

Health and Care Conference
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Health and Care Conference The state of the NHS

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The state of the NHS

- The Perfect Storm
 - Financial backdrop – safe £15-20bn
 - Management Cost Reduction – 40% plus
 - GP Commissioning – 60-80% of the budget
- Context
 - Demographics
 - Rising cost of care – technology and interventions
 - Rising expectations

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Current policy context

- Devolve commissioning 'power' to GPs
- Reduce management costs
- Devolve public health responsibility to local government
- Ensure choice and competition are sustained
- Non FTs to become Foundation Trusts by 2014
- Need for much greater efficiency
- Transformational change and 'reconfiguration' inevitable

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making financial sense of the future

The International Context

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European press paints a gloomy picture



Are we facing a healthcare crisis?

- The past twelve months have seen tales of spiralling healthcare costs and drastic reform
- Countries like Germany, France and the Netherlands - that were being held up as examples of efficiency and success as recently as 2008 - are now reporting billion euro healthcare deficits
- The risk is that we confuse austerity measures with health system failures - the UK is no exception
- The investment in the NHS over the past decade has seen significant successes
- When, in 2000 Blair pledged to increase health spend to bring in line with rest of Europe economists predicted he would fail
- Spend increased from 7% of GDP to 8.4% between 2000 and 2007 – just 0.4% behind the average
- But the average for Europe has risen to 11% so once again we are playing catch up

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How the UK measures up – Commonwealth Fund study



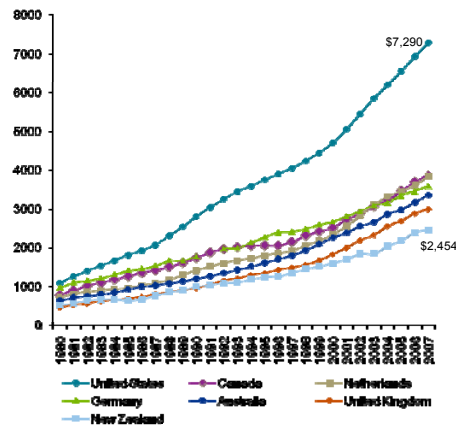
	Australia	Canada	Germany	Netherlands	New Zealand	UK	USA
Overall ranking (2010)	3	6	4	1	5	2	7
Quality care	4	7	5	2	1	3	6
Effective care	2	7	6	3	5	1	4
Safe care	6	5	3	1	4	2	7
Coordinated care	4	5	7	2	1	3	6
Patient-centered care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-related problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, healthy, productive lives	1	2	3	4	5	6	7
Health expenditures/capita, 2007	\$3,357	\$3,895	\$3,588	\$3,837 ^(a)	\$2,454	\$2,992	\$7,290

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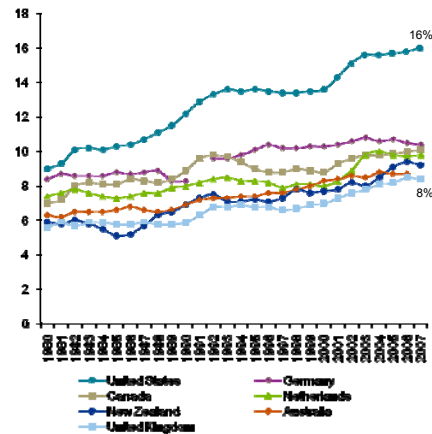
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Comparison of spending on health 1980-2007

Average spending on health per capita (\$ PPP)



Total expenditures on health as percent of GDP



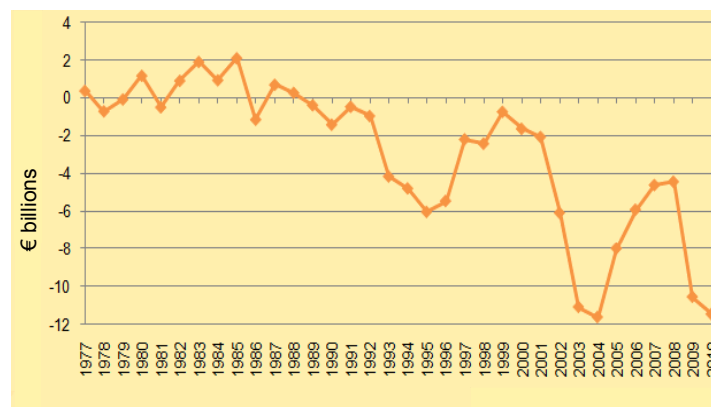
Note: (a) SPPP = purchasing power parity.
Source: Organization for Economic Cooperation and Development, OECD health data, 2009 (Paris: OECD, November 2009).

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We have also focused on containing spending

It is not only by these standards that we perform well. Perception can be misleading – one of the countries long held up as an example of efficient and effective healthcare has been running a deficit for many years.



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But other countries are still achieving more

Singapore gives us even more to think about if we look at the statistics:

	Singapore	France	Netherlands	UK	US
Healthcare spend % GDP ⁽⁷⁾	3.7	11.2	9.9	8.7	10.0
Infant mortality per 100,000 – age 0-1	2	3	4	5	6
Adult mortality per 100,000 – age 15-60	64	89	68	79	108
Life expectancy at 60 years	23.1	24.5	22.8	22.5	22.6
Cancer mortality per 100,000 – all ages	113	154	155	147	133
Cardiovascular mortality per 100,000 – all ages	164	123	154	175	179
Nurses per 10,000	44	80.9	151.5	114.7	98.2
Physicians per 10,000	15	33.7	39.3	24.8	24.3

Source: Organisation for Economic Co-operation and Development, OECD Health Data 2010, all other data were health system indicators.

- approximately one third of all health spending in Singapore is paid directly by individuals;
- savings for retirement and healthcare are mandated by government;
- the political environment cannot be ignored when drawing comparisons.

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Characteristics of healthy systems

- The Commonwealth Fund study highlighted the following characteristics of successful healthcare systems:
 - effective information technology to identify, monitor and share patient data;
 - use of quality improvement measures;
 - promotion of and coordination with primary care;
 - universal health insurance or state funded systems;
 - financial balance.

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What international experience tells us

Sweden in the 1990s: Public debt hit 80% of GDP

- Top down reductions of 11% were imposed across all departments.
- Targets were achieved, but the cuts did not reform the public sector.
- Innovation was suffocated. Medium term capacity and capability to respond to the inevitable second crisis was undermined.

Canada in the 1990s: Debt peaked at 102% of GDP











- After a public consensus, spending was reduced by 12.7%.
- A Program Review Board, led by politicians, was more discerning in targeting expenditure reductions.
- But structural reform was still largely ignored resulting in further financial difficulties a decade later.

Ireland in 2009 Budget deficit reaches 12.1%

- The Government established a Special Working Group to reduce spending in a targeted fashion by 9.3%.
- Welfare budgets were reduced and workforce reform was grasped. A pension levy reduced public sector pay by 7% and based entitlements on 'career averages' not final pay.
- Government reaction was swift and, not surprisingly, union opposition was strong.

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A Better Pill to Swallow – our international case studies

Organisation	Country	Hospital/ service redesign	Hospital avoidance /health promotion	Primary care	Mental health	Health and social care integration	Medicines management	Pay for performance
New South Wales								
Ontario Human Services Agency								
Intermountain								
Virginia Mason								
Geisinger								
PHARMAC								
CASAP								
Techniker Krankenkasse								
Torbay Care Trust								
NHS Institute								

The UK Challenge

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The NHS will have to reshape and innovate to keep up

- The NHS reforms will only heighten the importance of these characteristics. The future NHS landscape will be one where:
 - transparency of data will increase patient demand;
 - funding will be linked to outcomes rather than episodes;
 - organisations will need to work well across boundaries and to do that they will need to decentralise.
- To stay ahead NHS organisations will need to:
 - refine their business models;
 - use robust finance and operational data to support the redefining of pathways;
 - remain committed to people development;
 - have ambition and determination.

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How to do 'more with the same' - innovate

- So, progress has been made but the bar keeps moving
- The private sector has seen an average annual increase in productivity (market factor) of 0.3% from 1995-2008 the public health sector has seen a corresponding annual decline of 0.3%.
- With no 'real' increase in funding for the NHS the challenge is to plug the funding gap with productivity gains.
- The fundamental reform and massive reorganisation faced by the NHS must not detract and get in the way of the progress needed to increase productivity and innovation across the public sector.
- Being focused is vital to ensure we do not lose grip on quality or finance.

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There's no time to lose...

- Large scale change takes at least two years to implement. If only we'd started in 2008...but all is not lost. There are some quick wins that all NHS organisations should be considering.
- Workforce – we need to shift the mindset of NHS from ward to the board. Start to link pay to best practice productivity gains in the private sector. Set efficiency targets for all A&C staff and for consultant and GP contracts.
- Non pay – target 20% efficiency gains from the £200bn procurement budget across government.
- Infrastructure – establish public and private JVs for shared clinical and non clinical services.
- Assets – create new property companies and operating companies which treat assets as value creators, not cost centres.
- Borrowing – establish a proper NHS bank facility run on commercial lines to install new disciplines into lending, borrowing and paying investments back.
- The next challenge is to tackle the fundamental reorganisation through inspirational leadership, care integration, and innovative use of technology.
- There are some impressive success stories which show that it can be done.

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'Perform' – Less Blue Sky, More Brown Mud

- Challenges ahead will not be solved by more blue sky thinking
- Success will come through skill, dedication and hard work
- We have developed a series of propositions that have been tried and tested with our NHS partners
- Our propositions cover all types of NHS organisations
- Our work has helped deliver efficiency gains of up to 20%

- | | |
|------------------------------------|---------------------------------|
| ▪ Hothousing | ▪ Effective Commissioning |
| ▪ Organisational Architecture | ▪ Total Performance Improvement |
| ▪ Performance Through People | ▪ Board Grip |
| ▪ Integrated Pathways & Telehealth | ▪ Tax |
| ▪ System Synergy | ▪ Pain to Gain |



'Perform'

Integrated Pathways and Telehealth



Background

The costs of healthcare in the UK and globally are unsustainable

Rising demand, increases in chronic diseases and costs of drugs and medical equipment will put immense pressures on healthcare systems

Evidence indicates that Integrated Care Organisations are capable of delivering better health outcomes and value for money

Telehealth as part of integrated pathway redesign is capable of making a huge impact on outcomes, quality and costs leading to better overall management of LTCs

New areas of focus

Each year, 916,000 people are readmitted to hospital within 30 days, almost 600,000 as emergencies. This is costing the NHS £1.6 billion. From April 2011, this will not be funded. Local health and social care economies need to move quickly to introduce services in advance of this

Action needs to be taken within health economies to ensure that re-enablement funding is used to support the growth in telecare rather than plug the finance gap

'Perform'

Effective Commissioning



Effective Commissioning – today and tomorrow



Supporting the commissioners of today and developing the GP commissioners of tomorrow to deliver better care for patients, better health and value for local communities.

The NHS, NHS Foundation Trusts and the GP Commissioning Partnership have joined forces to commission and deliver better care for patients, better health and value for local communities. The NHS, NHS Foundation Trusts and the GP Commissioning Partnership have joined forces to commission and deliver better care for patients, better health and value for local communities.

–Effective Commissioning – today and tomorrow

- Our analytically rich 'Commissioning Transition' offer is designed to maximise the commissioning power of commissioners as they make their transition from PCT to GP Consortia Commissioning.
- Supporting the commissioners of today and developing the GP commissioners of tomorrow to deliver better care for patients, better health and value for local communities.
- To do this we have set up The KPMG Partnership for Commissioning which comprises the National Association of Primary Care (NAPC), Healthskills, Primary Care Commissioning (PCC), United Health UK and Morgan Cole.
- The Partnership works with commissioners through a three phase approach covering:
 - managing today
 - the transition to tomorrow
 - managing tomorrow.

'Perform'

Effective Commissioning – case study



Effective Commissioning – today and tomorrow



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–Background

- The KPMG Partnership is currently working with eight groups of GPs in London to help them develop the leadership skills required to make them excellent commissioners of services and leaders in their field

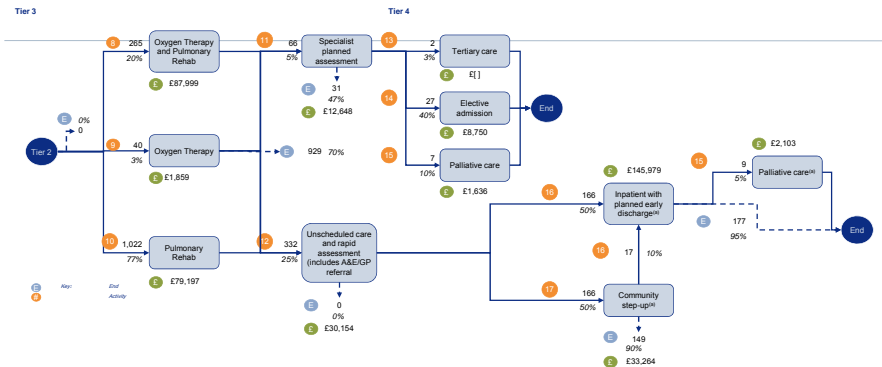
–What we do

- The Partnership launched on 12 January and is offering support for population health needs assessment, financial planning and contracting
- Leadership skills will be developed at an individual, team and organisational level
- The GP groups we work with will, through the partnership, have access to an evidence based, comprehensive package of business, finance, governance and personal development support

–Outcomes

- With use of innovative media (e.g. an online consortia network) and shared learning and design, the KPMG Partnership for Commissioning will develop and support the Pathfinders in the application of a practical toolkit.

Effective Commissioning – case study



- Clear care pathways for LTCs.
- Focus on care continuum, not individual teams.
- Reduce organisational boundaries.
- Tariff and incentives for entire pathway, not individual elements.
- Designed/owned/commissioned/managed by Accountable Care Organisation.

'Perform'

Tax



Background

- We have a track record of working with NHS organisations to provide tax advice and to reduce cost. Our tax team have routinely saved NHS Trusts up to £1million in tax savings from VAT, salary sacrifice and smart tax planning.

What we've done

- At one NHS Foundation Trust we have been working in partnership with the cost reduction team to review all 'big ticket' contracts

Outcome

- We identified a series of short and medium term savings
- c£500,000 in VAT savings were secured within six months of our initial review.
- Salary sacrifice savings of over c£400,000 have been identified
- Longer term tax/VAT efficiency savings range from £2-4m pa (acutes).

New areas of focus

- Our tax team are working with clients to support the new ways in which they are choosing to deliver services and ensuring tax implications are understood and savings identified
- Hot topics to consider are the outsourcing and reconfiguration of services such as pharmacy and the potential VAT savings that may exist

Insights into GP Commissioning Consortia

- No two consortia are the same:
 - Approach – form versus function
 - Legacy influence – PBC, transformation versus transition
 - Relations with PCTs and new transitional structures varies considerably
 - Transitional structures are a blessing and a curse in equal measure
- In the most developed consortia there is a theme of strong leadership
 - Strength of rapid and decisive decision making supported by huge amounts of zeal and energy
 - Risk of dominance and over reliance on one individual and to the process of broader practice engagement
- Knowledge and understanding within any Consortium varies widely
 - In general an engaged Board supported by a small coterie of active supporters
 - A central group who are agnostic and partially informed
 - Each has either laggards or saboteurs' – "What's an FT", LMC positions

Insights into where the GPs are now

- The leaders are time poor
 - In practice this currently means they want interventions and meetings in the evenings and at the weekends
 - Brevity and relevance is a virtue when dealing with Consortia leadership
 - Very keen to share experiences and materials with other Consortia – don't want to reinvent the wheel
- Different learning styles
 - A real appetite for new media and virtual learning – virtual networks and podcasts are in high demand
 - Content needs to be short, focused and explicitly relevant
- There are inherent tensions of being a GP and a Commissioner
 - Clinician versus Commissioner
 - Individual Patient versus the cohort
- For many there is real fear of the unknown
 - Don't know what they don't know
 - The level of cultural change – peer review, external scrutiny of data, perceived loss of autonomy

Summary

- We can learn from international comparators – but we have something to teach them as well
- We can learn from insurance based systems
- We will need to innovate to meet the scale of the challenge
- There are other UK opportunities to be explored
 - Integrated pathways and Telecare
 - Tax
 - GP Commissioners present a challenge and an opportunity

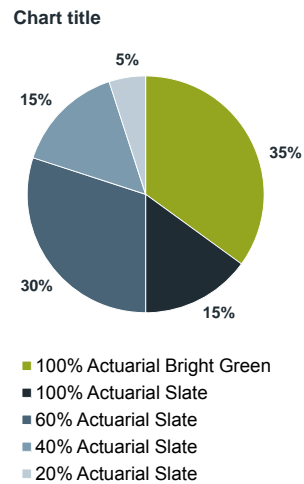
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Sample pie chart style

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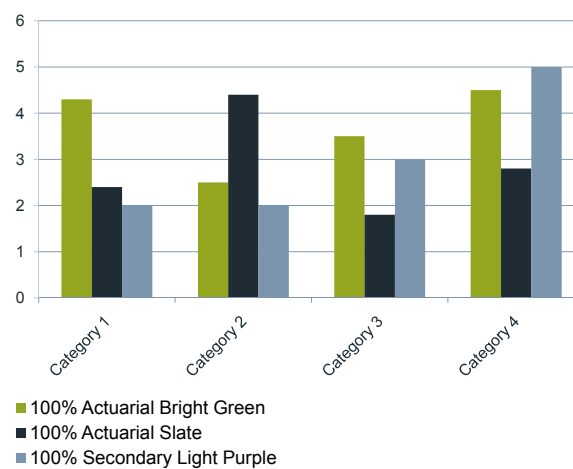
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Sample bar chart style

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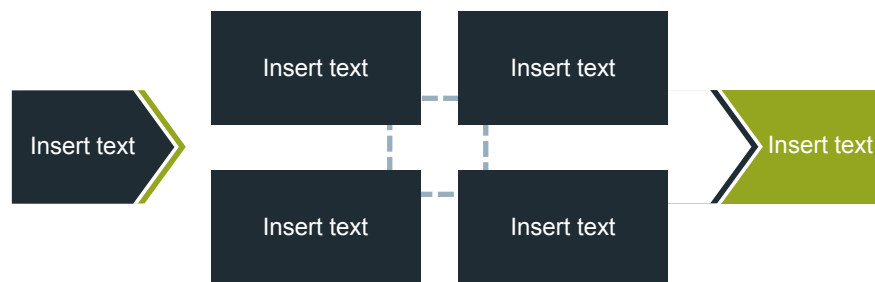
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Sample diagram style



Actuarial Bright Green is used to signify/highlight the greatest value and most positive outcome.

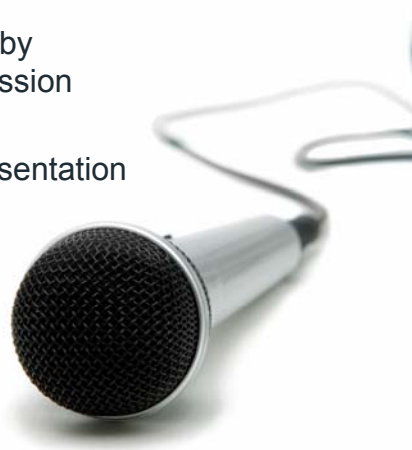
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Questions or comments?

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