effort required to make a change in the way care is delivered stops at the very moment the service is implemented more broadly, so ongoing support will be key:

1. Responsibility handed over from project team to contracting or performance team - those who have lived and breathed diabetes/ asthma/ anticoagulation/ musculoskeletal care...for the past few months hand over to those whom it might just be another spreadsheet of KPIs or contract
2. Lofty aims of improving patient experience, improving outcomes or reducing hospital costs get lost in a culture that looks just at numbers and where the contract becomes just another financial risk
3. Rather than a retrospective audit, a systematic, large scale data collection designed and put in place to capture data pre-implementation as well as post is required
4. Providers need to get on board with project – sharing data with commissioners is culturally averse for some providers but for meaningful and lasting change it is critical