

# Resources planning for healthcare - Operational Delivery Networks in London

Hospital Authority Convention 2013

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# Three questions

1. What are we doing and why?
  - Understanding the context and the key resourcing issues
  - Barriers to change
  
2. Has there been any meaningful success so far?
  - London Cancer Alliance
  - Decision support model for resource planning
  - Continuous improvement framework
  
3. Can this knowledge be used to make changes that will reduce costs, improve outcomes, or both?



# Challenging economic climate for healthcare

The UK economic environment is tougher and not getting better as quick as some people expected

- Healthcare funding is currently protected from public sector cuts in the UK;
- Throughout the economy the pressure to increase pay in line with inflation elsewhere in the economy is growing.
- In the UK a change in commissioning has created massive uncertainty for healthcare providers
- We have learned that the NHS Efficiency challenge won't be delivered by individual trusts but by sector wide solutions



# The current approach to resource planning does not deliver

- Funding decisions are often short term
- There is little appetite for leadership and innovation
- Finding the funds for longer term investment is difficult
- The NHS ‘internal market’ creates structural barriers to change.



*‘Cancer genomics offers hope of targeted drugs, but NHS must be prepared to pay’*

*The Times newspaper – December 17<sup>th</sup> 2009*



*‘Doctors barred from using new  
cancer treatment equipment’*

*The Observer newspaper - 2<sup>nd</sup> May 2010*



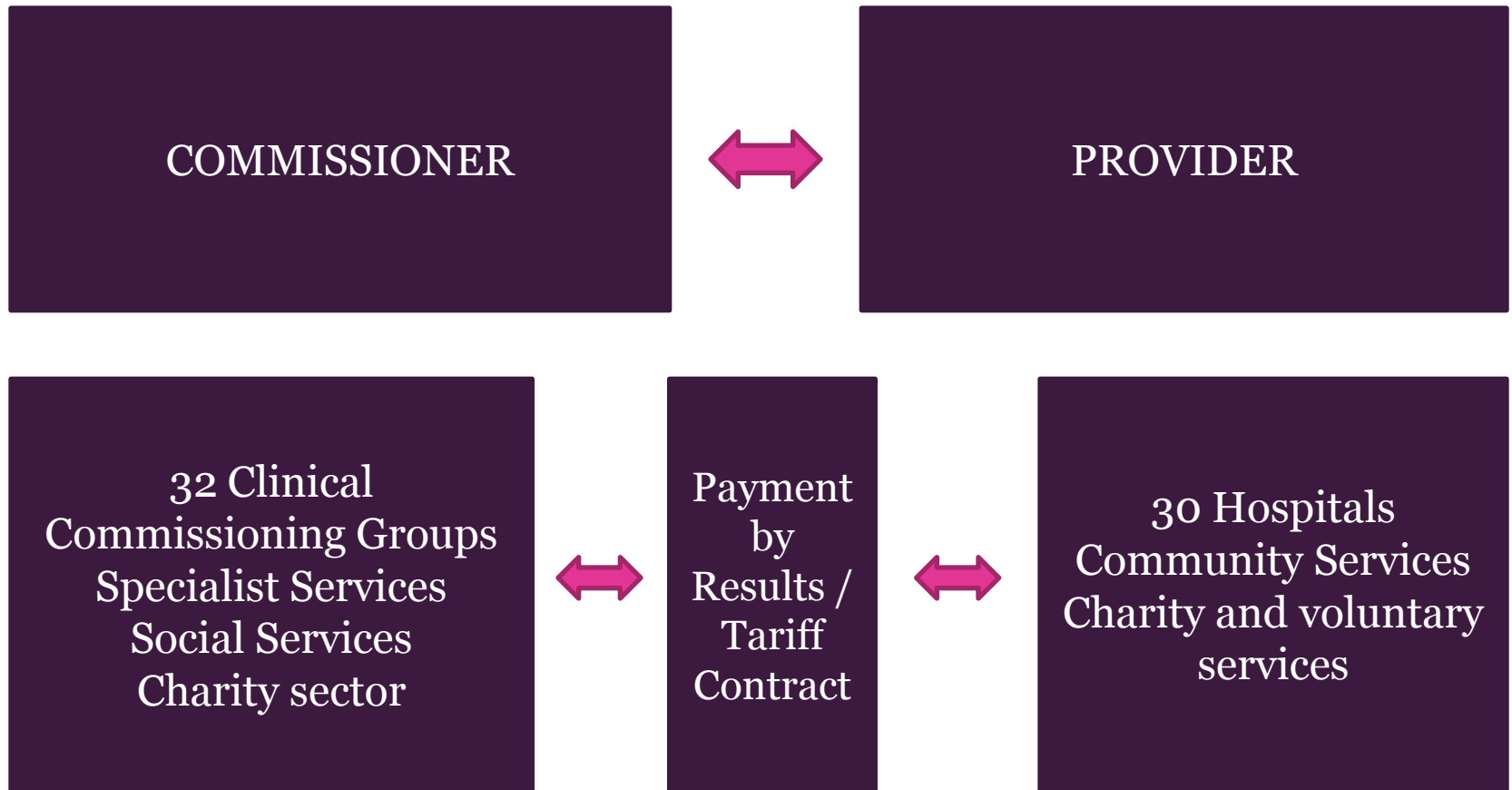
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*‘Simple test shows whether a cancer drug will work – but NHS does not use it’*

*The Times newspaper – December 10<sup>th</sup> 2009*



# The 'internal market'





# The pressure for change is growing

- £2.2bn cost and;
- Expected to increase by £400m in 2016



# Our new strategy for cancer care in London

## Objective

- Improve quality at no extra cost
- Reduce cost without detriment to quality
- Save 1000 lives

## Delivery

- Cancer Model of Care for London
- Joint body of commissioners
- Operational delivery networks



# Cancer Model of Care

Cancer Model of Care developed by 45 leading clinicians

## Levers for change

- ✓ Earlier diagnosis – reduce early mortality due to late presentation
- ✓ Care consistency – pathway optimisation
- ✓ Centre specialisation – complex activity into more specialised centres
- ✓ Care closer to home – move patients out of hospital to home or community palliative care setting



## Bringing clinicians together outside organisation boundaries will change the focus

- ✓ Clinicians already work across pathways – they see current system as unfair
- ✓ A wider focus helps to sort out problems
- ✓ See the consequences for patients and their budgets of pathway failures
- ✓ Peer review / league tables – clinicians value their reputation and patients are better informed about the choice of clinician
- ✓ Raises the profile of cancer in their own organisations – get more attention and support / resource



## A single budget

- ✓ Resources can be directed to the highest impact changes required
- ✓ Resources can be directed to different parts of the pathway
- ✓ Separate decision can be made over long term investment decisions and day to day running costs because total cancer spending is more transparent.
- ✓ Easier to identify and eliminate less effective care costs
- ✓ Can create incentives more closely aligned with Model of Care



# Building expert teams and improving communication channels

- ✓ Findings are rapidly disseminated across key stakeholder groups to build buy-in and alignment
- ✓ Teams of experts will own the model and provide resource support and coaching across the network
- ✓ Specific educational resource is identified and informal networks broadened



# Fostering debate and challenging assumptions

- ✓ Centres with local units
- ✓ Acute care and patient referrers
- ✓ Acute care and hospices, charities for end of life care
- ✓ Scientists and those who discover and innovate
- ✓ Public health professionals and politicians
- ✓ Friends and family



# Has there been any success so far?

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Two new Operational Delivery Networks;

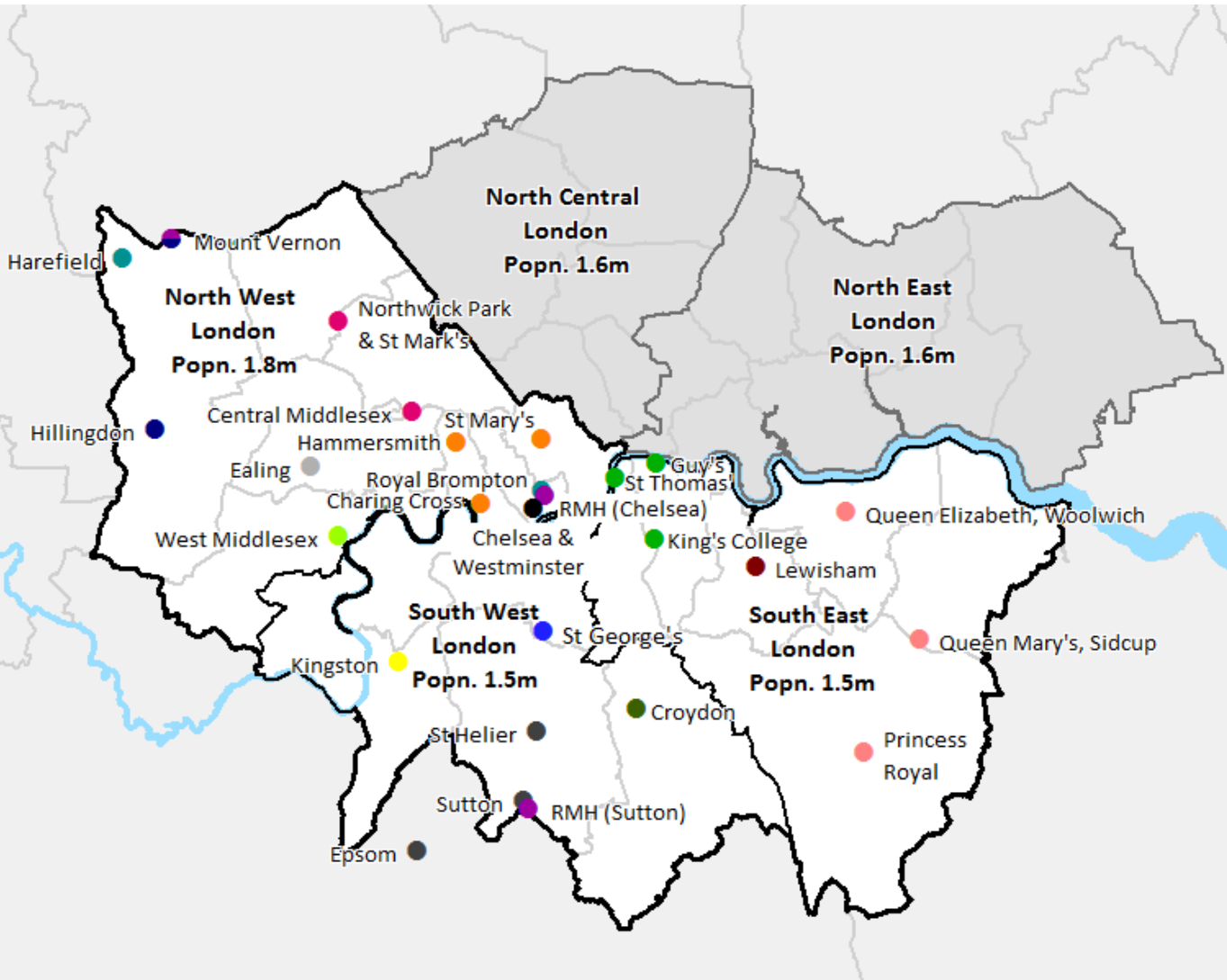
A decision support model;

Continuous Improvement Framework





# London Cancer Alliance (LCA)



London Cancer Alliance is one of two ODNs in London covering 17 hospitals and roughly two-thirds of London population and geography

## LCA: Governance

- Established under a Memorandum of Understanding signed with each hospital provider.
- Accountable through a Members Board comprises 7 CEOs; with independent Chair.
- Majority of activity is delivered through a Clinical Board; with two appointed Medical Directors (part-time) and independent Chair
- Remit to accredit cancer services and to advise commissioners
- Functioning as a single entity
- Employs practising clinical leaders from within its network



## LCA: Approach

- Self certification and exception reporting against clinical and financial metrics
- Patient pathway shadowing for quality measures
- Annual cancer quality accounts
- Incentive scheme for continuous improvement
- Failure regime



## LCA: Why be a Member?

- Considerable effort has been expended in ensuring that the goals and structure of the LCA are relevant for the key stakeholders.
- Hospitals are aware that, long term, the objective to allocate funds for patient care along pathways; and through ODNs. They can't really afford to miss the chance to influence commissioning decisions.



# Decision support model for resource planning

Provide the most realistic estimate of cancer care related activity and spend for London

Care costs for 2011 of £2.2bn of which 80% in hospital

Estimate the increase in spend and activity if we 'do nothing' i.e. do not implement the model of care

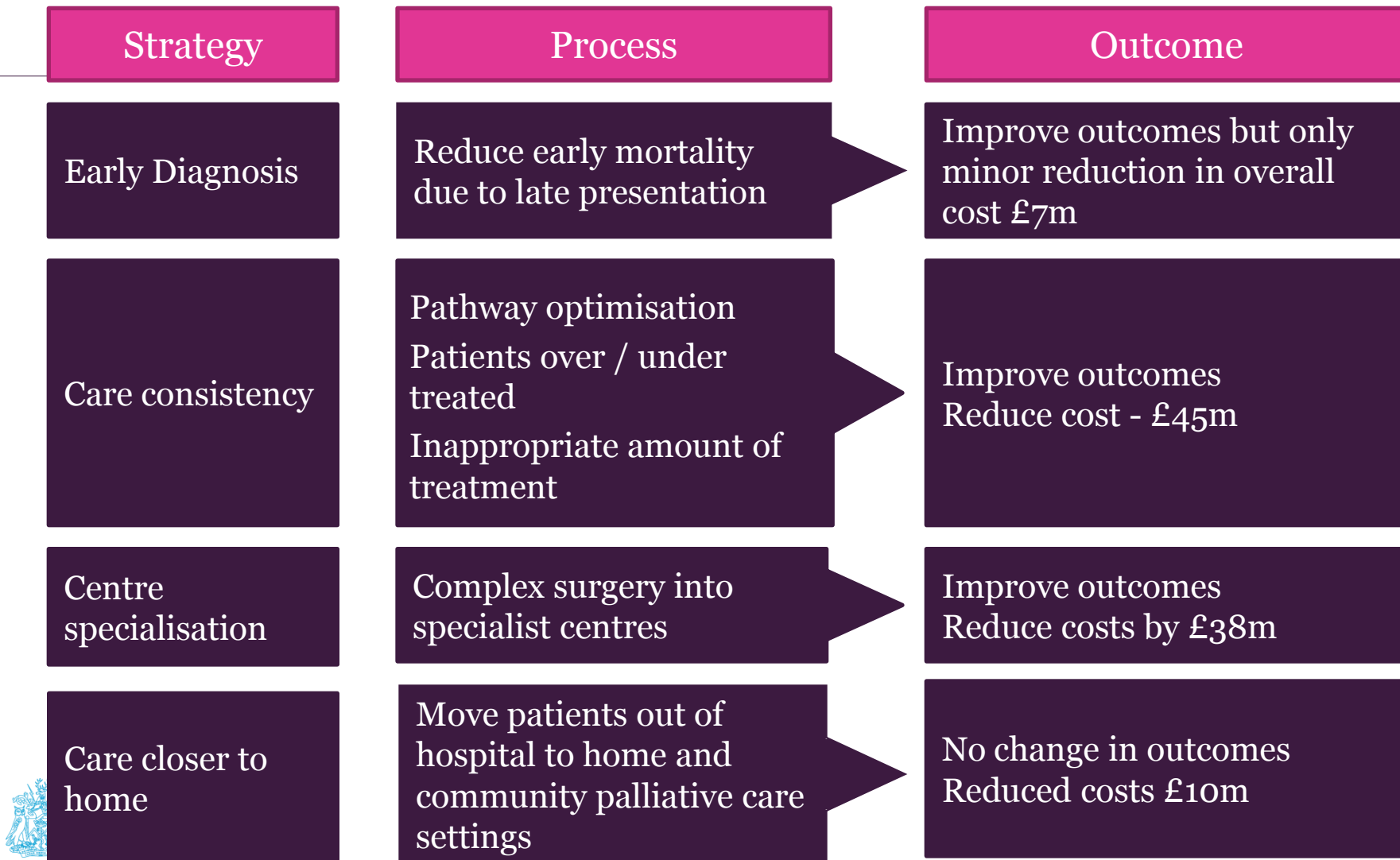
Costs rise by £400m  
Dependency on health care increases (4.4%) – 3600 more patients

Evaluate the levers in the model of care which will make the most significant impact

Cost saving of £100m across the system  
Dependency increases by 1.1% - 1033 patients



# Predicted outcomes



# Continuous Improvement Framework for performance management

- ✓ Set of prescribed metrics most associated with improved outcomes
- ✓ Small in number (30) to create focus and buy-in
- ✓ Early attention to data quality and improving measurement
- ✓ Sector wide feed back each month to all participants and commissioners builds



# Insights

## Governance

- ✓ Memorandum of understanding enables safe entry
- ✓ Avoid too much focus on money
- ✓ Spend time getting buy-in from all participants
- ✓ Provide regular feed back to remain relevant





# Insights

## For clinical buy-in

- ✓ Clinicians will operate outside boundaries; but the best are self selecting and issues will come when going gets tough for others
- ✓ Move quickly to deliver information for clinical engagement. Successful innovation starts from forensic analysis of patient data and then validating the statistical assumptions by engaging with patients.
- ✓ Keep it simple – temptation to use too many metrics; becomes too bureaucratic



# Insights

## For external stakeholders

- ✓ Challenge to find quick wins to satisfy funders
- ✓ Established new links with Academic Health Science Networks



# Conclusion

- ✓ Operational delivery networks will transform cancer care because they provide a clear mandate for clinicians to manage care and resources across organisation boundaries.
- ✓ Hospitals have bought in to the new model because the model of care has exposed the risks; both economically and for patient safety if they do not change their position.
- ✓ And the new decision support model and continuous improvement framework are providing the tools to reinforce the changes.
- ✓ This model will be extended nationally; both for cancer services and for other chronic diseases where patients follow pathways of care across agency boundaries.

