

Equity and excellence

A NEW ERA OF PARTNERSHIPS??

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The Perfect Storm?



The Politics



The Government intend to:-

- Increase the current offer of **choice of any provider** significantly, and will explore with professional and patient groups how we can make rapid progress towards this goal;
- Create a presumption that all patients will have choice and control over their care and treatment, and **choice of any willing provider** wherever relevant (it will not be appropriate for all services – for example, emergency ambulance admissions to A&E);
- Introduce **choice of named consultant-led team** for elective care by April 2011 where clinically appropriate. We will look at ways of ensuring that Choose and Book usage is maximised, and we intend to amend the appropriate standard acute contract to ensure that providers list named consultants on Choose and Book;
- **Extend maternity choice** and help make safe, informed choices throughout pregnancy and in childbirth a reality – recognising that not all choices will be appropriate or safe for all women – by developing new provider networks. Pregnancy offers a unique opportunity to engage women from all sections of society, with the right support through pregnancy and at the start of life being vital for improving life chances and tackling cycles of disadvantage;

And.....

- Begin to introduce choice of treatment and provider in some **mental health services** from April 2011, and extend this wherever practicable;
- Introduce **choice in care for long-term conditions** as part of personalised care planning. In **end-of-life care**, we will move towards a national choice offer to support people's preferences about how to have a good death, and we will work with providers, including hospices, to ensure that people have the support they need;
- Give patients more information on **research studies** that are relevant to them, and more scope to join in if they wish;
- Give every patient a clear **right to choose to register with any GP practice** they want with an open list, without being restricted by where they live. People should be able to expect that they can change their GP quickly and straightforwardly if and when it is right for them, but

What's really going on here?

Sort out Public Health

**Make
commissioning
work**

**Open up NHS
to full market
competition**

**Handle the
cash situation**

**Give patients
more say**

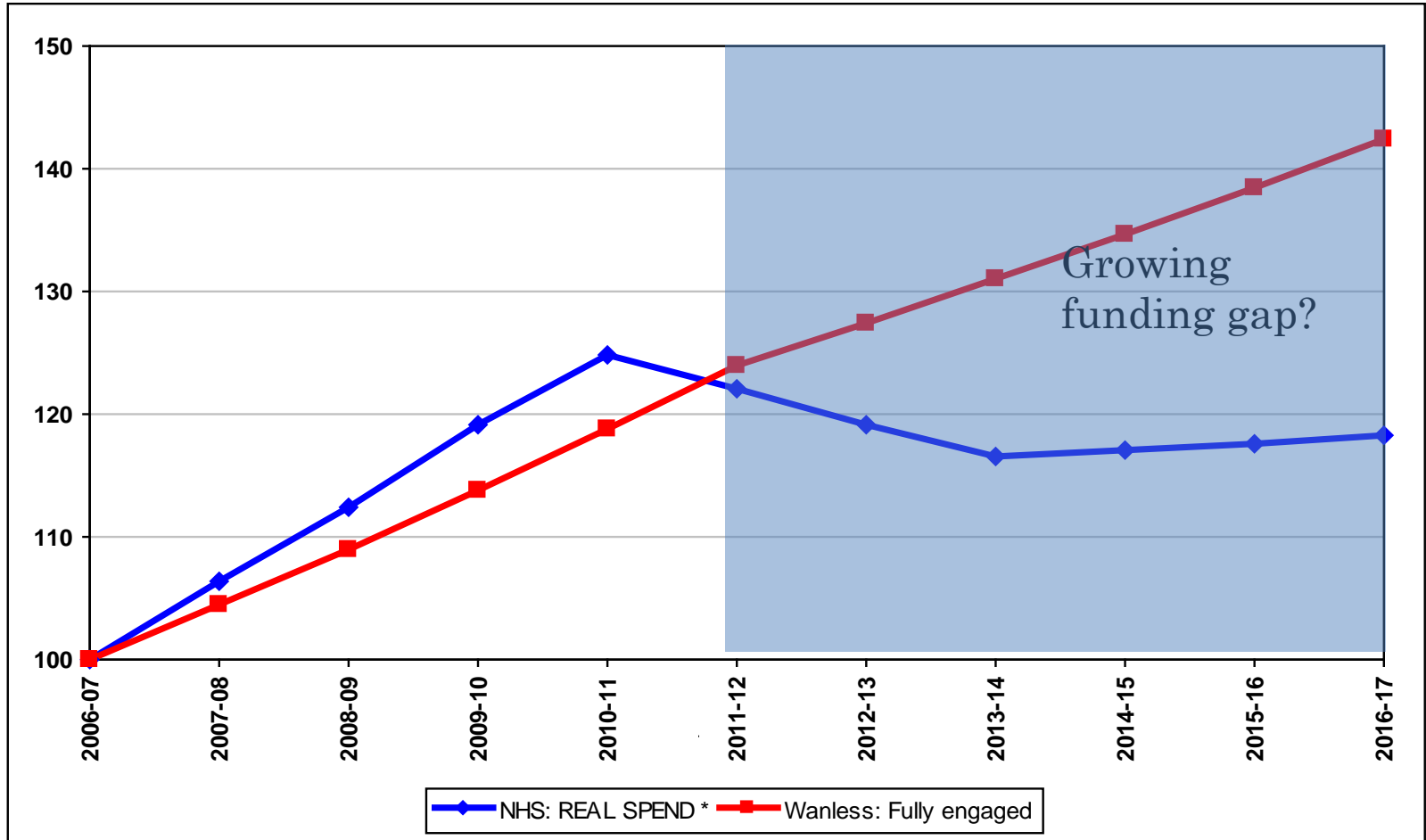
**Remove hiding
places**

***The financial
background...***



NHS Funding v Fully Engaged

INDEX 2006/7 = 100

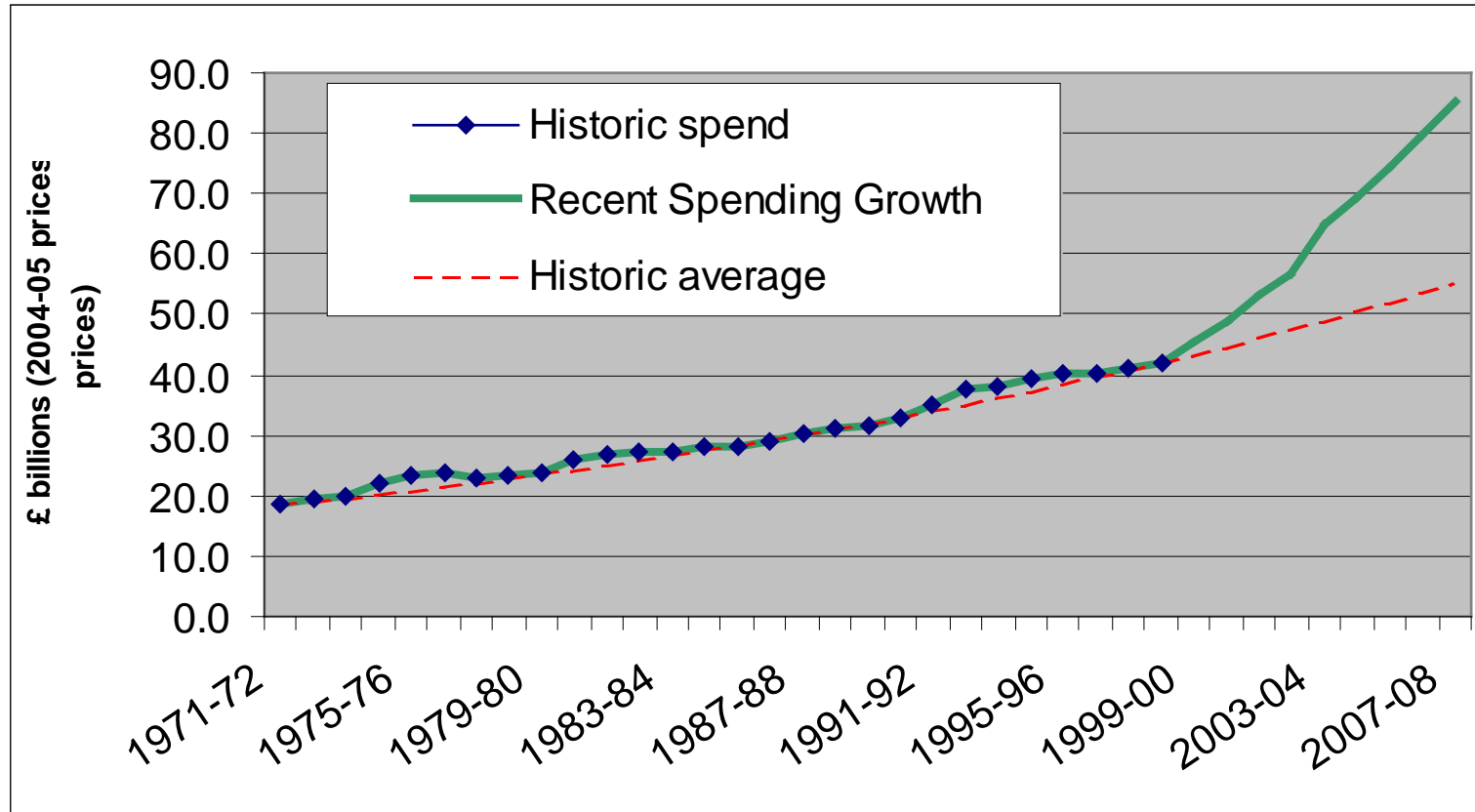


* NHS real spend based on IFS projections

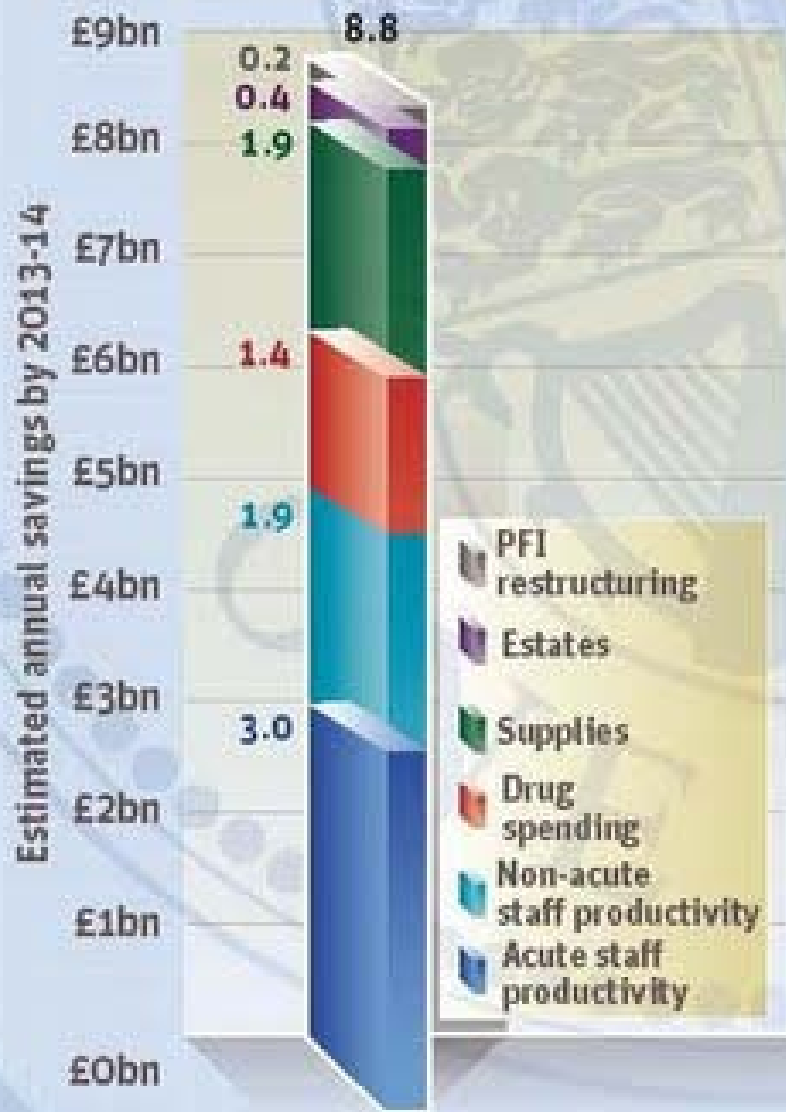
IFS 2009

Financial climate

(Health spending rates since 1971) Source HM Treasury



Maximum potential savings

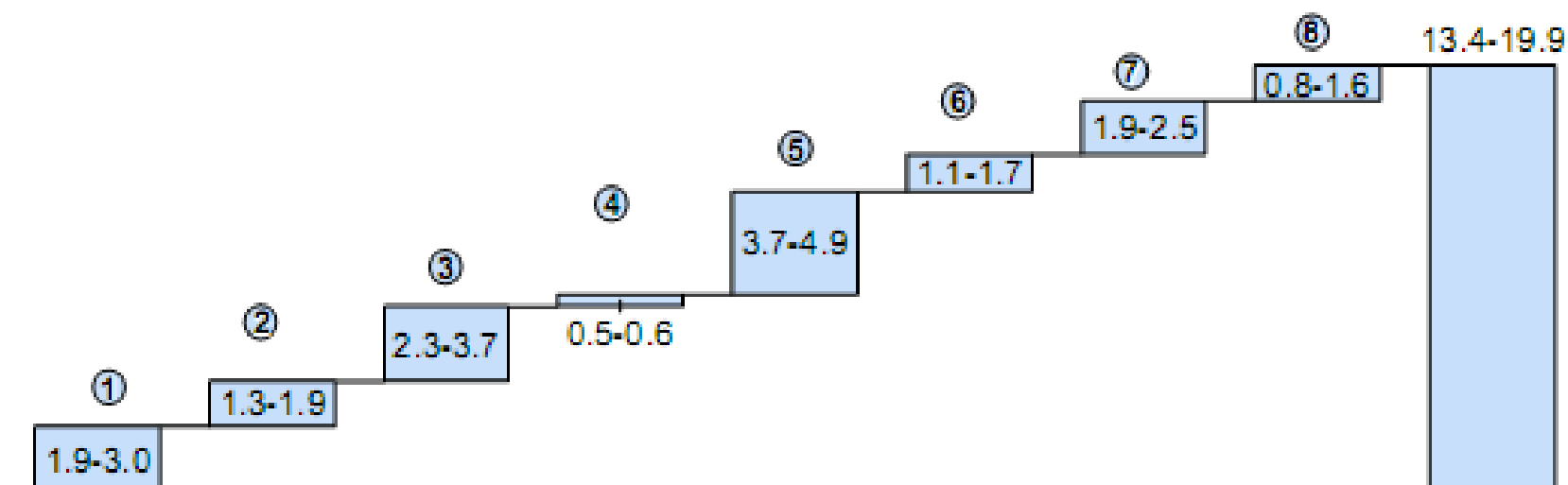


Breakdown of the potential through the implementation of the identified opportunities

ESTIMATE

£bn. 2013/14 recurrent potential savings. England

○ Programme number



Programme

Drive acute providers' productivity
 Driving non-acute providers' productivity
 Supply Chain/procurement
 Estates optimisation
 Optimising spend within care pathways
 Enforcing PCTs contracts/standards
 Enhancing self care and chronic diseases mgmt
 Local health economy reconfigurations
 Total potential

Current spend
 £bn

22 15 29 5 63 56 19 24 92

% reduction
 vs. 2008/09
 spend

9-14% 8-12% 8-13% 11-14% 6-8% 2-3% 10-13% 4-7% 15-22%

How to balance the books?

“Doing the Right things right”



Stop doing
things



Different
Place



Increase
Efficiency



Different
Provider



Decrease
Dependency

GPs Move Centre Stage

- Instead of a separate Commissioning body like a PCT the Government intend that groups of General Practitioners will form consortia and take on collectively many of the responsibilities. It is argued that General Practitioners have a good and detailed understanding of the health of local communities and would be best placed to commission services based on their needs. As many as 500 consortia could potentially be created. These bodies would be accountable to an independent NHS Board who would be responsible for ensuring consistent performance and that the new arrangements were fit for purpose.

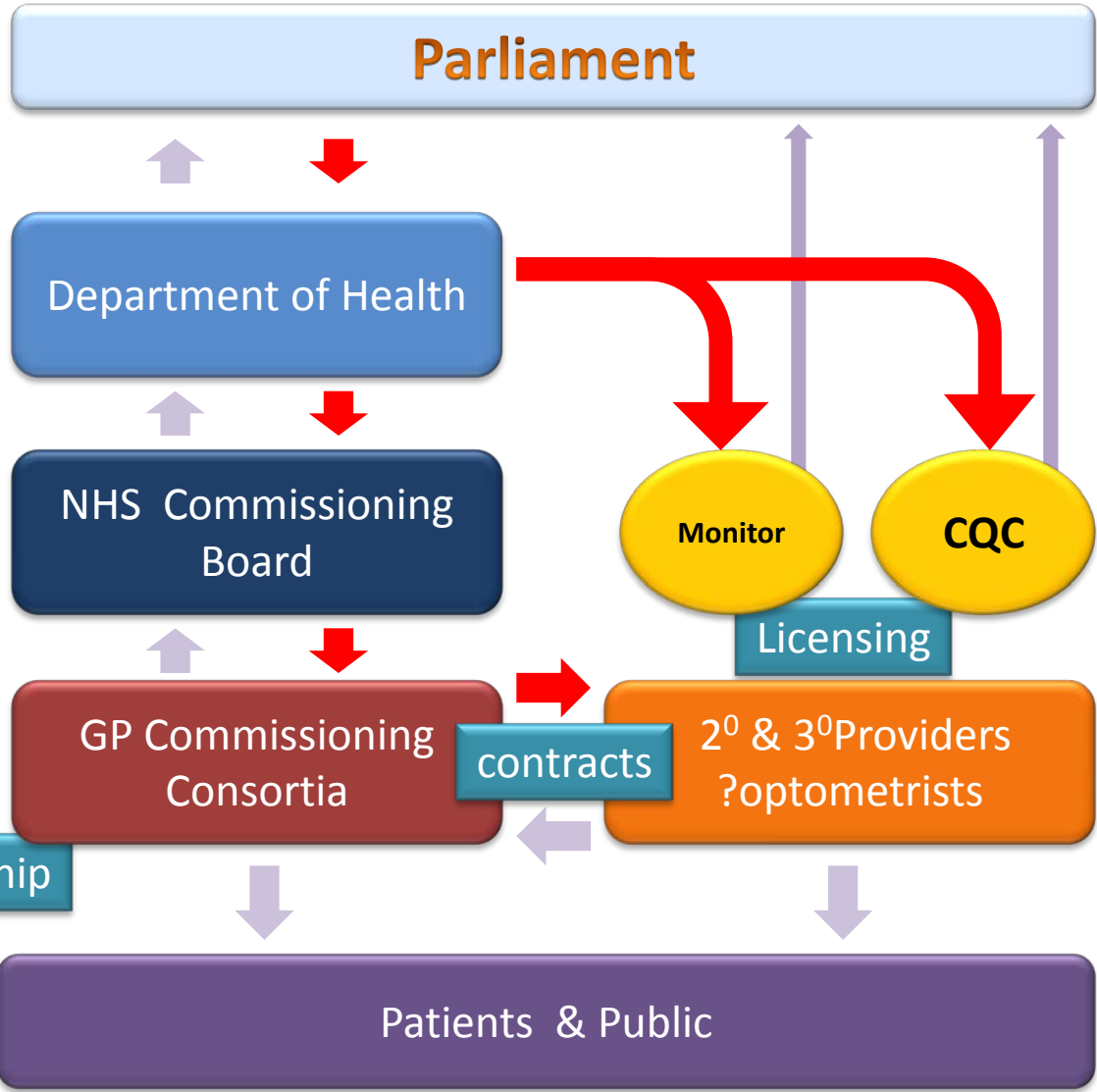
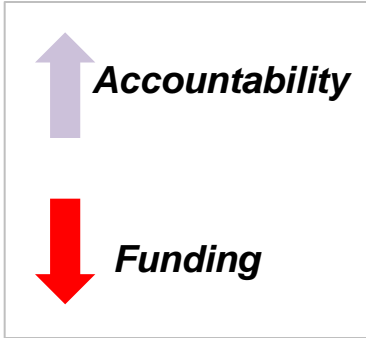


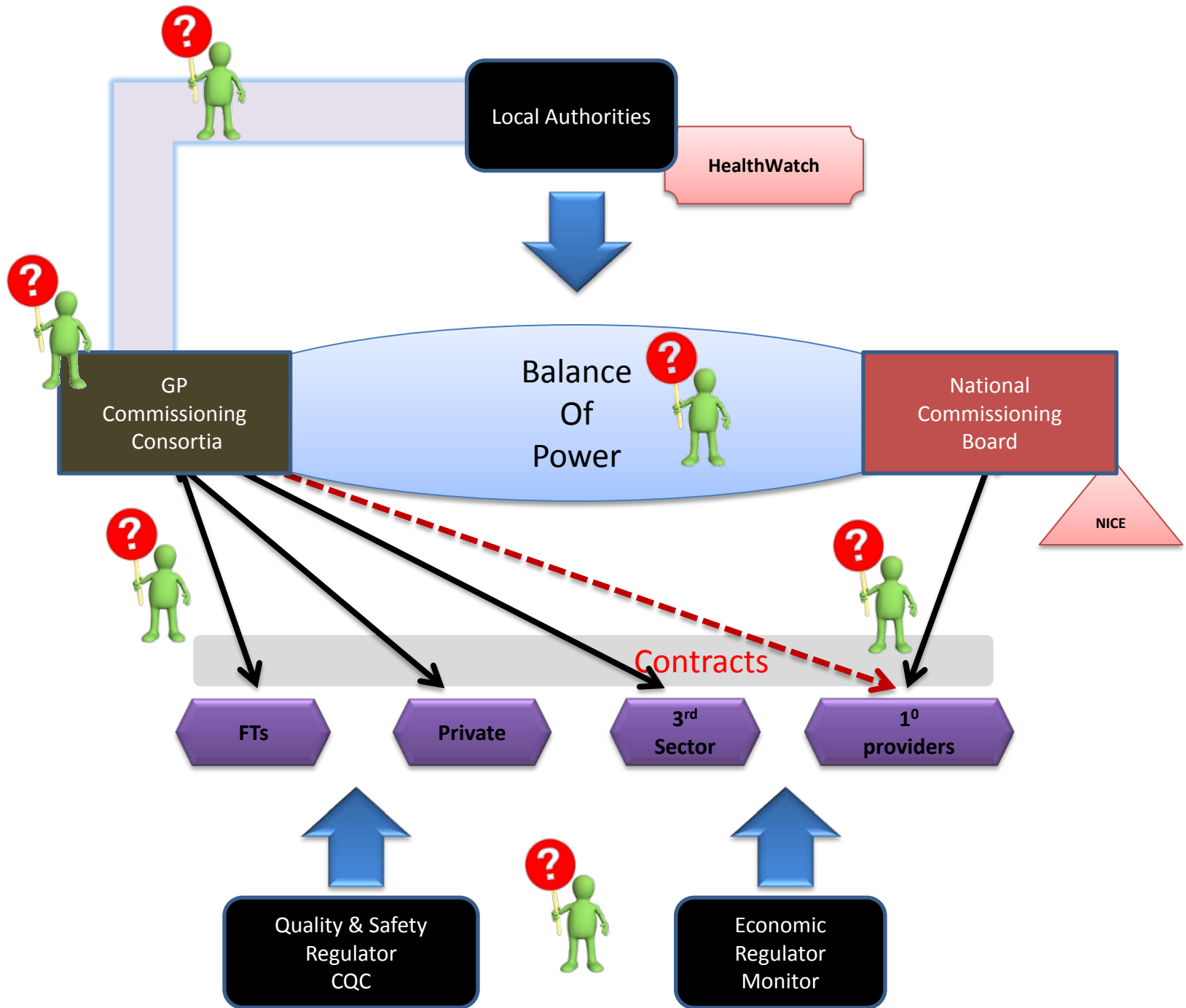
When will this happen?

- **In 2010/11:** GP consortia to begin to come together in shadow form (building on practice based commissioning consortia, where they wish).
- **In 2011/12:** a comprehensive system of shadow GP consortia in place and the NHS Commissioning Board to be established in shadow form.
- **In 2012/13:** formal establishment of GP consortia, together with indicative allocations and responsibility to prepare commissioning plans, and the NHS Commissioning Board to be established as an independent statutory body.
- **In 2013/14:** GP consortia to be fully operational, with real budgets and holding contracts with providers.

Providers

- All NHS Provider Trusts to become Foundation Trusts
- Strong pressure to use social enterprise models
- Any Qualified Provider concept...
- Regulation requires two part licence...





Back to Basics: Business Fundamentals

**Weighted
Capitation**

= Medical Costs

+

**Management
Costs**

Units x Unit Price

Direct + Shared

**Population Health
Management**
(Access, Safety, Quality)

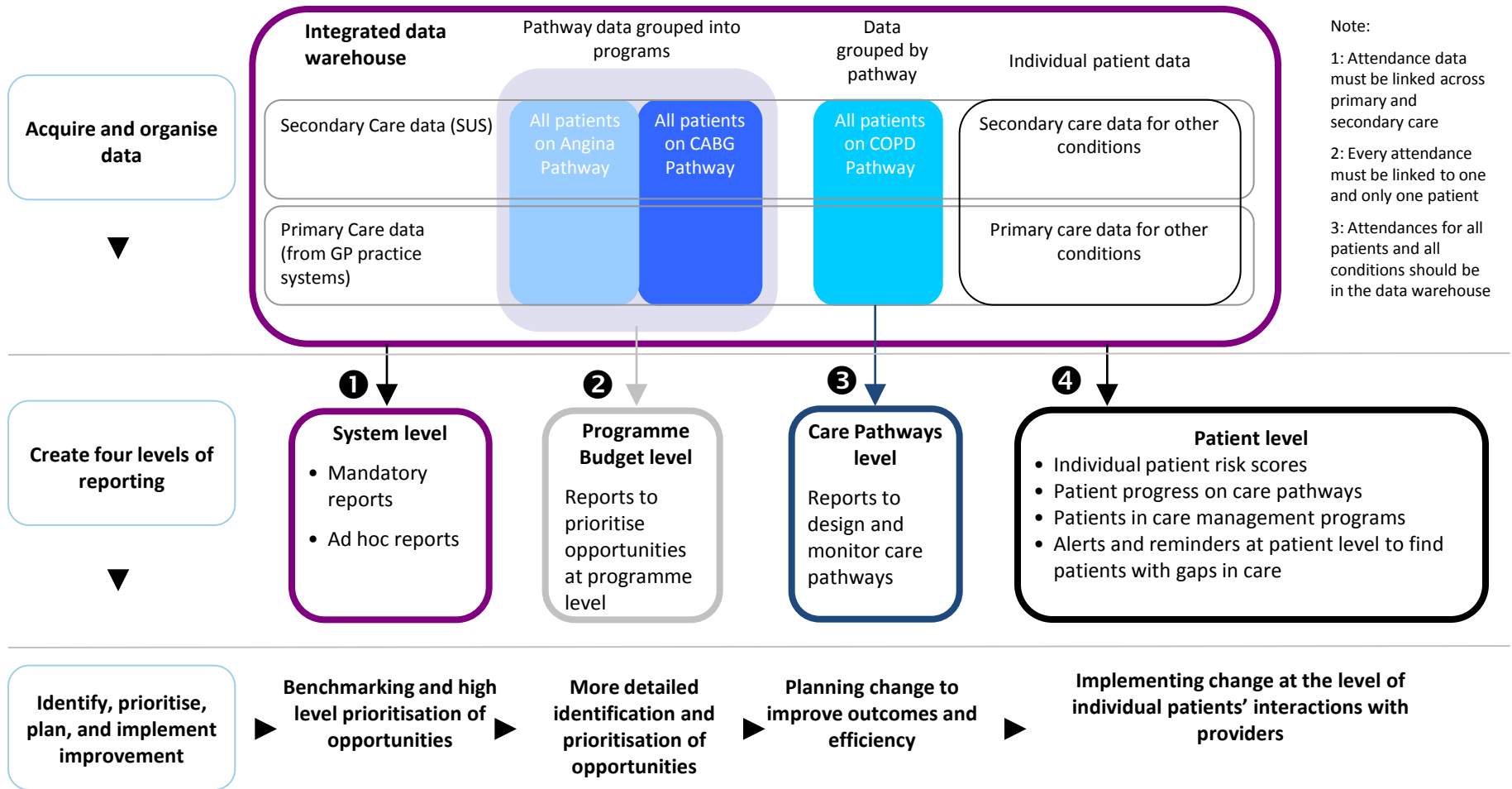
Demand Management
(Clinical Excellence, Engagement,
Utilisation / variation management)

**Value for
Money**
(Contracting at
Scale, Pay for
Quality)

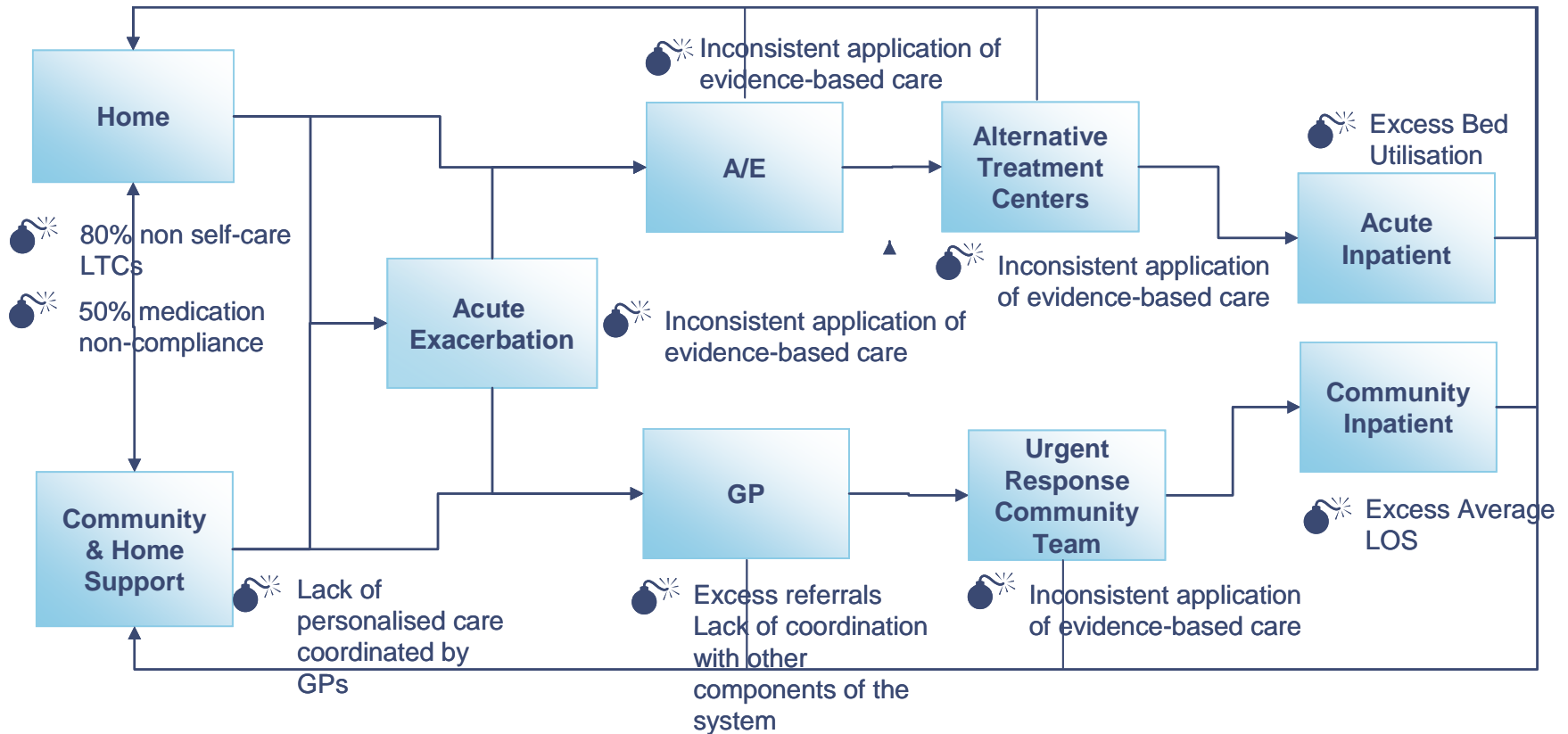
Core Competencies
(Strategy, Contracts
Management,
Stakeholder
Engagement / Relationships
Management)

**Back Office
Support** (Informatics,
Management Reporting,
Payments Management, IT
including decision support
capabilities, Finance, HR)

Critical Enablers: The Power of Information



Back to Basics: Targeting Opportunities



From Performance Targets to Outcomes

- **The Coalition Government's NHS reforms outline plans to move to outcome targets and relax 'process' targets such as the 18-week wait target for planned care and the 48-hour GP access target.**
- **However, the four-hour A&E target will continue to be performance-managed, although the target will be revised to 95 per cent of all patients being seen within four hours rather than the current target of 98 per cent.**
- **It is intended that greater public reporting of outcomes will result in patients choosing better providers, and pressure from commissioners through contracting will provide the stimulus for providers (mainly hospitals) to keep waiting times down.**
- **NICE will have greater role in setting evidence based care pathways, standards and treatments**

What does it mean for you

- Diverse plural market..AQP
- OPTOMETERISTS fit the bill
- Patient voice /choice..drive this choice
- On the high street with presence
- Money tight..so new solutions sought
- Outcomes driven ..can you find the outcomes ?
- Can you be flexible and nimble ?
- Influence with NICE and others will be important
- Engagement with CCGs important locally
- Engage with health and wellbeing boards ..you have a presence

Take Home Messages

First mover advantage is key

Impacting quality and cost requires a new era of private / public partnerships..INCLUDING other providers

Working with commisioners to get them ready to receive innovation

System wide, with AQP

Go back to basics and focus on critical enablers

