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An integrated MSK service for Mid-Nottinghamshire

Mid-Nottinghamshire
Integrated Care Partnership
Creating happier, healthier communities together

MSK Together – Our Perspective on Value

April 2021

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- Focus from institution to population
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- ✓ Increases in Healthy Life Expectancy of the population you serve
- ✓ Reductions in the gap in healthy life expectancy between groups in the population you serve (inequalities)

- ✓ Improvements in the quality of life of the people with a condition
- ✓ …others

- ✓ The resources you use in achieving these population and personal outcomes

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Come together as a MSK Together team of clinicians, managers and, importantly, patients, with a common aim of improving value (delivering the triple aim) and the desire and momentum to get on with it…

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What we, the clinicians, managers and patients that make MSK Together, ***want***…

- To be given greater authority and responsibility to be able to use resources for the benefit of people with MSK conditions in Mid-Nottinghamshire
- To be held accountable for the Triple Aim
  - Population health of people with MSK conditions
  - Patient outcomes of people with MSK conditions
  - How we are using the £28m allocated to us based on improvements and comparisons

What we, the clinicians, managers and patients that make MSK Together, ***need***…

- Agreement from our partners that this is the way forward- or if not, what is?
- To continue to work as a partnership to achieve the best outcomes for our population
- Visible and loud reaffirmation in the MSK Together programme including a commitment to:
  - Be part of leading the change
  - Working together with finance and contracts leads, find ways in which greater responsibility and authority for resource use can be moved to MSK Together over time, thinking as a system
  - Commitment to creating an integrated dashboard – resource requirements
  - Agreement over a new governance approach that supports accountability and moves from 'transactionalism'
  - Agreement on the value framework- this is how success will be measured (the first task of a strategic commissioner)
  - Needs-based allocation of resources (the second task of a strategic commissioner)

Planned next steps

Developing the specification for the dashboard

Use Socio-Technical Allocation of Resources process for our three conditions

Appendices

Other documents behind our work- please ask if you want copies of these

- Our Perspective on Value- full report
- High level summary of patient survey and semi-structured interviews
- Value Framework
- Value improvement ideas for testing (working paper)
- Consolidated NECS analysis

What the programme was set up to do

ICS, ICP and CCG leaders across Nottingham and Nottinghamshire wanted the MSK Together programme to act an exemplar and learning opportunity for the new way of working, namely to:

"take collective responsibility for managing resources, delivering NHS care, and improving the health of the population they serve"

By drawing on the previous work of MSK Together, the work of Prof Sir Muir Gray and the principles behind accountable care, could we find out how we could use the resources allocated to MSK in Mid-Nottinghamshire more wisely to increase healthy life expectancy and reduce the gap in healthy life expectancy?

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Our Perspective on Value- on a page

What we found

This report was produced by the collective efforts of MSK Together (clinicians, managers and patients) in order to generate discussions about how they might increase value.

MSK conditions are common and major contributors to a reduced healthy life expectancy.

Spending on MSK Conditions has fallen over recent years. In 2019/20 spending was in line with comparable areas. The biggest area of spend is on orthopaedic procedures (notably hip and knee replacements).

Since the introduction of the MSK Hub, hospital activity has fallen, notably for back procedures (including spinal injections, now designated of limited clinical value). Hip replacements have remained the same and there has been an increase in knee replacements. Imaging has increased.

After adjusting for age and sex there are wide variations between general practices for out and in patient activity and prescribing. General Practice deprivation is not a factor in this. This might represent under or over use and possible inequity of access.

Compared to people from least deprived areas, people from more deprived areas access hospital service c.20 years earlier; access hospital care and have back surgery at the same rate; and are less likely to have a hip or knee replacement.

Outcome measurement is wide spread but many different measures are used (making comparison difficult) and most are hard to access (or not reported on routinely). There is considerable variation in the ability of services to improve the quality of life (however measured). Patients report a sense of fragmentation and being left unsupported between service providers.

What we realised

The levels of shared decision making are much improved, but could be better.

Currently the NHS is not orientated toward the population of people with MSK Conditions. Data, contracts, financial flows, measures of success and the way we operate clinically is (mostly) institution based.

We do not have a way of determining how much we should spend on MSK conditions.

Although there are examples of working as integrated teams, that is often not the case, leaving patients stranded.

We are doing a lot of good outcome measurement. But do not always achieve the outcomes that people expect of us, possibly because we are not focussing on the whole person.

There is probable inequity in the provision of care that we were unaware of. That there appears to be a difference in care requirements for people from more and less deprived backgrounds which might contribute to differences in healthy life expectancy.

The causes of variation are complex and need to be understood and addressed through better support, especially to general practice.

What we want to do

Our aim is that *By working together, for the benefit of all people with MSK conditions, we will continually improve value by making best use of our allocated resources, equitably enhancing the quality of life through providing appropriate support for empowerment and self-care.*

Take forward the emerging ideas for value improvement so we can debate them, test them, refine them and in so doing, continuously improve value for the people we serve.

To be supported with good data that allows us to think and understand what is happening to people with MSK conditions in Mid-Nottinghamshire- in real-time and allowing us to compare over time and with others.

To focus on the outcomes we have agreed, and have these as the measure of our success.

To be given the authority to move resources from lower value to higher value interventions in order to optimise outcomes. Over time, as we demonstrate our ability to increase value for the population of people with MSK conditions that we serve, each individual within that population and the local community as a whole, to gain greater control of resources.

Who contributed to Our Perspective on Value report?

‘Our Perspectives on Value’ report represents the collaborative production of many people across Nottinghamshire

People with MSK Conditions who use our services

Nottingham and Nottinghamshire Clinical Commissioning Group

Nottinghamshire Healthcare NHS Foundation Trust

Sherwood Forest Hospitals NHS Foundation Trust

MSK together — An integrated MSK service for Mid-Nottinghamshire

pics — Primary Integrated Community Services Ltd

active notts

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Mid-Nottinghamshire Primary Care Networks

What we've achieved so far – MSK Together

- ✓We have developed a community of activated and interested clinicians, managers and patients, from across all MSK services, who want to improve value.
- ✓Ideas are flowing, there is momentum and energy.
- ✓There is scepticism…

Specifically our aim is

By working together, for the benefit of all people with MSK conditions, we will continually improve value by making best use of our allocated resources, equitably enhancing the quality of life through providing appropriate support for empowerment and self-care.

What we've achieved so far – the people we serve

We asked patients (and frontline service providers) what they think about the current service and the outcomes they want

They experience fragmented care and a sense of being abandoned.

They want to feel better, to have a better quality of life, less pain, be able to understand and manage their own condition and experience integrated care.

"You're left to fend for yourself … you don't know who to go to to ask questions."

"Week after week, it does get you down."

"Pain stops a multitude of other things from happening."

"I have been abandoned."

"Knowing helps me deal with it."

We have developed personal, population and social outcomes by which we want to be judged- Personal outcomes: living with MSK conditions

Outcome
To have as good a quality of life as possible which will include being independent, being able to work, socialise and enjoy leisure pursuits and to be able to participate in community and family life.
To reduce pain and its impact on my quality of life as much as possible through appropriate pain relief and management strategies.
To understand my condition, the cause, treatment options and long-term prospects so I can make informed decisions about my care.
To receive the support, advice, guidance and resources that I need to enable and empower me to manage my condition

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We have developed personal, population and social outcomes by which we want to be judged- Personal outcomes: care and support

Outcomes
To have my condition assessed, investigated and diagnosed in a timely and effective manner to restore me to health as early as possible.
To have flexible access to specialist MSK services so I can have my condition reviewed when I need it, to prevent deterioration and to deal with any changes.
To be listened to by health and care professionals and to have my concerns and wishes heard and respected so that care and treatment I receive is personalised to me.
To experience integrated care, so all those people and organisations providing me with MSK care appear to work together as one team

Note: experience of care should closely match CQC national patient surveys, although these are institutional focussing on areas of care

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We have developed personal, population and social outcomes by which we want to be judged - Population outcomes- contributing to ICS goal

Outcome
Maximising healthy life-expectancy and healthy ageing
Minimising inequity to reduce the gap in healthy life-expectancy
Using resources optimally
Conducting research to innovate and improve outcomes

We have developed personal, population and social outcomes by which we want to be judged - Social outcomes

Outcome
Ensuring that staff have a positive experience working in MSK Together and receive appropriate development

Other social outcomes will be defined by Nottingham and Nottingham shire ICS and Mid-Nottinghamshire ICP including:

- Environmental outcomes
- Economic outcomes
- Social outcomes

What we've achieved so far – how we use resources for the population with MSK conditions - 1

Hard to do because data is based on institutions, not populations- this is how the NHS thinks.

- MSK conditions are common and major contributors to a reduced healthy life expectancy.
- Spending on MSK Conditions have fallen over recent years. In 2019/20 spending is in line with comparable areas. The biggest area of spend is on orthopaedic procedures (notably hip and knee replacements).
- Since the introduction of the MSK Hub, hospital activity has fallen, notably for back procedures.
- Hip replacements have remained much the same and there has been an increase in knee replacements.

What we've achieved so far – how we use resources for the population with MSK conditions - 2

- Imaging has increased a lot.
- There are wide variations between general practices for out and in patient activity and prescribing.
- Compared to people from the least deprived areas, people from more deprived areas access hospital service ~20 years earlier and are less likely to have hip or knee surgery
- Outcome measurement is widespread but: It cannot be compared; Hard to access/ seldom shared; Variable ability to improve healthy life expectancy

What is this about?

- Finding a way for the MSK community to have greater responsibility and authority for using needs-based allocated resources
- Thinking in populations as a core approach including:
  - Tracking progress on the basis of the MSK population
  - Success being measured on outcomes for the whole population
- Moving from transactional relationships
  - Being held to account- not being ‘performance managed’
  - Learning and improving- not ‘standardising’

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We want to start by focussing on a few key conditions

- MSK is broad, we should start by focussing on a few key conditions such as:
  - Back pain- major burden of disease, huge activity, some great MDT work already so good to build on
  - Knee pain- huge area of spend, growing, good to test the idea of optimisation, relatively high number of people with worse quality of life
  - Fibromyalgia- complex condition, probably failing people now (un met need), need to find better ways of supporting people
- Over time more conditions will be addressed

For each condition we believe there are five areas where greater value may be tested

Starting with these key conditions test opportunities for:

- Providing effective services earlier in the progression of a condition
- Optimising the use of key procedures
- Optimising general practice MSK care
- Maximising self care
- Increasing equity