Healthcare Improvement Scotland

A triple crown for triple value

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Healthcare Improvement Scotland

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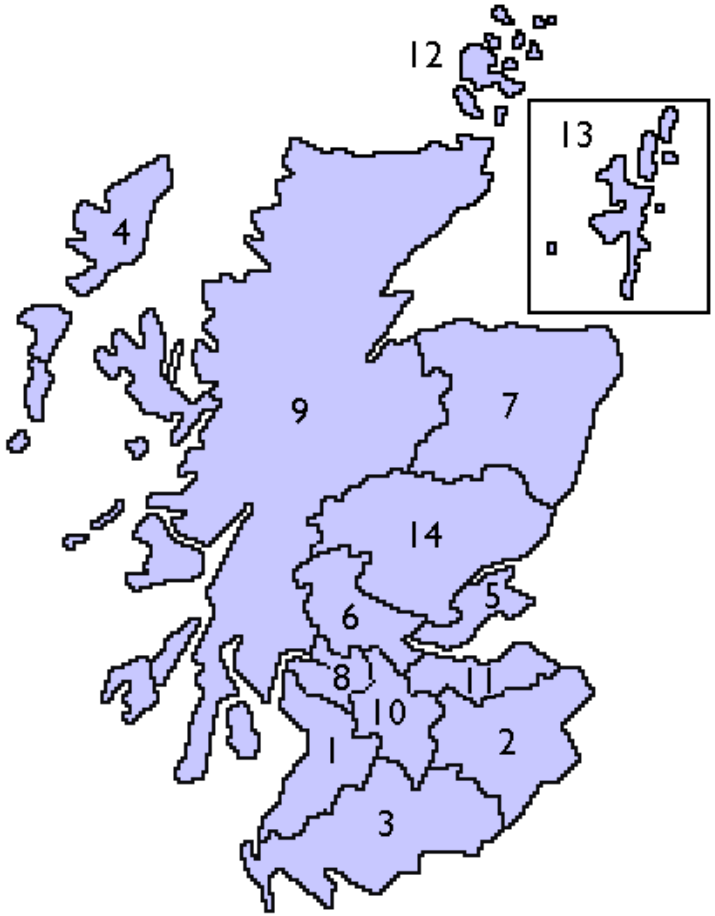
NHS Scotland- the same but different??

- Health matters devolved
- 14 NHS Boards and 7 Special Health Boards (for now....)
- Wide range of populations fro central Glasgow to remote and rural Highlands
- Population 5.2 million
- Size provides opportunities to work together
- Scottish Medicines Consortiun (2002)



Health and Social Care Integration

The Scottish Government
Riaghaltas na h-Alba

Supporting people to live well and independently at home or in a homely setting in their community for as long as possible

- www.scotland.gov.uk/HSCI
- follow us on twitter @scotgovIRC

There's no ward like home

Medicines- we've been busy!

- 2010- CEL Guidance on IPTRs
- 2012- Swainson Review SMC and ADTCs
- 2013- Health +Sport Enquiry into Access to Medicines
- 2013 SMC Task and Finish Group
- 2013 More guidance on IPTRs
- 2013 Rare Conditions Medicines Fund (RCMF)
- 2013-Peer approved clinical system (PACS) pilot
- 2014 New Medicines Fund replaces RCMF [illegible] PPRS rebate

- 2014- Change to SMC processes- introduction of Patient and Clinician Engagement (PACE)
- 2014- ADTC Collaborative formed
- 2015- Effective Prescribing Programme Board set up
- 2015- More Health and Sport enquiries
- 2016- CMO Realistic Medicine
- 2016- PACS adopted nationally
- 2016- Montgomery Review into effect of SMC changes
- Coming next...Single National Formulary, Scottish Model of Value and.....

What are we?

- Area Drug and Therapeutic Committee (ADTC) Collaborative
- Part of Medicines Team
- Developed in response to review of Access to new Medicines
- 14 ADTCs across Scotland

What is ADTC Collaborative doing?

Supporting the Effective Prescribing Programme

Introduction of biosimilars

Effective use of biologicals- patient pathway, 10 quality steps

Governance framework for multiagency working

Consensus statements reducing variation

Hepatitis C guidelines

Prostate Cancer use of gonaderelin analogues

DOACS Anticoagulants

Consistency across local ADTCs

Transparent decision making

Formulary decision template

Horizon scanning

Introduction of HEPMA

Early access to medicines scheme

Medicines Factsheet

- Launched June 2016
- Available electronically
- Patient journey starting at consultation
- Explains how healthcare professionals decide whether to prescribe a medicine and which to prescribe

...but actually applicable to all interventions

http://www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/adtc_resources/medicines_factsheet.aspx

- ✓ Potential to underpin conversations between patients and healthcare professionals
- ✓ Fulfils NHSScotland quality ambitions
- ✓ Educate the public on medicines risks and benefits
- ✓ Engage patients in shared decision-making

- ➢ **Higher quality care and better outcomes**

- ➢ **Reduced waste and harm, improved safety**

Montgomery review of access to new medicines 2016

http://www.gov.scot/Resource/0051/00511595.pdf

✓Access increased
✓Ultra orphan medicines need own system

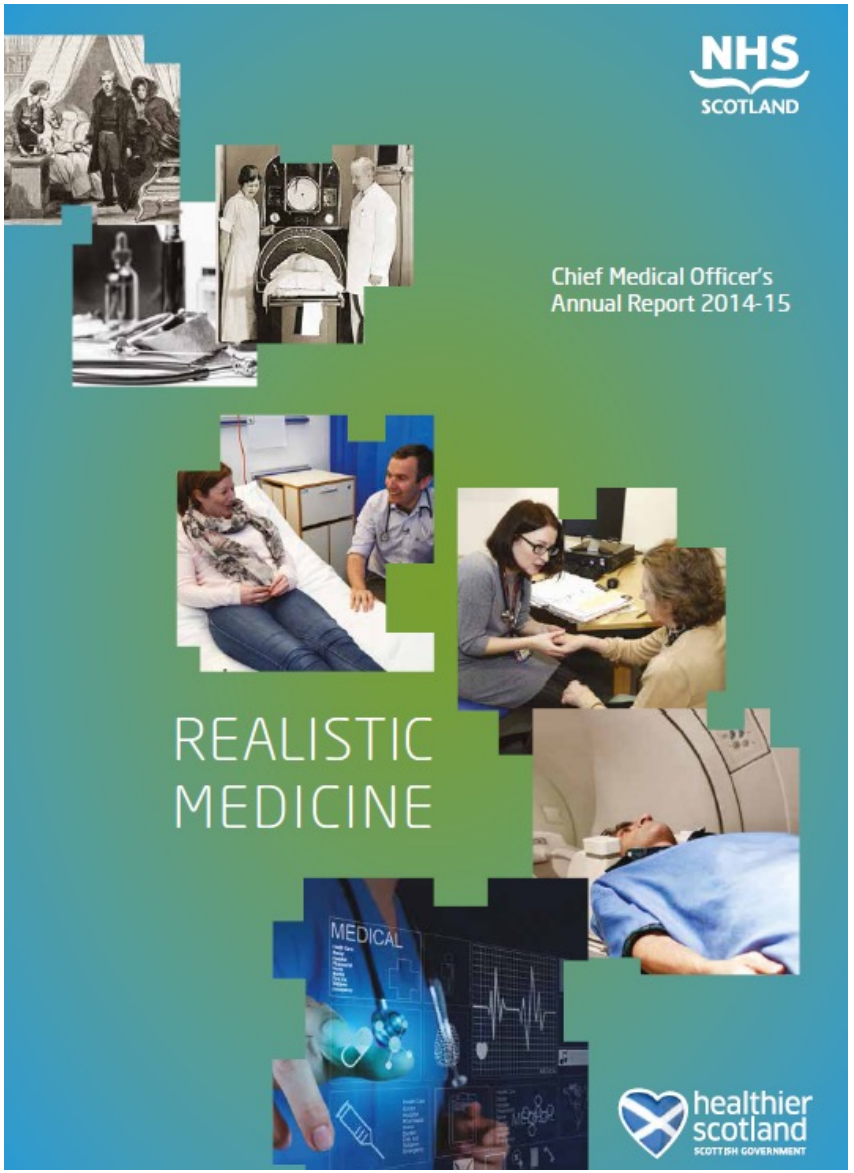
"The reforms I am announcing today will help more patients to get better access to treatments that can give them longer, better quality lives.

Challenges

- Must have a system capable of saying no
- How will NMF be sustained post 2018/19?
- Affordability
- Measurement of outcomes
- Patient reported outcomes
- Wider societal benefits
- Medicines not treated equitably
- Need to manage interface between pharma and NHSS

Chief Medical Officer's Annual Report (Jan 2016) How can we:

- further reduce the burden and harm that patients experience from over-investigation and overtreatment?
- reduce unwarranted variation in clinical practice to achieve optimal outcomes for patients?
- ensure value for public money and prevent waste?
- to share clinical decisions that focus on outcomes that matter to individuals?
- to improve further the patient doctor relationship?
- better identify and manage clinical risk?
- become innovators improving outcomes for people they provide care for?

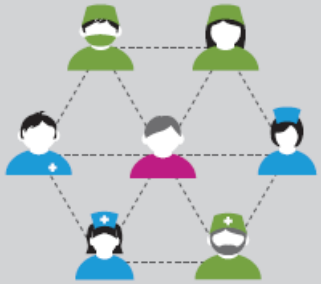


REALISTIC MEDICINE

CAN WE:

CHANGE OUR STYLE TO **SHARED DECISION-MAKING?**

BUILD A **PERSONALISED** APPROACH TO CARE?



REDUCE HARM AND WASTE?

REDUCE **UNNECESSARY VARIATION** IN PRACTICE AND OUTCOMES?

MANAGE RISK BETTER?

BECOME IMPROVERS AND INNOVATORS?

Patients' preferences matter
The Kings Fund

Patients who are fully informed choose less treatment and have less regret


Big
BENEFITS
Package


SAFETY
FIRST


RISK


Strengths
Weaknesses


Risks
Benefits

Patients' preferences matter.
The Kings Fund

Influenced by attitude to risk, litigation fear, peer pressure, incentives, industry promotion etc

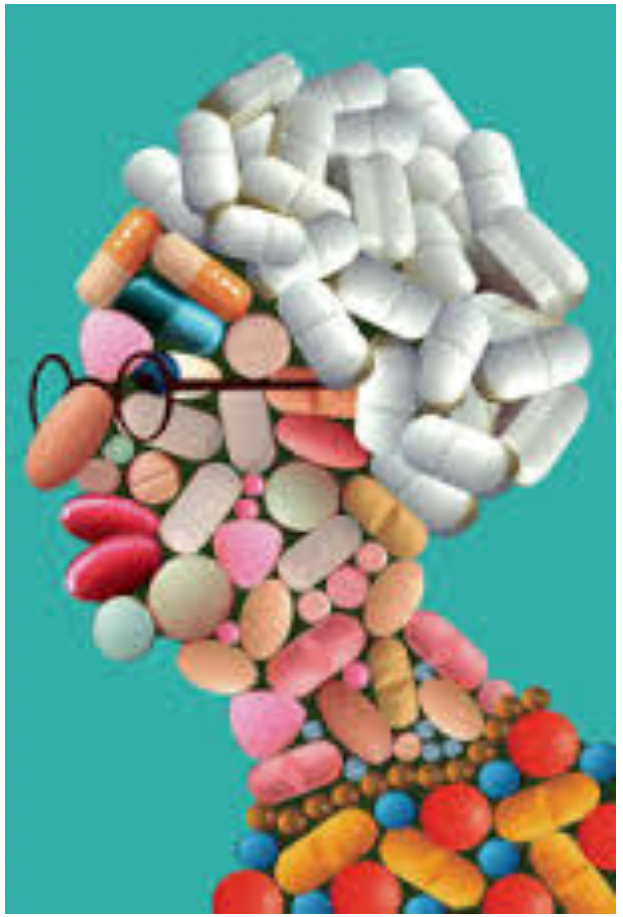
"...My little black book of lawyer's numbers."

Patients' preferences matter.
The Kings Fund.

Doctors generally chose less treatment for themselves than they suggest for patients.

NHS wastes over £2bn a year on unnecessary or expensive treatments

Leading medical body cites overtreatment and over diagnosis as key problems, along with patients who demand treatment now



thebmj

BMJ 2015;350:h1217 doi: 10.1136/bmj.h1217 (Published 5 March 2015)

EDITOR'S CHOICE

Too much medicine

Fiona Godlee *editor in chief, The BMJ*

Overdiagnosis means different things to different people, say S M Carter and colleagues in their exploration of the social and ethical dimensions of too much medicine (doi:10.1136/bmj.h869). Born out of the Preventing Overdiagnosis 2014 conference in Oxford, their article and others in this special collection (thebmj.com/specialties/digital-theme-issue-overdiagnosis) serve to presage the next conference in Washington, DC, in October 2015, for which registration is now open (www.preventingoverdiagnosis.net). There is much to discuss: how should we define overdiagnosis and its ugly siblings overtreatment, medicalisation, and disease mongering; what do we know of their causes; and what evidence based solutions are available, both general and specific? Above all, who gets to judge when care is inappropriate in any individual case? Pulling this theme issue together, Helen Macdonald and Elizabeth Loder conclude that decisions on what constitutes "just right" medicine are best made by individual patients in true collaboration with their doctors, armed as far as possible with relevant, reliable, and independent information about benefits and harms (doi:10.1136/bmj.h1163).

Therein lies the rub. How good is the available evidence base? When it comes to new drugs entering the market, not very, say Michael Köhler and colleagues (doi:10.1136/bmj.h796); but new legislation in Germany may help and should be adopted internationally, they add. Drug companies wanting to market their drugs in Germany must now provide a standardised dossier containing all available evidence of the drug's benefits, with special emphasis on outcomes relevant to patients and how the drug compares with existing competitors. Köhler and colleagues found that, in comparison with conventional sources of publicly available information about new drugs (such as journal articles and registry reports), the information in the dossier was far more complete and clinically relevant.

This sounds like progress, even if, as Peter Doshi and Tom Jefferson say in their linked editorial, it's odd that clinical study reports aren't included (doi:10.1136/bmj.h952). We know from the Tamiflu saga, on which Doshi and Jefferson worked, that these long and complex documents that drug companies submit to regulators provide invaluable information that should be in the public domain. Excluding them because content is "commercially confidential" seems out of date, they say, especially since the European Medicines Agency has pledged to release all clinical study reports in its possession.

Even so, Germany and its Institute for Quality and Efficiency in Health Care are setting an international standard for other countries to follow. The same might have been said of the UK's Quality and Outcomes Framework (QOF), the world's largest pay for performance scheme. As Grant Russell says in his editorial, this grand experiment has been closely watched around the world (doi:10.1136/bmj.h1051), but Evangelos Kontopantelis and colleagues have now provided what Russell believes to be the best evidence on its lack of effect in terms of population health (doi:10.1136/bmj.h904). They found no significant relation between practice performance and either all cause mortality or cause specific mortality. Social deprivation remained the main predictor of mortality.

Whether QOF's financial incentives to investigate and prescribe have also caused harm and waste from too much medicine is work for another day.

Cite this as: *BMJ* 2015;350:h1217

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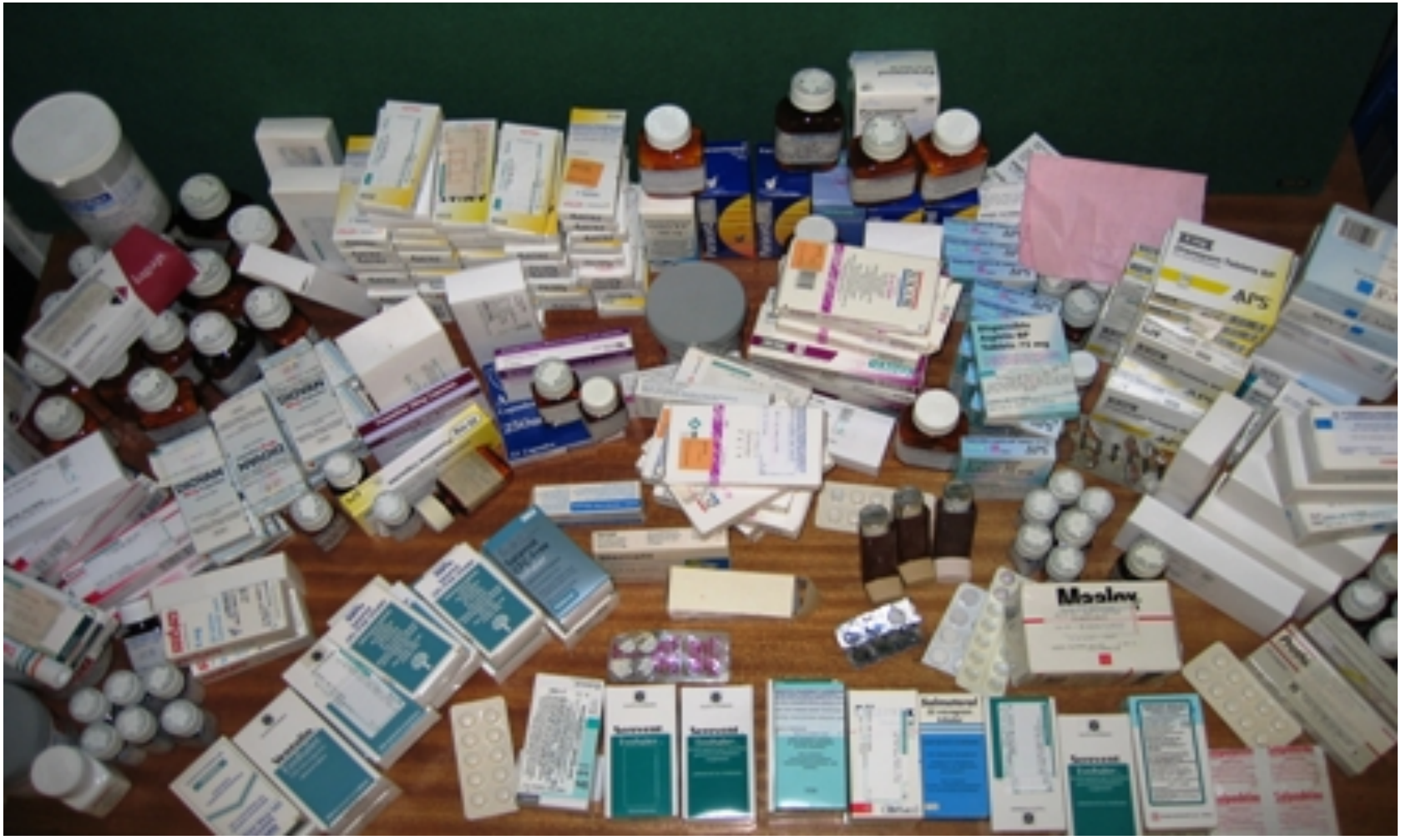
theguardian


APS
Maalox

YOU ARE AT THE CENTER OF YOUR CARE

Your team may include your doctor plus health coaches, social workers and other professionals based on what YOU need.

What matters to you?

Ask what matters... Listen to what matters... Do what matters...


WHAT MATTERS TO YOU
The Ann Fraser Atrium
Outpatient
Reception


WHAT MATTERS TO ME:-
E-ORE

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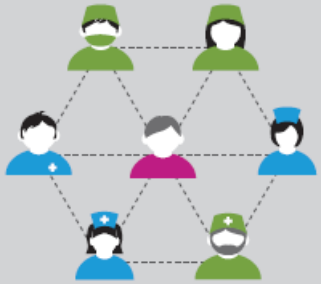


REDUCE HARM AND WASTE?

REDUCE **UNNECESSARY VARIATION** IN PRACTICE AND OUTCOMES?

MANAGE RISK BETTER?

BECOME IMPROVERS AND INNOVATORS?

- Will the focus continue to be on access?
- How can we move away from “postcode prescribing” to an understanding that variation may be acceptable
- Medicines are one treatment option for patients but not always appropriate
- A more open debate with the public about the opportunity costs and limited resources

Bitter Pill

Decisions on patient care are tough. The NHS must make them, not politicians

To govern is to choose and to choose is to disappoint. Earlier this year, Kezia Dugdale used her time at first minister's questions to highlight the case of Anne MacLean-Chang, a nurse from Elgin who has secondary breast cancer. Grampian health authorities had declined to sanction treating Mrs MacLean-Chang with Kadcyla, on the ground that doing so, at a cost of £90,000 a year, represented poor value for money. This, Ms Dugdale claimed, was a disgrace. What would the first minister do about it?

Ms Sturgeon told parliament that her government had not intervened — and indeed could not intervene — in Mrs MacLean-Chang's case. It would be "entirely wrong" to "have a system that is based on politicians deciding to intervene in individual cases", she said. The first minister accused her opponents of "politicising" the issue and ignoring the unavoidable truth that, in the matter of deciding which drugs should be available to

There were "multiple contacts" between officials, including the chief medical officer and the health authorities in Aberdeen. That allowed Ms Sturgeon to announce that the initial decision to deny Mrs MacLean-Chang treatment would be overturned after all, even though Kadcyla is not normally available on the NHS.

Gratifying as this will have been for the patient and her family, this kind of political interference undermines the integrity of the system by which clinical decisions are made. Not every patient can have their case raised in parliament; not every patient can have their case taken up by the first minister's officials. Addressing one apparent injustice — the denial of life-prolonging drugs — risks creating another by privileging one group of patients over another. Nor is it appropriate for the first minister to micromanage clinical decisions.

NHS spending decisions are not taken lightly

spent twice and every pound spent on one patient is no longer available to be spent on others. This may be regrettable; it is also unavoidable.

This pressure on NHS resources is hardly unique to Scotland, nor even to the other NHS systems across the United Kingdom. Healthcare costs are rising throughout the developed world as demand for ever-more innovative and effective healthcare continues to outpace the supply. This, like the problems caused by an ageing population, is a good problem to have but also one that is not easily solved. It is easy to lambast "heartless" health administrators but doing so hardly advances the wider national interest.

Mrs MacLean-Chang, like other patients with serious illnesses, cannot be blamed for seeking to publicise her case but Ms Sturgeon was right to insist that politicians should not intervene in individual cases. However, that public insistence upon due process appears to have been privately und

Patients missing out due to drug rationing

Continued from page 1

drugs are approved for NHS funding in Scotland is taken by the SMC, a panel of experts, and an equivalent body, the National Institute for Health and Care Excellence, in England. Both bodies make separate decisions.

Following the new shake-up, decisions about "ultra orphan medicines" — for conditions that affect very small numbers — will be taken out of the hands of the SMC. The review found only one out of seven medicines for treating the rarest health problems had been approved by it since the 2014 overhaul.

The report, launched during a visit to Maggie's Centre [illegible]

THE TIMES

Sturgeon's pressure on cancer drug is revealed

Gregor McNie Comment

As a cancer patient, being told the NHS doesn't fund a drug which could [illegible] you priceless [illegible]

about the need for more and better data — vital to understanding the true impact of these drugs for patients and, crucially, minimising harms.

Also, the local decisions on individual funding requests [illegible] drugs [illegible]

Treating the 'self-inflicted'

Restricting treatment for patients "self-inflicted" conditions is problems associated with drug smoking has been suggested review of access to drugs in Tefun Montgomery, who review, said several peop contributed felt that the should, otherwise differe said, included limiting vided for problems ca smoking and drug as It had been questio should be treating o seen as self inflicte A health authority shire has propose non-life-threate

less about "reindustrialis Scotland these days.

Be that as it may, it to be attacked from right and the Labo left. The impact to reinforce the

MASSIE

Sturgeon can't satisfy everyone for ever. Real choices must be made

News

Tuesday December 13 2016 | THE TIMES

Life-saving treatments barred on NHS must be handed out fairly, say patients

Helen Puttick
Scottish Health Correspondent

Patients, charities and doctors have called for transparency and consistency in the prescription of drugs not routinely available on the Scottish NHS.

Anne MacLean-Chang, a nurse from Elgin, will receive Kadcyla, a breast cancer drug, on the NHS, after her story appeared in the media. She had initially been denied the drug and it is not usually prescribed in Scotland.

Lesley Stephen, another patient, did not speak out when she was refused the drug and had to pay for it herself.

Mrs Stephen said she felt angry that women had to go to the press to get the treatment.

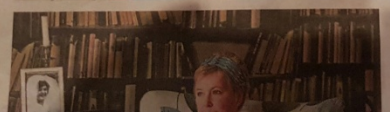
"I was not angry with other women because they did what they had to do, but I felt very angry that I had been refused because I had not gone public," she said.

As well as fighting to try and stay alive, I was fighting the health board, writing to the chief executive of NHS Grampian, trying to get more time with my family, and going to the press was a last resort. So much. You should not have to live your life on show like that."

She said that she knew other women had been refused Kadcyla despite their clinician recommending it, including one who is considering paying for the treatment herself.

"The system absolutely needs to be more transparent from a patient's point of view. It feels like all the decisions are made behind closed doors."

Drugs are assessed for use on the NHS by the Scottish Medicines Consortium. Doctors can seek exceptions that are rejected using individual [illegible]



Anne MacLean-Chang, above with Winston, her husband, and children, Nathan and Oliver, will receive Kadcyla on the NHS. Lesley Stephen, left, paid for the drug because she was denied it

Continued from page 1

treatment request decision relating to the provision of Kadcyla for this patient [Mrs Maclean-Chang].

"He spoke with panel members and the patient's treating clinician to understand the context and circumstances. Having considered the unusual circumstances of this case the medical director sanctioned the use of Kadcyla in this particular case."

Emails show, however, that the statement appears to have been edited to omit references to the original decision of the IPTR panel to refuse Mrs Maclean-Chang, after following correct procedures.

A position statement from the medical director to the board says Kadcyla was refused "as there were a number of alternative treatments available for the patient's condition".

The press statement also omits a phrase used in one version that makes clear that the drug was not being granted on "compassionate" grounds as opposed to clinical grounds.

In addition, the decision to overturn the original ruling was questioned internally the day after Ms Stephen's announcement by an unnamed senior member in an email to Laura Wilson, NHS Grampian's director of corporate communications and the board secretary.

It read: "From my viewpoint, and as much, perhaps more, aware and cognisant of the potential impact of political intervention in the decision taken within the confines of national parameters, actual and clinical decision.

"What happens to the next person who write to the press, how accountable [illegible]

You always have a choice, never say you don't have a choice, you do as long as you are willing to accept the consequences

Keith Grint


Our most significant opportunities will be found in times of greatest challenge
Thomas S. Monson
LDS women

Thank you

Happy to chat further.

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