



Rheumatology Project – Executive Summary

SW AHSN & JSL Consulting June 2016

Background

The management of patients with inflammatory rheumatoid conditions has improved dramatically over the past 12 years due to the development and use of biological drugs.

As more patients have access to these new medications we have seen a shift in the provision of healthcare services from an inpatient to a more ambulatory-based care model. At the same time, we have seen the use of biological treatments increase dramatically both nationally and locally.

Across Devon and Cornwall, in addition to seeing the biologic expenditure trajectory increase year on year by more than 15% to the point of being financially unsustainable, CCGs had identified different patterns in biologic use. Through the limited commissioning information available to the CCG's, there was a view that the growth was due to patients with rheumatoid arthritis, but this had never been validated. The increase in biologic spend has moved rheumatology into the spotlight from a high cost drug spend perspective, even though the commissioning of activity was a low priority.

In May 2015, the SW AHSN commissioned a review of rheumatology services provided by the 5 trusts in Devon and Cornwall. The main aims of the review were to get a better understanding of the:

- reason why biologic treatment expenditure continues to increase year on year
- considerable variation in the use of biologic therapies across Devon and Cornwall
- issues being faced by rheumatology services

together with

- looking at opportunities for system and process improvement, spread of best practice and innovation

Review findings

Whilst there is national best practice consensus and NICE guidance showing what good rheumatology services should look like, anecdotally there is not always a consensus approach to the commissioning (and as a consequence) the provision of the speciality across the UK.

The review findings support this anecdotal view, not only is there variation relating to biological usage, with a two-and-a-half-fold difference in some instances in trusts of similar size, but there is huge variability relating to access to services, resource utilisation, quality of care and patient outcomes. In addition, the review found that the increase in expenditure was not purely related to rheumatoid arthritis but to other conditions as such as ankylosing spondylitis and psoriatic arthritis.

The review identified that despite rheumatology being viewed as a low consumer of healthcare resources, and therefore has a low priority and profile with commissioners, the opposite is actually the case. Each year the Devon and Cornwall CCG's pay for:

- > 1,500 elective inpatient episodes at a cost of > £2 million
- > 39,000 outpatient attendances at a cost of > £5.6 million
- Approximately 2,500 patients to receive biologic treatments at a cost of >£18 million

In addition to high commissioning costs there are avoidable patient and quality costs within the system which have never been identified or prioritised. As a consequence of service pressures and year on year increased in demand on follow up capacity, we see:

- >5,000 patients with a booked appointment awaiting a follow up review who have not been seen within their clinical review window,
- >5,000 patients sitting on pending lists with NO appointment date for a review appointment.

The review found that there was direct correlation between rapid access to a rheumatology specialist, aggressive early treatment with Disease-Modifying Anti-Rheumatic Drugs (DMARDs), and the use of biologics.

The key issues contributing to this are as follows:

- consultant resources not meeting Royal College Guidelines
- poor quality of referrals by GPs and an inconsistent approach to triage
- none of the trusts are fully compliant with NICE quality standard 33 for rheumatoid arthritis
- long waiting times for initial specialist appointments for patients with early synovitis (range of 2- 10 weeks)
- acute providers' inability to rapidly and systematically review patients early on in their disease
- lack of specialist nurse and allied health professional resource

These issues are compounded by a lack of:

- a commissioning strategy for the speciality, despite the local CCG's spending more than £26 million per year
- robust commissioning intelligence relating to the speciality with a lack of triangulation of activity, cost and data – with no minimum data set in place between commissioners and providers
- a joined up approach between CCG performance and high cost drug teams - the review found a system where we contract for high cost drugs plus agreed levels of activity – rather than commissioning for outcomes

as a consequence of the above lack of robust commissioning intelligence we cannot measure what good looks like.

In addition to the direct patient care system weaknesses, the review identified system and process issues that have a direct bearing on commissioner expenditure and risk, these include:

- none of the trust are fully compliant with Hackett or Royal Pharmaceutical Society recommendations for Homecare services
- there is no 1 clinical management information system for the collection and analysis of service delivery metrics
- there is no 1 clinical management information system for the collection and analysis of patient reported outcome/experience measures (PROM's and PREMs')
- failures in the system relating to the recharge of pass through costs and management of patient access schemes

Whilst the review identified examples of best practice across the systems it also showed that we do not have one trust that can demonstrate achievement of best practice across the ENTIRE pathway.

Recommendations

- development of a Peninsular wide commissioning service strategy with service specification and KPI's
- assessment of current and future state based on the above strategy and specification
- development of single commissioning minimum data set
- establishment of a Peninsular referral triage system for all new GP referrals
- development of a Peninsular wide PROMS and PREMs framework
- development of common system for capture and coding of outpatient activity and outcomes
- provider self-assessment to Hackett and RCP recommendations, with agreed actions to ensure compliance
- improved financial controls be put in place across trusts relating to pass through costs and access schemes
- adoption of a single clinical management information system
- development of a common risk share strategy
- development of a common strategy for use of biosimilar biologics

Conclusion

In conclusion the review identified that there is a need to move from an activity and drug spend input led transactional contracting system to an outcome-based commissioning model which ensures consistent delivery and outcomes across the entire pathway of care.

If we are to see reductions in the cost of biological drugs across the Peninsular there needs to be a whole system approach adopted, which sees the shift in investment from avoidable biologic spend to more rapid, high quality, targeted specialist services. This shift would not be a like for like shift, but would be overall cash releasing, whilst improving patient outcomes and reducing clinical variation.

The review allowed for the very first time oversight of rheumatology services across the Peninsular. It identified that the use of biologic treatment has a link to service models and access to treatment, and showed that whilst there are examples of excellence, the consistent provision of high quality care and access to services is patchy across the Peninsular.