Whole systems approaches to high-quality commissioning

Commissioning Pathways of Care

The King’s Fund Annual Conference, November 2011

Bob Park, Director, North East London Cancer Network
Background

- Assumption throughout is commissioning improved outcomes
- 1995 Calman Hine report: patient-centred, seamless pathways of care with GP alongside the patient all the way
- ‘Networks of proficiency not bricks and mortar’ – expertise and competence
- North East London Cancer Network was formally constituted in 2000/2001 in response to NHS Cancer Plan
- ELCN designated as a commissioning network in 2006 responding to emerging NHS reforms – and this focus confirmed by Cancer Reform Strategy 2007
- But in 2006 a London level view on cancer was that commissioners and providers were separate and ‘grown up providers would know what they had to do’
A philosophical response to this

Commissioning against pathways
The approach in practice

- Engage clinical teams, with user involvement, to tell you ‘what good looks like’ – map the pathways (30)
- In the same way, identify key metrics to monitor ongoing compliance with the pathway
- Pathway level online ‘Quality Outcomes Risk Register’ with process for identifying, logging then assessing gaps from the agreed pathways
- Process for accountability for remedial and mitigating action
- In NELCN, reference group monitoring this on behalf of commissioners is chaired by a service user
Developing the approach

- NELCN commissioning exemplar project funded by National Cancer Action Team developed standard pathways working with Map of Medicine
- Map of Medicine now contract with NCAT to review and approve a core set of cancer pathways – available to public on NHS Choices
- Flowchart pathways with click links to narratives summarising guidance and referencing evidence base – hyperlinks to evidence base
Secondary care - triple assessment clinic

This pathway has been locally developed and approved by The National Cancer Action Team for use in England & Wales.

Key:
- More information
- Primary care
- Secondary care

Diagram:
- Triple assessment clinic (by Day 14)
  - Clinical assessment
  - Diagnostic imaging
    - Core biopsy and/or fine needle aspiration
      - Cancer excluded
      - Cancer diagnosed or not excluded
        - Consider diagnostic staging
        - Inform patient and GP. Allocate key worker.
        - Go to initial MDT review

Locally reviewed 21-Aug-2009, Due for review 30-Oct-2019

View provenance for this pathway
Developing the process – funding flows

- Further commissioning exemplar project to understand the costs of cancer along whole pathways
- NAO report on poor understanding of costs and need for strong commissioning. The King’s Fund report on programme budgeting
- Initial focus on breast and lung cancer – ‘challenging’ work but breast now complete and lung in final stages
- Formal joint working agreement between North East and West London Cancer Networks, Roche and NCAT
- Clinical and technical workshops to validate Map of Medicine pathways.
Flowcharts of breast cancer patient pathway

Triple Assessment

Early & locally advanced

Advanced disease
Developing the process – funding flows

- Pathway then mapped to numbers: HRGs, tariffs and proxy local tariffs: funding flows and cost to commissioners
- ACCA are currently validating technical approach as a project
- Output is a ‘population-based predictive funding flows model’
- Allows input of 60+ clinically validated parameters
Developing the process – funding flows

- These parameters can then be adjusted to model impact of changes – stage of presentation, different chemotherapy regimens, follow up patterns etc.
- Our approach was as ‘commissioners’ so we have been consistent in using funding flows – tariffs or proxies.
- But model can be used by providers to include their actual costs – or marginal costs etc.
- NCIN workshop on health economics – potential to develop standard pathways for HE analysis – proof of concept for this?
- Current exercise to extend to ‘early detection’ pathway with colorectal as initial pilot and also to ‘surivorship’ phase.
Pathway mapped to tariff
- national pathway expanded by how provided
- cross-match OPCS codes
- OPCS grouped to HRGs

Generate missing costs
- CPORT cost module
- RPORT data
- bottom-up costs for other areas e.g. MDT

Patient flow ideal
- clinically informed
- IOG / best practice informed

Demographics
- current & predicted incidence

Pathway Cost
Predictive model
- population level cost for each pathway
- sensitivity analysis (impact on cost & degree of confidence)

Outputs
- fully loaded costs of each pathway
- cancer funding needs by PCT for 2011 & 2016

Standard cost

Actual cost
Current cost
- for sample trusts
- current cost for stages of pathway

Payment mechanism
- for London trusts
- understand payment system for non-tariff cancer activity

Patient flow actual
- HES informed
- clinically validated

Patient journey analysis
- using NELCN PCTs & Trusts
- cost implications of different types of patients
Funding flows as a lever for quality?

- Has PbR influenced quality – can it lever improved outcomes?
- Cross-subsidisation and ‘deals’
- Example of uplift for new drugs - £millions
- Move away from PbR in any event?
- ‘Commissioning can only drive change if it has a direct impact on the income of healthcare providers. Funding flows need to incentivise the best practice contained in this report. At its simplest, this means commissioners defining the best, safest practice for a patient pathway and then ensuring that this and only this is the practice they pay for’

Commissioning cancer in London for 2012/13

- Cancer pathways will be commissioned from 2 designated ‘Integrated Cancer Systems’ (ICS)
- Initially for secondary and tertiary care but with aspiration of whole pathway systems and key ICS priority of earlier detection of cancer
- ‘An ICS will function as an integrated, actively managed single entity....’
- Specification will consist of a Map of Medicine pathway together with an agreed set of outcome metrics
- For breast, lung, colorectal and brain cancers, there will be shadow commissioning using ‘bundle tariffs’ covering elements of whole pathways rather than individual episodes
The evidence base

- ‘High-quality care can be achieved when interventions that work are applied to the right patients, in the right moment and in the right place. Improving quality in health can thus be seen as a matter of finding out and defining what is the best clinical practice and of promoting everyday practice following such defined best practice’ (Velasco-Garrido et al, Purchasing for quality of care, WHO EOHSP 2005)

- ‘Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge’ (Campbell, 1975 referenced ibid)

- Commissioning evidence-based pathways will improve quality and productivity and therefore assure improved outcomes and value for money.
Michael E Porter, NEJM Dec 2010¹:

‘Achieving high value for patients must become the overarching goal of health care delivery, with value defined as the health outcomes achieved per dollar spent.’


“Any true health care reform will require abandoning the current complex payment schedule altogether. Instead, payers should introduce value-based reimbursement, such as bundled payments, that cover the full care cycle...”
The Value ‘thesis’ and Quality

- Porter (with Kaplan) argues that there is a crisis in healthcare costs – implicitly in the US – but in the UK also?
- The goal of high value ‘unites the interest of all actors in the system’
- Outcomes and costs are therefore the key variables and this therefore encompasses efficiency. “Cost reduction without regard to the outcomes achieved is dangerous and self defeating leading to false ‘savings’ and potentially limiting effective care”
- ‘Collusion of mediocrity’ – Paul Zollinger Read, Nov 2011
- Outcomes based but an underlying assumption of evidence based processes and Integrated Care
- So if Quality = the evidence based care that achieves the outcomes you require, there is a critical need to understand cost in relation to quality as well as outcomes
On integrated care

- Well – ask Nick Goodwin
- But we should aspire to models such as Geisinger

‘...our underlying purpose, our goals in health care, what we in CMS are now referring to as the ‘triple aim’. The ‘triple aim’ refers to better care for individuals, better health for populations and lower per capita costs without any harm whatsoever to patients.

‘What we know from decades of research is that at the heart of capabilities to deliver the ‘triple aim’, better care, better health and lower cost, is one core design concept and that is integration of care’

Don Berwick as Administrator Centers for Medicare and Medicaid Systems (CMS): workshop regarding accountable care organisations and implications for US anti-trust law etc