RightCare
Commissioning for Value

Co- creating the National Surgical Commissioning Centre

Nigel Beasley
co-Chair East Midlands Clinical Senate

Reducing spending on low clinical value treatments

Health briefing, April 2011

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Delivering more for less

audit commission

- NHS could save up to £500 million a year by carrying out fewer ineffective or inefficient treatments

- ‘Croydon List’ 34 low priority procedures - carpal tunnel surgery, cataract surgery, hip and knee revisions, hernia repair, varicose veins, grommets and tonsillectomy.

guardian.co.uk

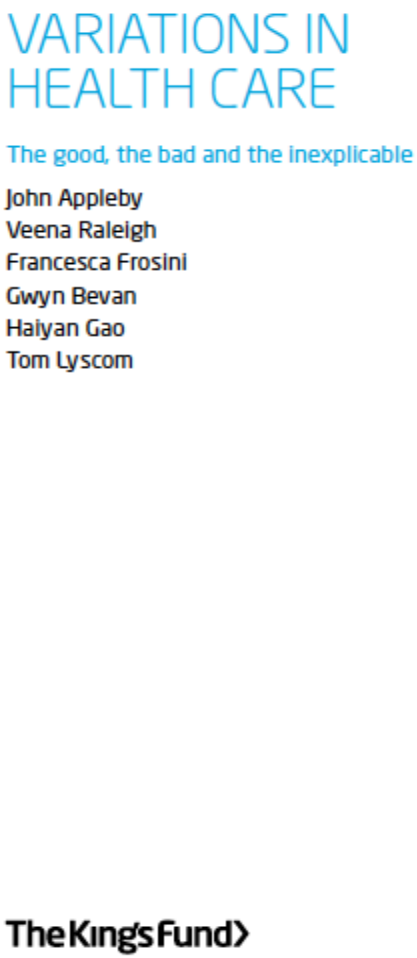
Patients denied key treatments due to NHS cost-cutting, surgeons warn

Open letter accuses health trusts of letting public down by branding some elective surgery 'lower value'

Read the FSSA's letter

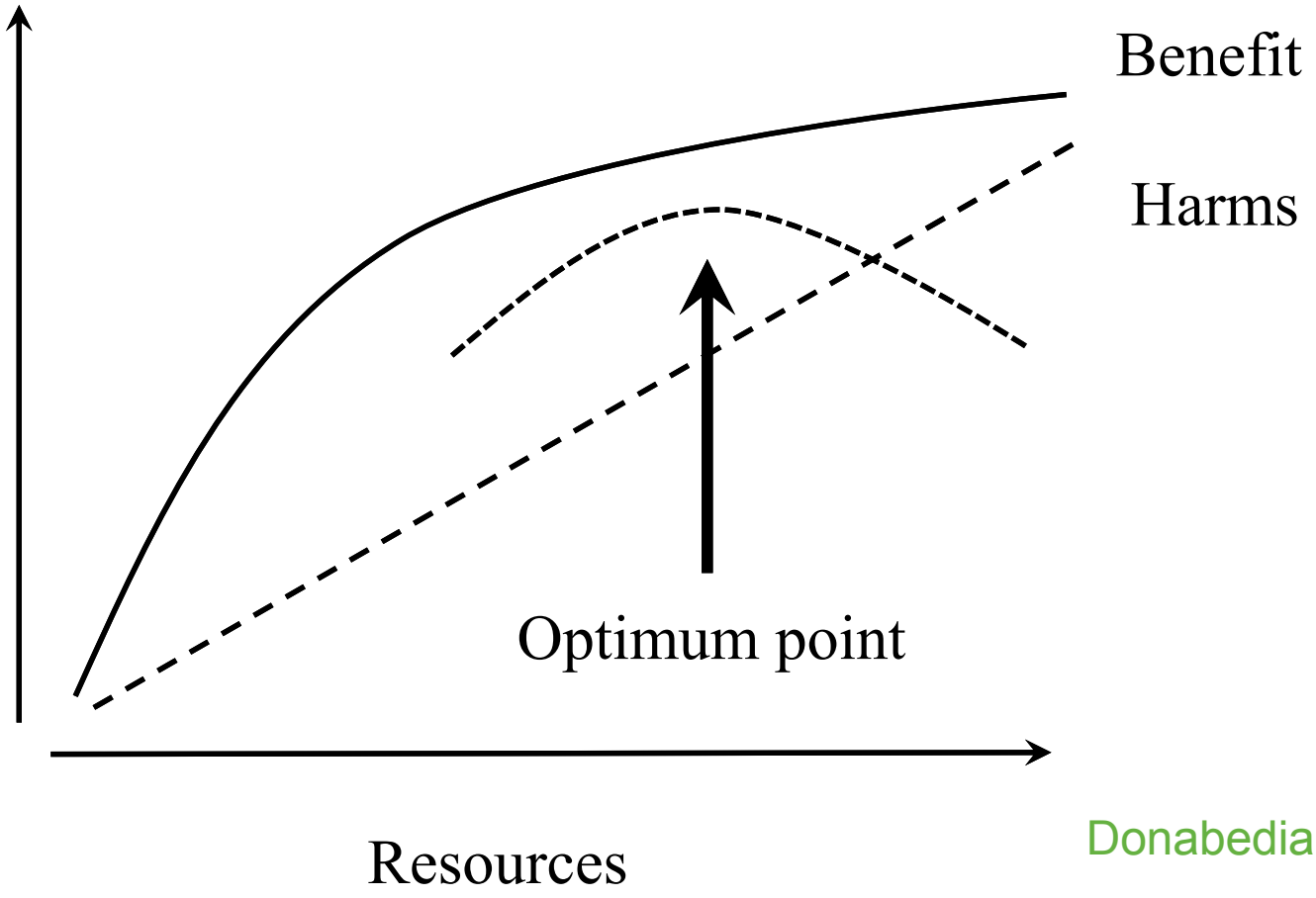
Denis Campbell, health correspondent
The Guardian, Monday 18 April 2011

British surgeons warn NHS cost-cutting is leading to key precedures being branded of limited clinical value. Photograph: Christopher Furlong/Getty Images



- ‘the existence of persistent unwarranted variations in health care directly impacts on equity of access to services, the health outcomes of populations and efficient use of resources’
- ‘when there is strong evidence and a professional consensus that an intervention is effective, there tends to be little or no variation in clinical practice, but for interventions with a weak evidence base and professional uncertainly there is wide variation’
- ‘this does not means that individual practitioners are uncertain, it’s just that each makes different decision based on their experience, knowledge and interpretation of the evidence for effectiveness’

Effectiveness



Donabedian 1980

Value

- 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.

- This goal is what matters for patients and unites the interests of all actors in the system.

- If value improves, patients, payers, providers, and suppliers can all benefit while the economic sustainability of the health care system increases.

Michael Porter NEJM 2010

Value Based Clinical Commissioning of Elective Surgical Care

Emerging Views of Commissioners & Surgeons and Production of High Value Care Pathways

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RightCare

NHS

Commissioning Guidance

- Define high value care
  - primary care, community specialist care, secondary care
  - criteria for referral and intervention
- Measure high value care
  - variation
  - quality dashboard – process and outcome measures
  - Procedures Explorer
- Lever change
  - audit and peer review measures
  - CQUINS, Quality Schedule of Contract

- Patient and clinician facing information
- Research Questions

National Surgical Commissioning Centre

National Surgical Commissioning Centre
Commissioning guides
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ASGBI
Association of Surgeons of Great Britain and Ireland

British Hernia Society

RCS
ADVANCING SURGICAL STANDARDS

2013

Commissioning guide:

Groin hernia

Sponsoring Organisation: Association of Surgeons of Great Britain and Ireland / British Hernia Society
Date of evidence search: November 2012
Date of publication: September 2013
Date of Review: September 2016

NICE accredited

NICE has accredited the process used by Surgical Speciality Associations and Royal College of Surgeons to produce its Commissioning guidance. Accreditation is valid for 5 years from September 2012. More information on accreditation can be viewed at www.nice.org.uk/accreditation

Guide development group for groin hernia

A commissioning guide development group was established to review and advise on the content of the commissioning guide. This group met twice, with additional interaction taking place via email.

Name	Job Title/Role	Affiliation
Mr David Sanders	Surgeon, Co-chairman	British Hernia Society
Mr Martin Kurzer	Surgeon, Co-chairman	British Hernia Society
Mr David Bennett	Surgeon	
Mr Andrew de Beaux	Surgeon	
Dr Jennifer Hislop	Health Economist	
Prof Andrew Kingsnorth	Surgeon	
Miss Louise Maitland	Nurse Specialist	
Prof Paddy O'Dwyer	Surgeon	
Mr Aali Sheen	Surgeon	
Mr Brian Stephenson	Surgeon	
Dr John Tisdale	General Practitioner	
Ms Lynne Hall	Commissioner	
Mr Nigel Laurie	Patient Representative	
Mr David Watford	Patient Representative	

GPs should refer:

- all patients with an overt or suspected inguinal hernia to a surgical provider except for patients with minimally symptomatic inguinal hernias who have significant comorbidity (ASA grade 3 or 4) **AND** do not want to have surgical repair (after appropriate information provided)[3,4]
- irreducible and partially reducible inguinal hernias, and all hernias in women as '**urgent referrals'**[5,6]
- patients with suspected strangulated or obstructed inguinal hernia as '**emergency referrals'**[5,6]
- all children <18 years with inguinal hernia to a paediatric surgical provider

Medical Imaging:

- Medical imaging should be considered in patients in whom there is diagnostic uncertainty or to exclude other pathology.[7]
- Ultrasound scan (USS) is recommended as the first line investigation. Herniography is rarely performed but can be utilised if local expertise is available as an alternative to USS[8]
- Magnetic resonance imaging (MRI) should be considered if USS is negative and groin pain persists[9,10]

Which patients require an operation?

- Surgical repair should be offered to patients with a symptomatic inguinal hernia[11]
- Patients with asymptomatic hernias can be managed conservatively but there is a likelihood of requiring surgery in the future[3,4,12]
- Patients should be warned of the potential complications of repair including chronic pain. Five years after an inguinal hernia repair only a small proportion of patients, between 2% and 3.5%,[13] report moderate to severe chronic pain. Laparoscopic inguinal hernia repair has been reported to result in less chronic pain than open repair.[13]

Peri operative management:

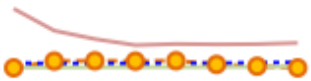
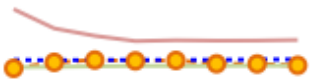
Open vs. laparoscopic repair:

Follow Up: Routine outpatient follow up is not required after inguinal hernia repair

Quality Specification/CQUIN

Measure	Description	Data
Day case rates	70% day case rate	HES data
7 day Readmission rates	<5%	HES data
30 day Readmission rates	<5%	HES data
Reoperation <12 months	<5%	HES data
Lap - recurrent groin hernia	³40%	HES data
Lap - bilateral groin hernia	³40%	HES data
PROMs data compliance	³75%	PROM

Primary Inguinal Hernia Repair - Unilateral (Open)

Metric	Period	Value	Mean	Chart	Trend
Age/Sex Standardised Activity (per 100,000 population)	RY Q4 1213	67.14	74.01		
Average Length of Stay (Days)	RY Q4 1213	0.27	0.36		
7 Day Readmission Rate (%)	RY Q4 1213	0.00	1.39		
30 Day Readmission Rate (%)	RY Q4 1213	0.88	2.59		
30 Day Reoperation Rate (%)	RY Q4 1213	0.88	1.91		
Daycase Rate (%)	RY Q4 1213	80.26	75.49		
In Hospital Mortality Rate (per 1,000 discharges)	RY Q4 1213	0.00	0.05		

- Activity Volume
- Short Stay Rate (<48 Hours) (%)
- Average Length of Stay (Days)
- 7 Day Readmission Rate (%)
- 30 Day Readmission Rate (%)
- 30 Day Reoperation Rate (%)
- Daycase Rate (%)

Select Organisation

NHS EREWASH CCG
NHS HARDWICK CCG
NHS MANSFIELD AND ASHFIELD CCG
NHS NEWARK & SHERWOOD CCG

Intervention

Open
Laparoscopic
Arthroscopic
Bilateral
Closed
Colonoscopy
Embolisation
Epithelioma
Flexi Sigmoidoscopy
Injection of botulinum toxin
Lateral internal anal sphincterotomy

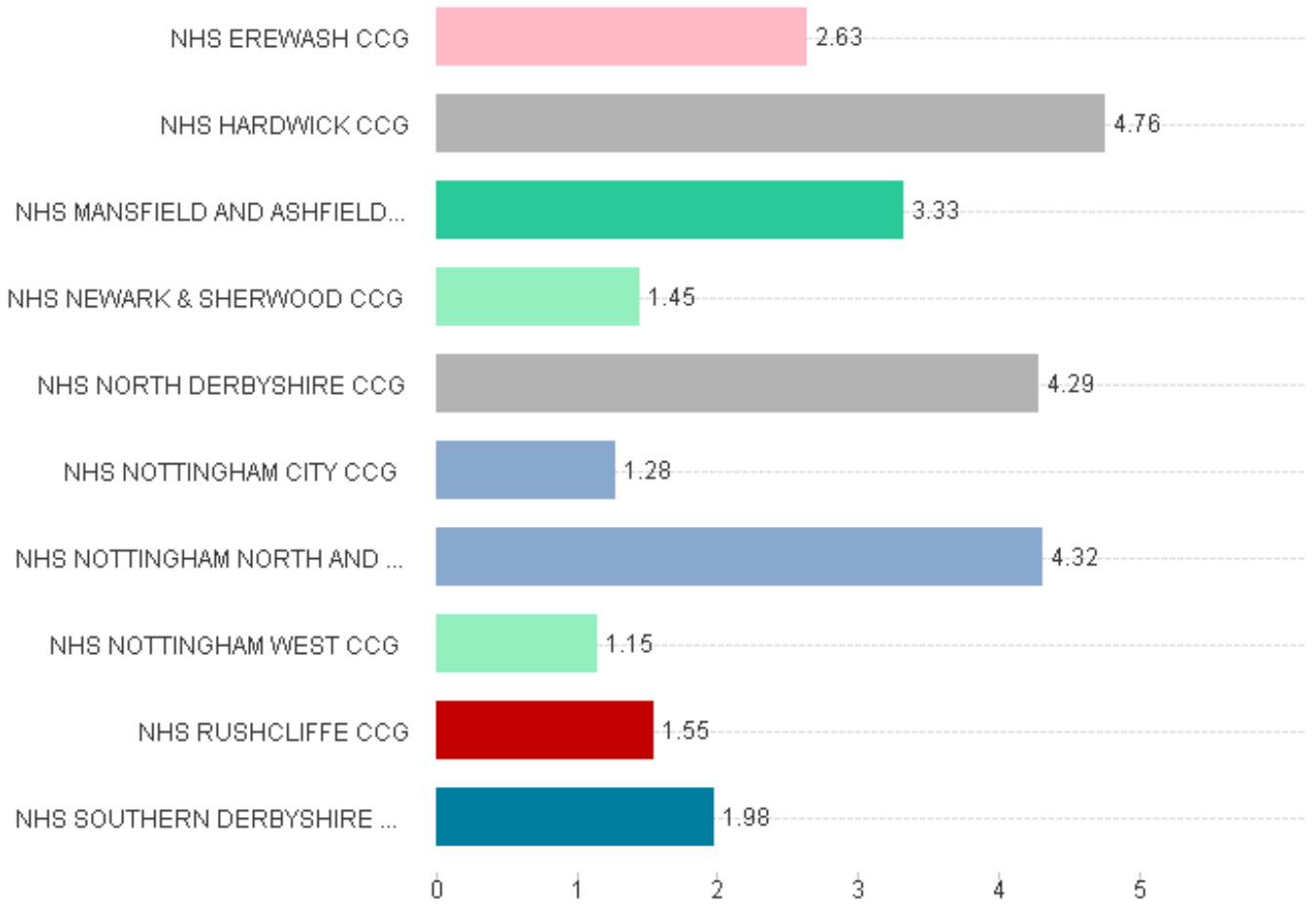
Adult/Paeds

Adult
Paediatrics (<17)

Back | Clear | Forward

30 Day Readmission Rate (%) for Primary Inguinal Hernia Repair - Unilateral (Open)

CCG



Research recommendations

We identified several gaps in available evidence in the course of conducting his guidance. The following areas should be addressed:

- RCT of laparoscopic vs. open inguinal hernia repair in patients with pre-operative risk factors for developing chronic pain
- cohort study (with well-matched groups) comparing laparoscopic and open LA inguinal hernia repair in patients > 70 years
- Laparoscopic vs. open surgery for femoral hernia repair
- Mesh vs. suture open femoral hernia repair
- Use of MRI in occult hernia

Lessons learned

Must understand key levers

- commissioners – money
- providers - targets

Must consider education and training - curriculum

- HEE
- Royal Colleges
- Specialty Associations

Must engage at all levels

- NHS England
- CCGs, providers
- surgeons