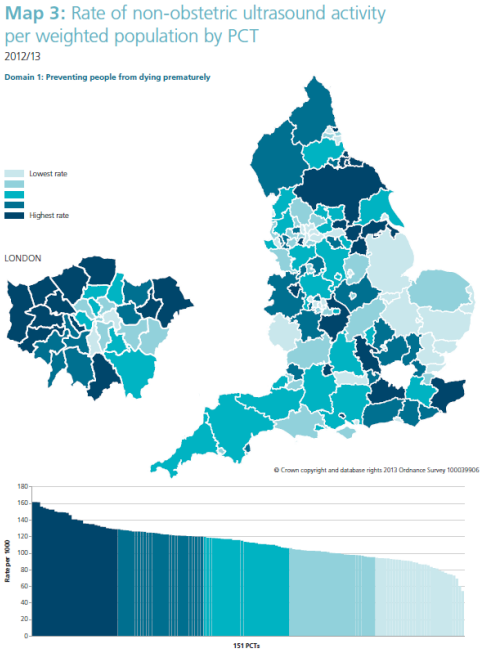
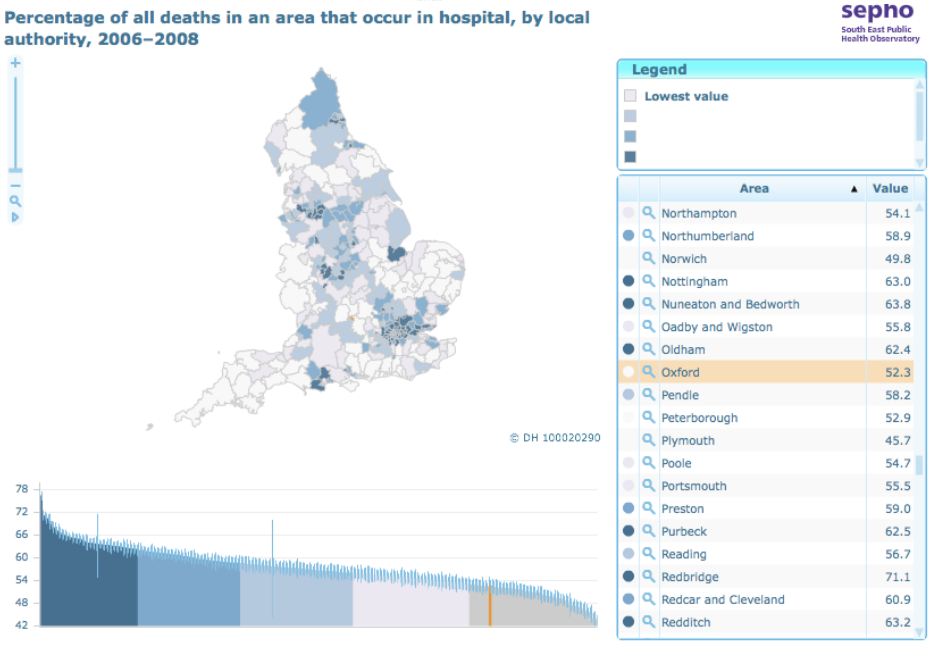
After 50 years of technological progress and investment & the 20 years of evidence based medicine, quality and safety improvement all societies still face three massive problems.

The first is unwarranted variation in healthcare ie ”Variation in utilization of health care services that cannot be explained by variation in patient need or patient preferences.”

Jack Wennberg

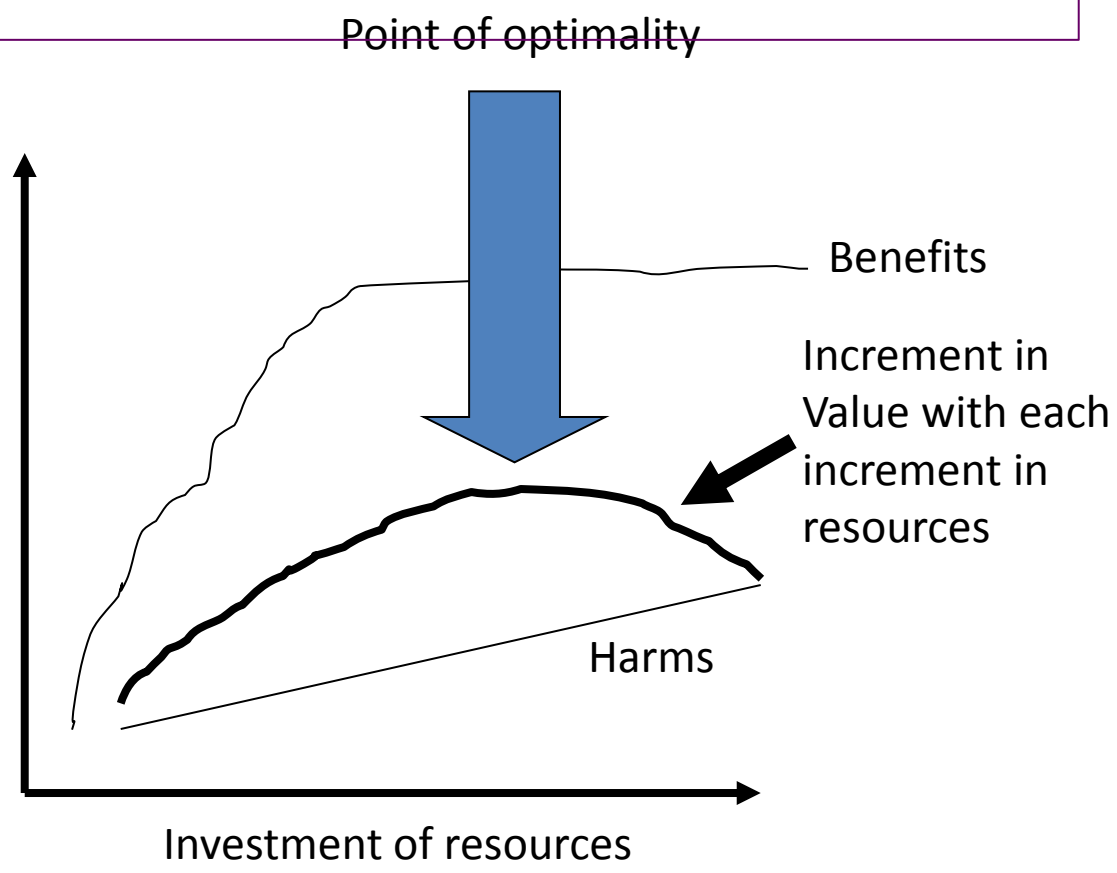
Variation reveals the other two problems





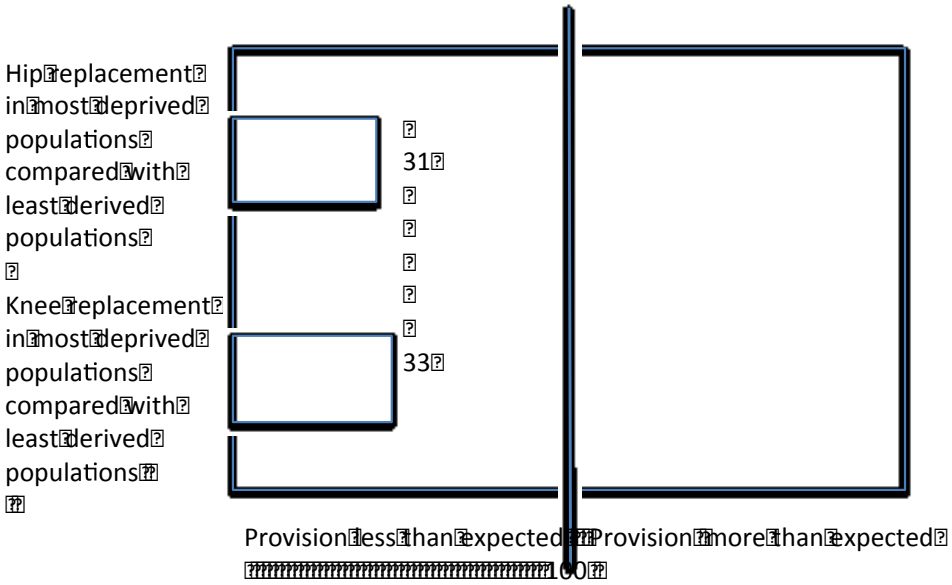
The first is OVERUSE of lower or zero value interventions which results in

1. **waste of resources**
2. **harm**



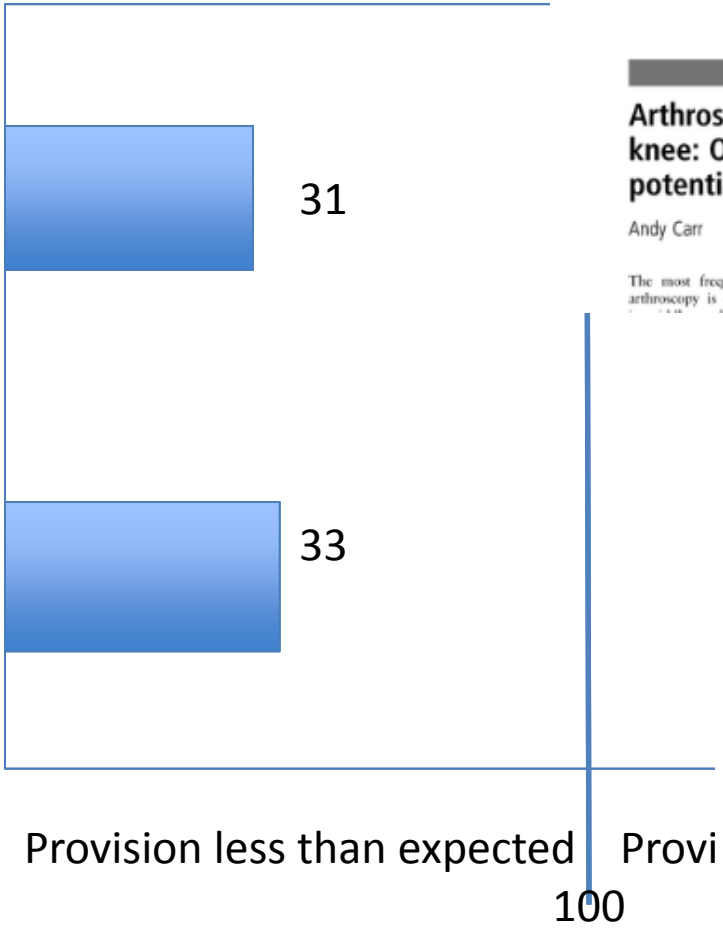
The second is Underuse of high value interventions which results in

1. Preventable disability and death eg if we managed atrial fibrillation optimally there would be 5,000 fewer strokes and10% reduction in vascular dementia, and
2. inequity



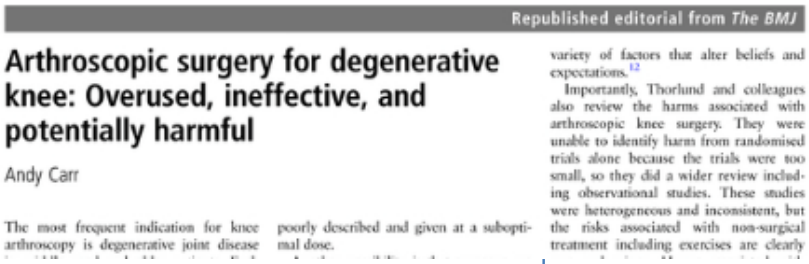
Hip replacement in most deprived populations compared with least derived populations

Knee replacement in most deprived populations compared with least derived populations



Br J Sports Med 2015;**49**:1223-1224 doi:10.1136/bjsports-2015-h2983rep

Republished editorial from The BMJ



Republished editorial from *The BMJ*

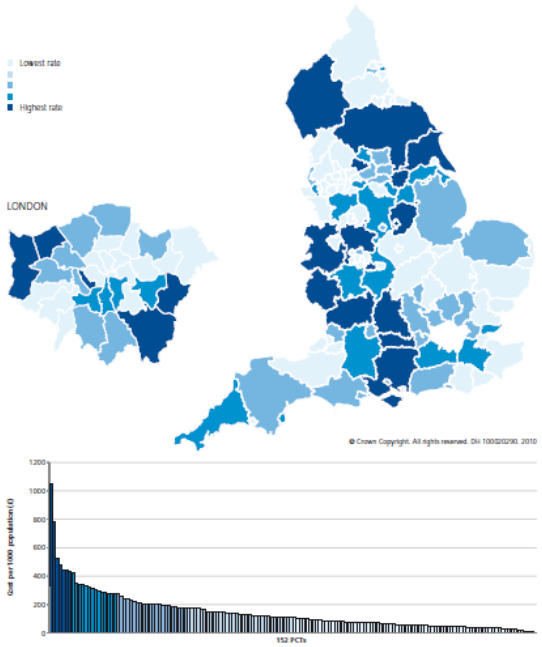
Arthroscopic surgery for degenerative knee: Overused, ineffective, and potentially harmful

Andy Carr

The most frequent indication for knee arthroscopy is degenerative joint disease poorly described and given at a suboptimal dose.

variety of factors that alter beliefs and expectations.[12]

Importantly, Thorlund and colleagues also review the harms associated with arthroscopic knee surgery. They were unable to identify harms from randomised trials alone because the trials were too small, so they did a wider review including observational studies. These studies were heterogeneous and inconsistent, but the risks associated with non-surgical treatment including exercises are clearly



THERE IS ALSO TRIPLE WHAMMY HEALTHCARE !
OVERUSE +
UNDERUSE +
UNWARRANTED VARIATION

In the next decade need and demand will increase by at least 20 % so what can we do? Well, we need to continue to

1. Prevent disease, disability, dementia and frailty to reduce need
2. Improve outcome by
    a) Provide only effective, evidence based interventions
    b) Improve quality and safety of process to improve outcome to reduce cost of redo or recurrence
3. Increase productivity by Reducing cost -

These measures have reduce need and improve efficiency BUT we also need to increase value

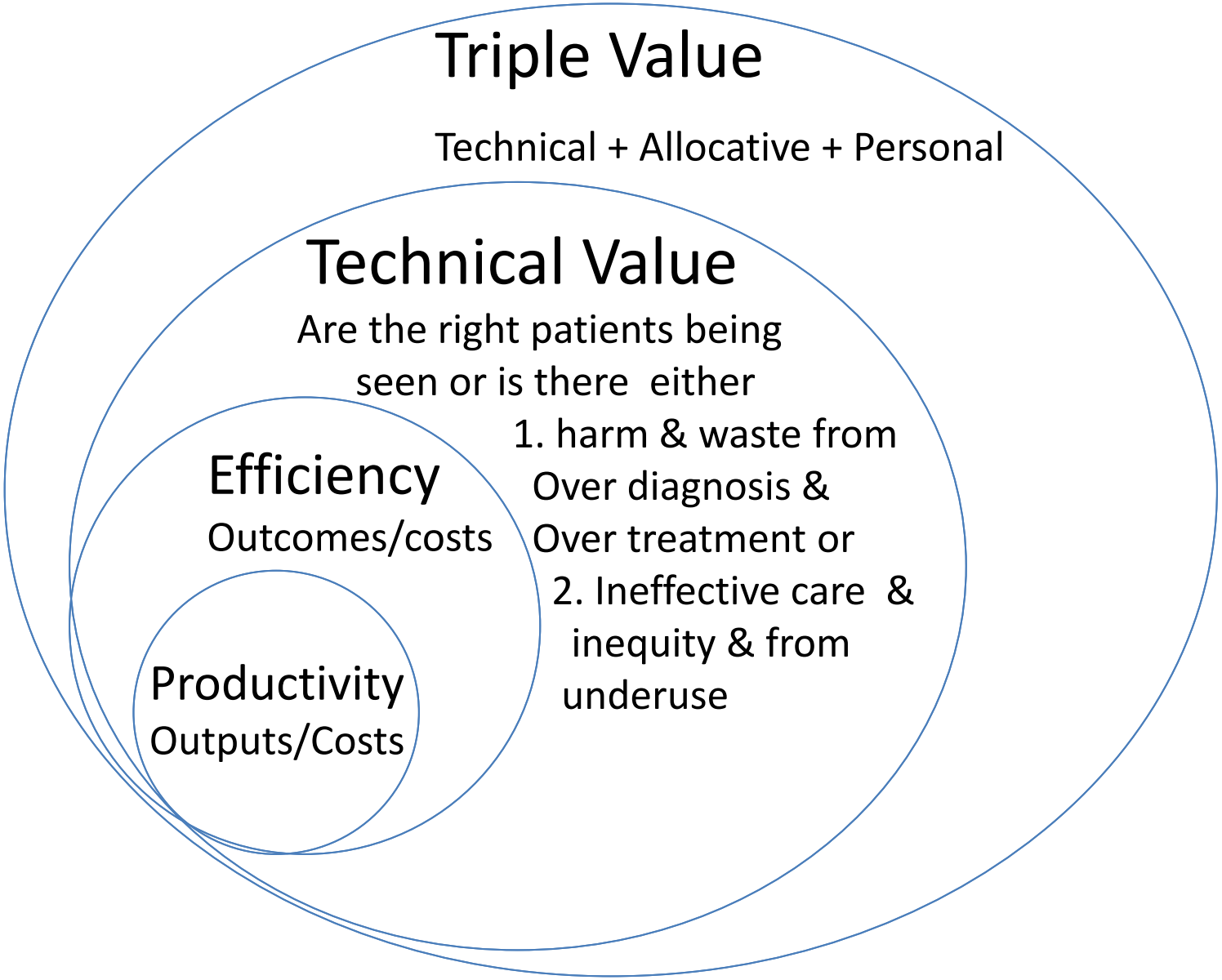
The Aim is **triple value**

- Allocative, determined by how well the assets are distributed to different sub groups in the population
  - Between programme
  - Between system
  - Within system
- Technical, determined by how well resources are used for outcomes for all the people in need in the population
- Personalised value, determined by how well the outcome relates to the values of each individual

ACADEMY OF MEDICAL ROYAL COLLEGES

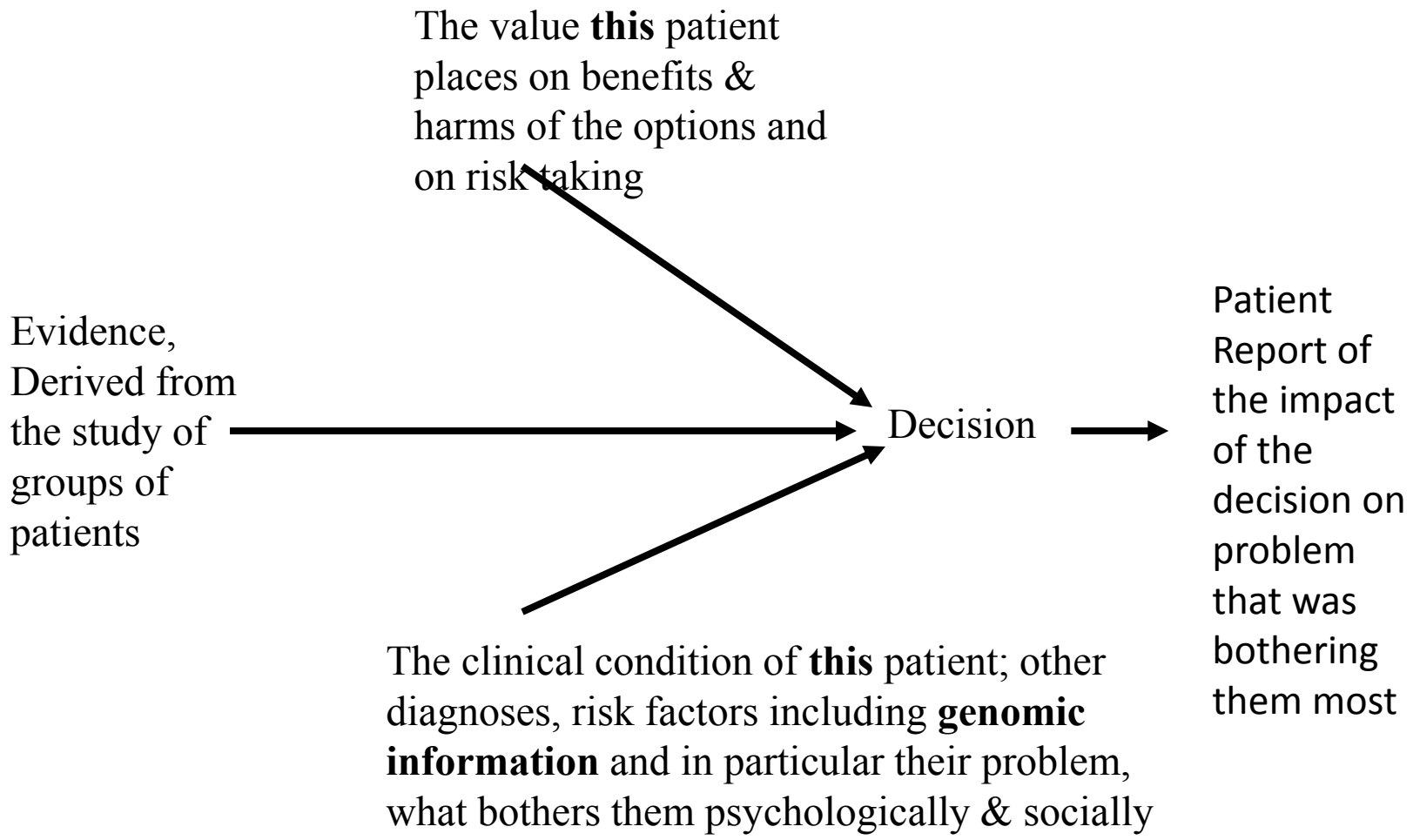
Protecting resources, promoting value: a doctor's guide to cutting waste in clinical care

waste is anything that does not add value and as the Academy's re[port emphasises we need to develop a 'culture of stewardship' to ensure the NHS will be with us in 2025 and 2035


Triple Value
Technical + Allocative + Personal
Technical Value
Are the right patients being seen or is there either
1. harm & waste from Over diagnosis & Over treatment or
2. Ineffective care & inequity & from underuse
Efficiency
Outcomes/costs
Productivity
Outputs/Costs

THE RIGHTCARE METHOD OF INCREASING VALUE FOR POPULATIONS AND INDIVIDUALS IS BY

1. Ensuring that every individual receives high personal value by providing people with full information about the risks and benefits of the intervention being offered
2. Shifting resource from budgets where there is evidence from unwarranted variation of overuse or lower value to budgets for populations in which there is evidence of underuse and inequity
3. Ensuring that those people in the population who will derive most from a service are in receipt of that service
4. Implementation of high value innovation eg troponin in heart disease funded by reduced spending on lower value intervention
5. Increased rates of higher value intervention eg helping a higher proportion of people die well at home funded by reduced spending on lower value terminal care in hospital



And if genomic information is included the term used is usually precision medicine rather than personalised medicine

5.The Rightcare method for ensuring that every individual receives high personal value is providing people with full information about the risks and benefits of the intervention to prevent overuse through over diagnosis and overtreatment by

- Ensuring that what is bothering the individual patient most is articulated and recorded by the service
- Providing information about the risks and benefits of every decision eg the decision to offer a drug, is presented in absolute numbers
- Providing decision aids for complicated decisions in which there is a significant risk of harm
- Helping the patient reflect on their values, both online and face to face, in the light of the information presented,
- Eliciting patient feedback to ensure these steps are taking place

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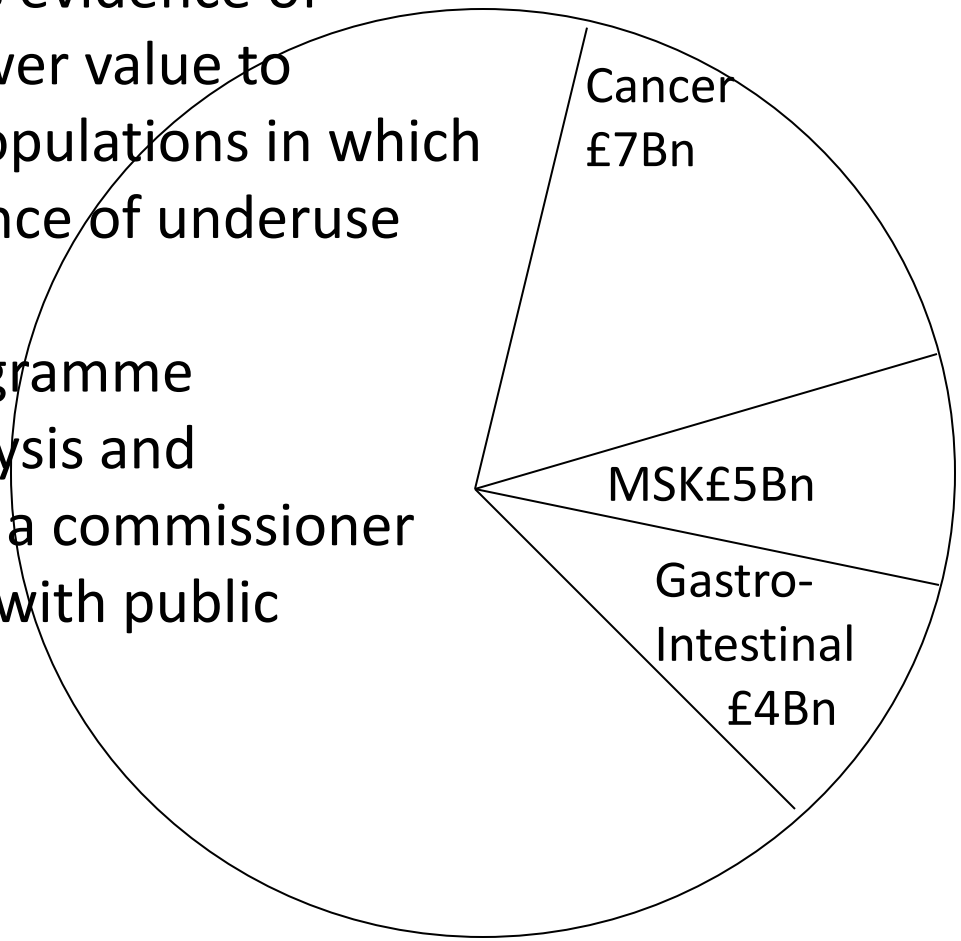
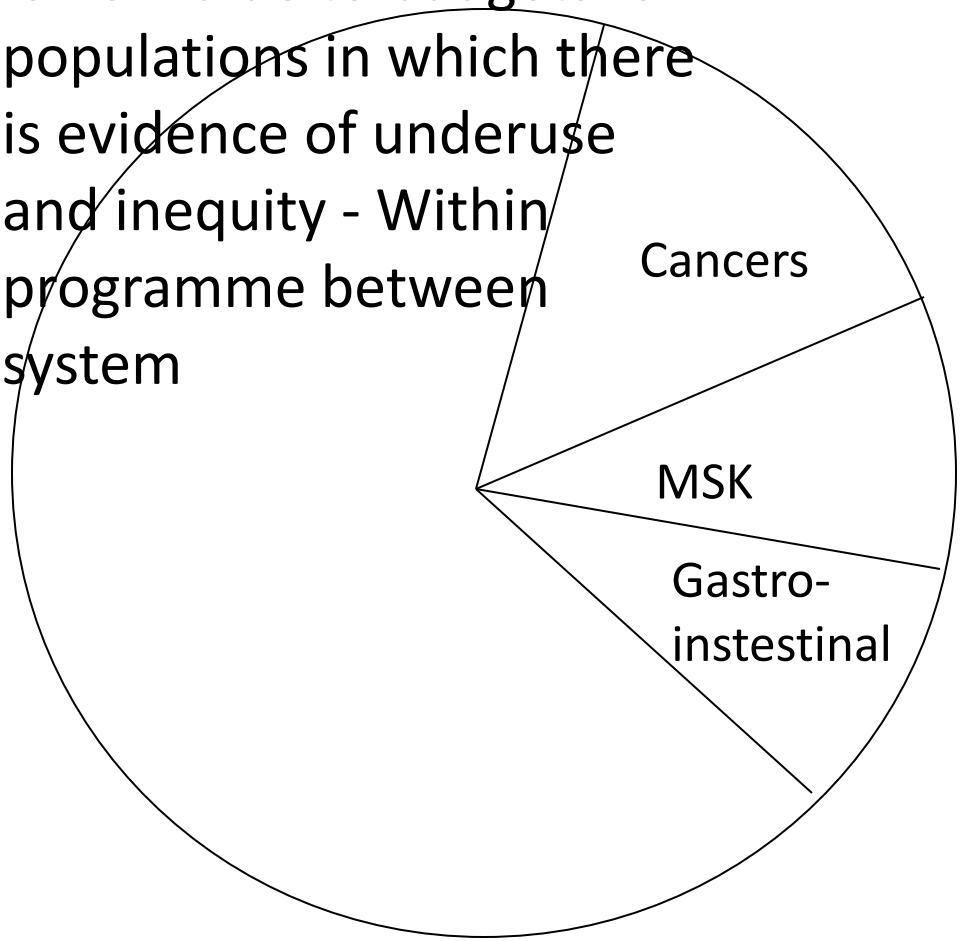
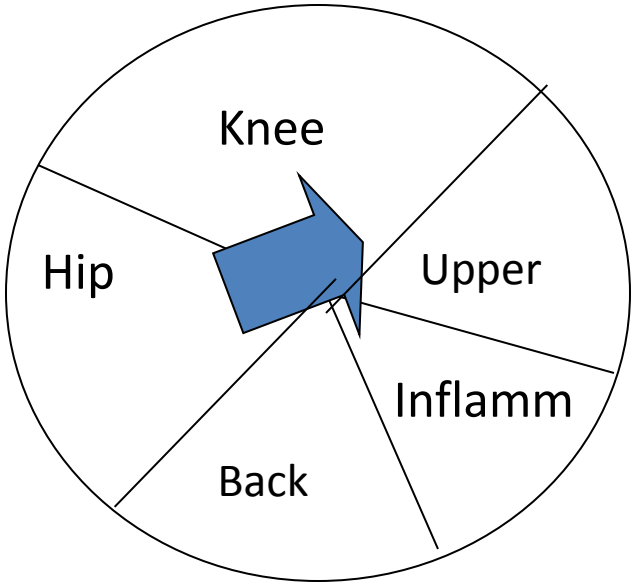
2. Shifting resource from budgets where there is evidence of overuse or lower value to budgets for populations in which there is evidence of underuse and inequity -

Between Programme Marginal Analysis and reallocation is a commissioner responsibility with public involvement;?



2. Shifting resource from budgets where there is evidence of overuse or lower value to budgets for populations in which there is evidence of underuse and inequity - Within programme between system





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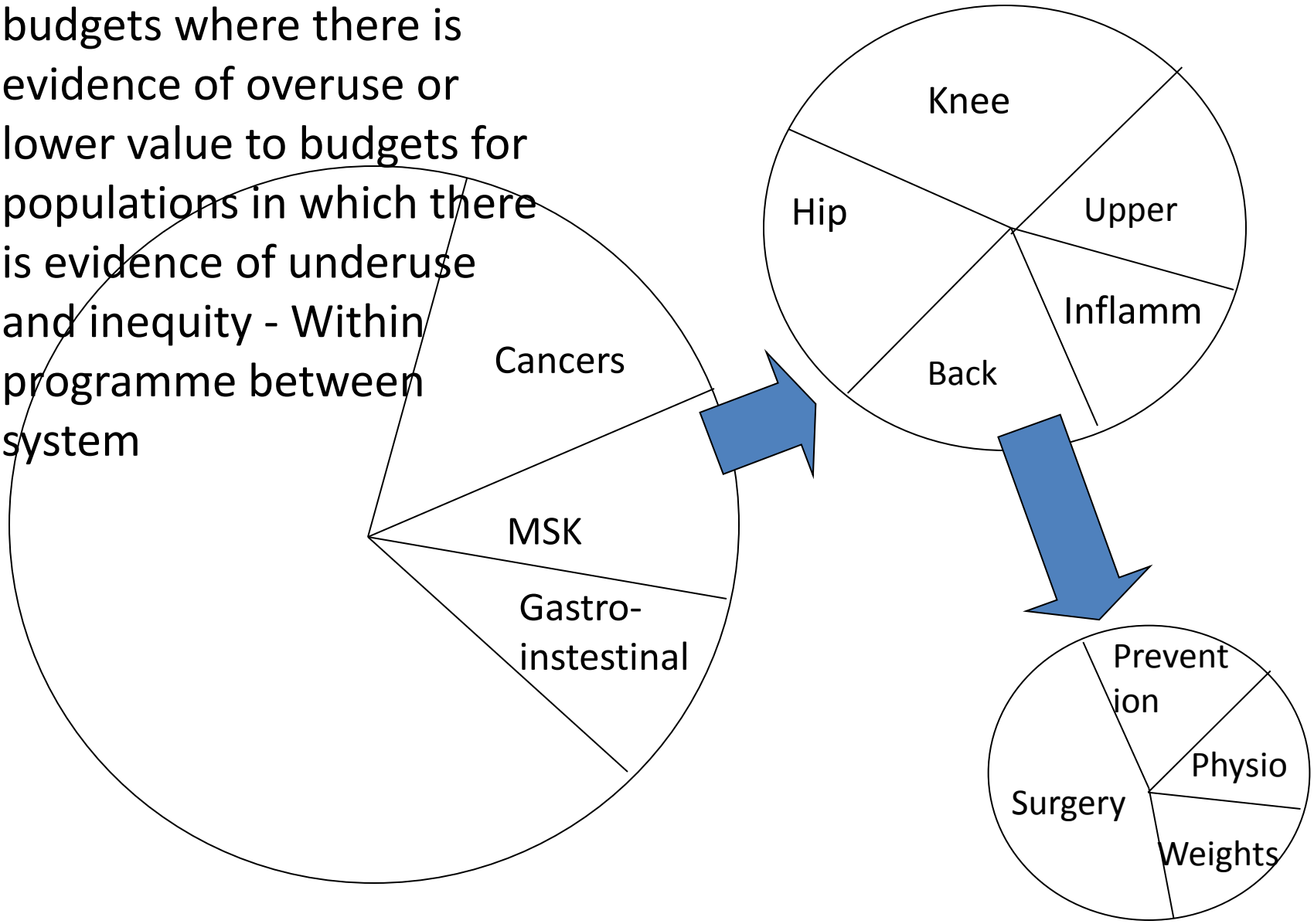
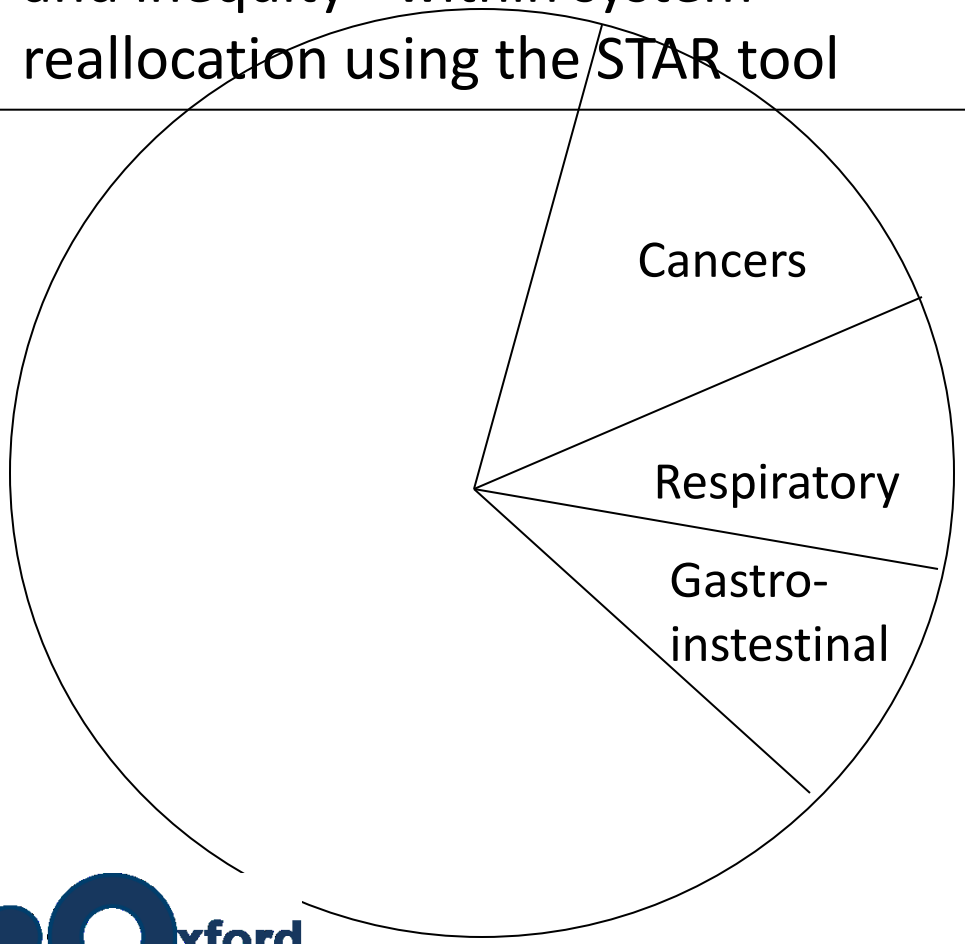
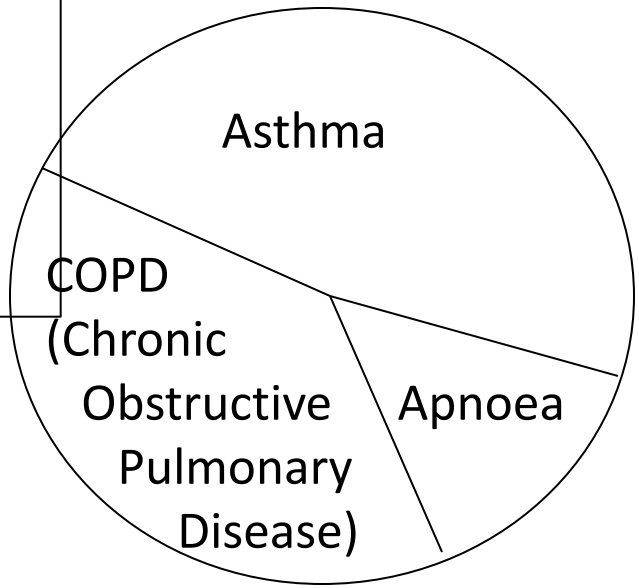
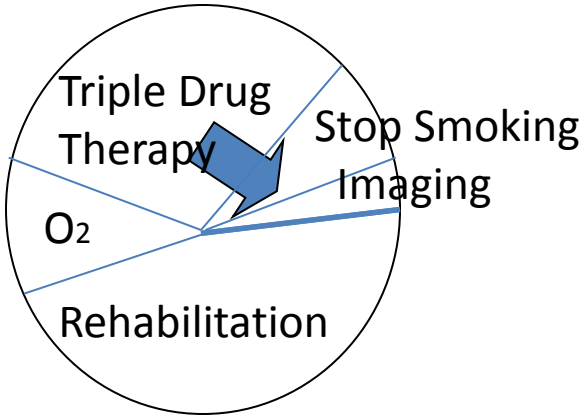


1. Shifting resource from budgets where there is evidence of overuse or lower value to budgets for populations in which there is evidence of underuse and inequity - within system reallocation using the STAR tool

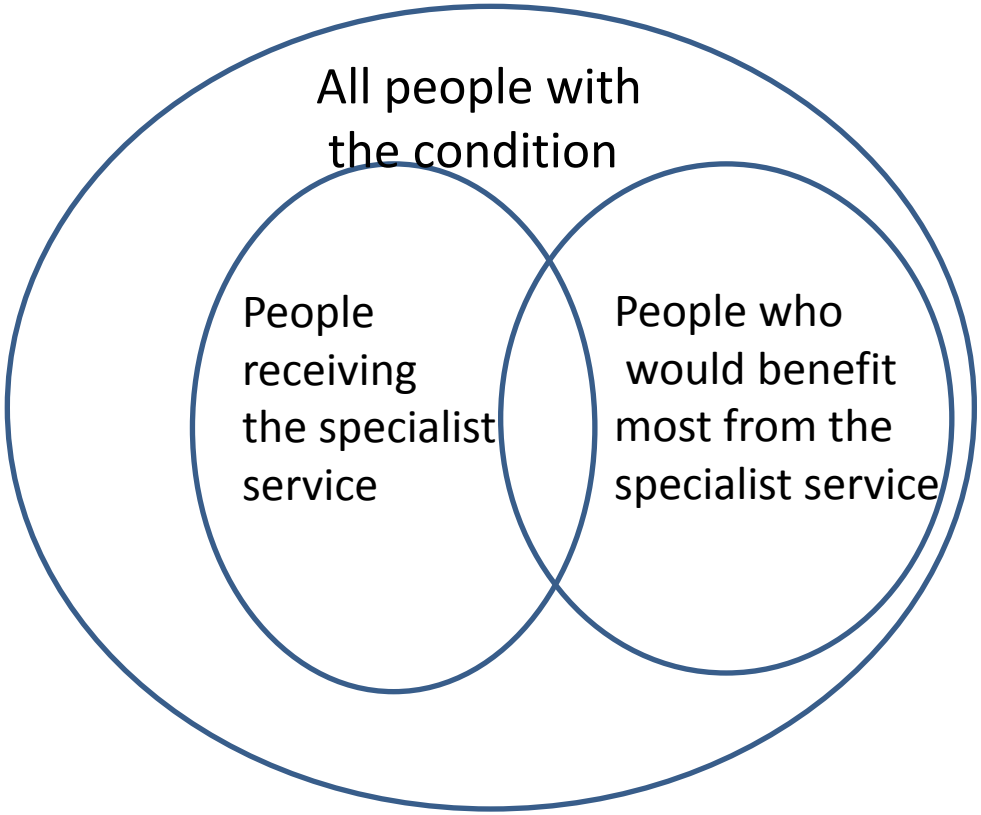






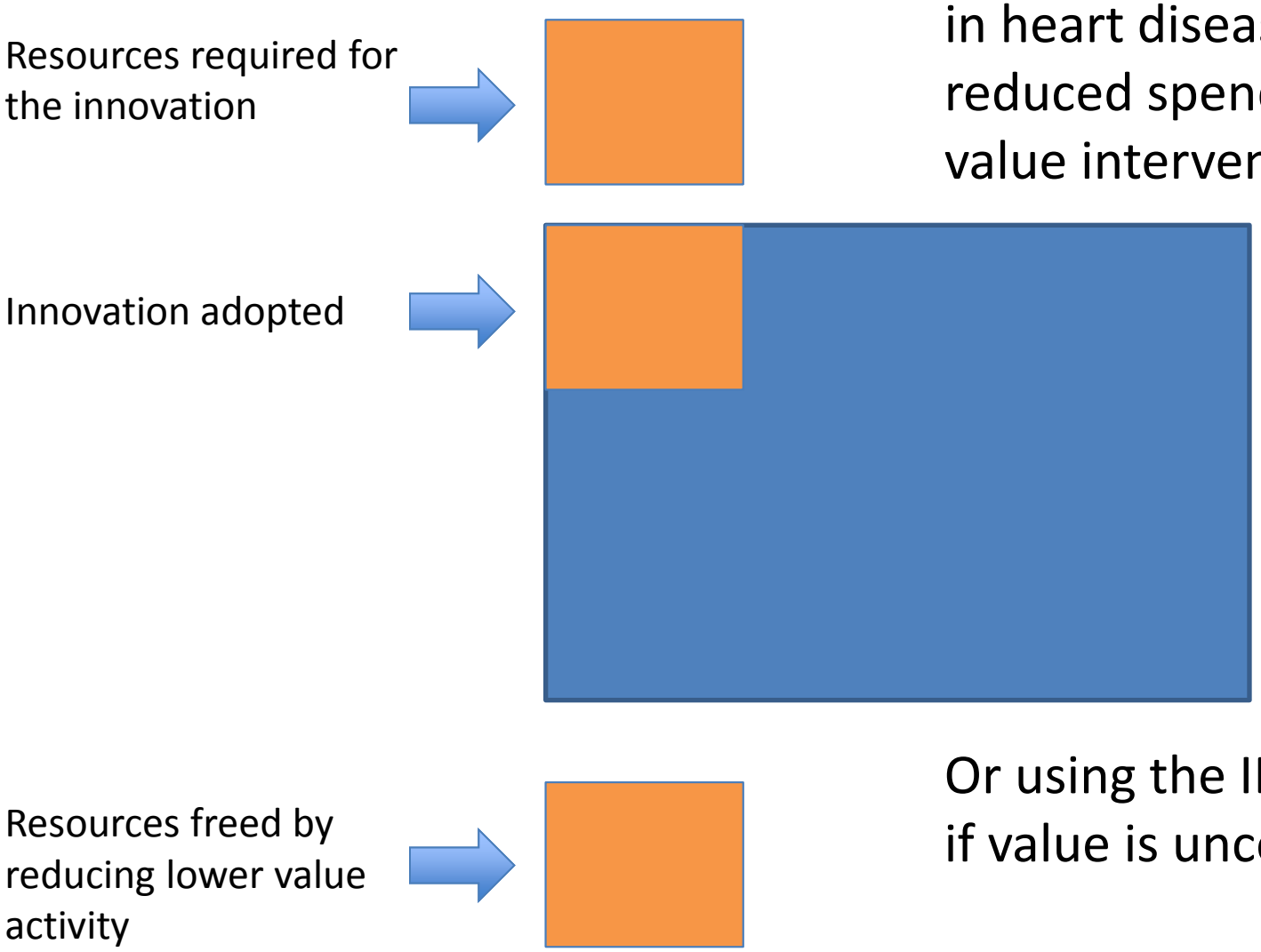
Oxford

3. Ensuring that those people in the population who will derive most from a service are in receipt of that service if necessary by reducing the number of people seen by that service directly



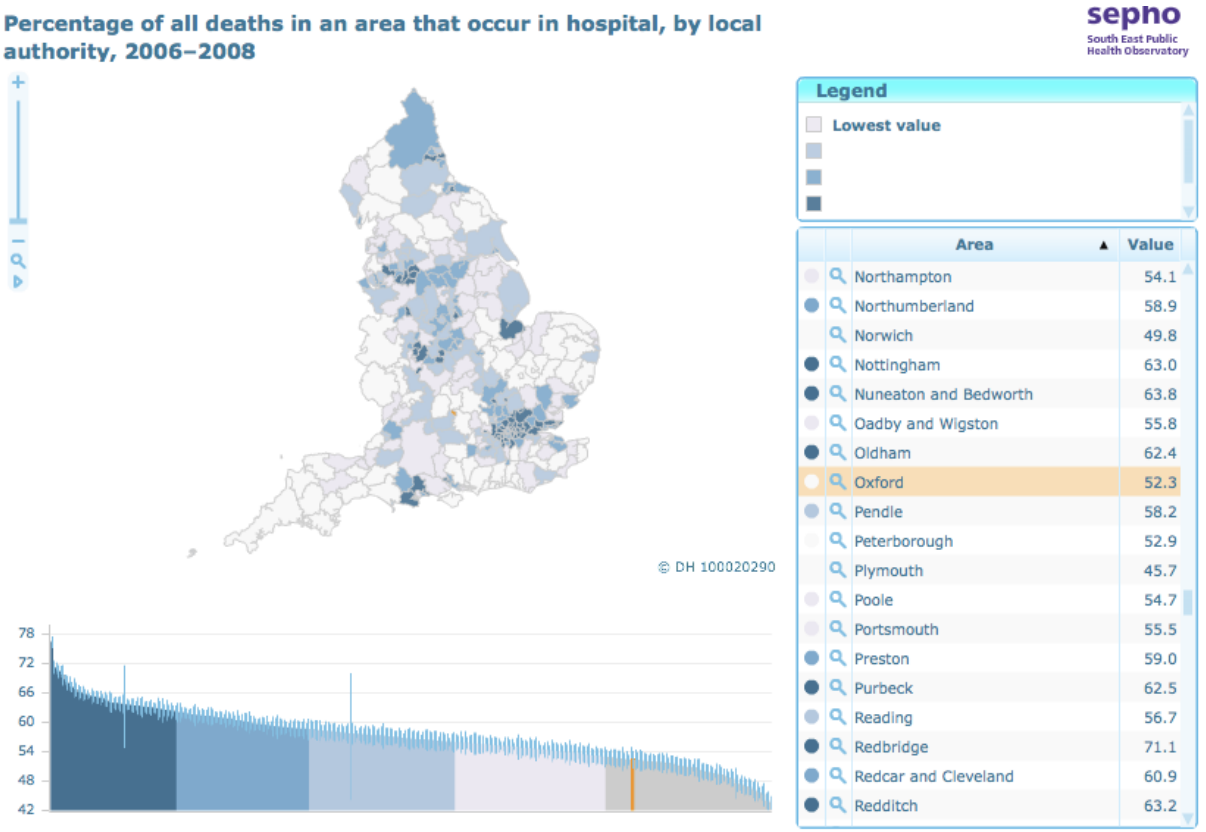
This requires clinicians including specialists to become population focused as well as delivering high quality care to referred patients and the surgical services initiative which is part of the Efficiency programme will develop this approach

4. Implementation of high value innovation eg troponin in heart disease funded by reduced spending on lower value intervention



Or using the IDEAL method if value is uncertain

5. Increasing rates of higher value intervention funded by reducing spending on lower value terminal care in hospital
eg helping a higher proportion of people in the population die well at home,



The Care Archipelago

GENERAL PRACTICE

MENTAL HEALTH

COMMUNITY HEALTH SERVICES

SOCIAL SERVICES

HOSPITAL SERVICES

The Commissioning Archipelago

GP/
Pharmacists/
optometrists

152
Local
Authorities

211 CCG's

Public
Health

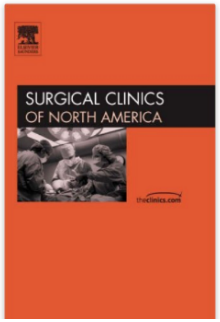
Specialist
commissioning

5. Population healthcare focuses primarily on delivering care to populations defined by a common need which may be a symptom such as breathlessness, a condition such as arthritis or a common characteristic such as frailty in old age, not on institutions , or specialties or technologies. Its aim is to maximise value for those populations and the individuals within them

and New Models of Care are evolving to meet the needs of populations and individuals

Population based and personalised surgery

phase 1 – the surgeon as operator
phase 2 –the surgeon as clinical scientist



Evidence-Based Surgery, An Issue of Surgical Clinics: 86 (The Clinics: Surgery) Hardcover – 26 Apr 2006
by Jonathan L. Meakins MD (Author), Muir Gray Kt CBE DSc MD (Author)
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Shared decision making is integral to future surgical care. It is not possible without the organization and applications of knowledge. Evidence-based surgical practice is inevitable as practice and outcomes become patient centered. This issue will offer articles on developing skills for evidence-based surgery,

phase 3 - the surgeon as manager
phase 4 – the population based surgeon

Responsibility	***Action***
Productivity	Doing things cheaply
Efficiency	Doing the right things right
Better value	Doing the right things
Sustainability	Doing things greenly
Equity	Doing things fairly
Population	Doing things to help all patients in the population, not just the referred patients.

5. Increasing rates of higher value intervention funded by reduced spending on lower value eg

HIGHER LEVELS OF

- district nurses
- identification and treatment of people with atrial fibrillation
- promotion of activity among people with long term conditions
- prevention of a second fracture in people with fragility fractures

LOWER LEVELS OF

- Polypharmacy
- Knee ligament arthroscopy
- Unnecessary hospital follow ups
- Non generic prescribing

WE NEED A NEW LANGIAGE

Ban old language

PrimarySecondaryAcuteCommunityManagerOutpatientHubandSpoke

Introduce new language

A **SYSTEM** is a set of activities with a common set of objectives and outcomes; and an annual report. Systems can focus on symptoms, conditions or subgroups of the population
(delivered as a service the configuration of which may vary from one population to another)

A **NETWORK** is a set of individuals and organisations that deliver the system's objectives
(a team is a set of individuals or departments within one organisation)

A **PATHWAY** is the route patients usually follow through the network

A **PROGRAMME** is a set of systems with ha common knowledge base and a common budget