

Commissioning skills

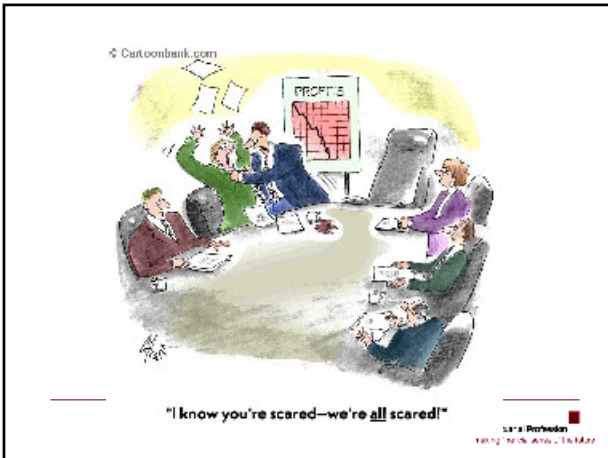
Alison Tonge
Director of Finance Stockport PCT

Actuarial skills and commissioning

- **Assessing the new commissioning function in PCT's**
- **Capacity, Activity and Risk Planning**
- **Scenario planning and Efficiency**
- **Micro and Macro methodologies**
- **Opportunities for joint working**


Financial context

- High growth aveg 7-8% real terms from 2001 to 2008- aim to catch up then maintain – forecast 3% from 2008 onward
- National contracts – impact not fully estimated
- High targets on access – 18 weeks by Dec 08
- Public health and choosing health only in last 2 years of growth
- Productivity measures unclear – 1.5% drop in hospital activity but if quality adjust this rises
- Most commissioners face unavoidable cost increases which are taking up growth – GP contracts, dental contracts, prescribing, activity, trust deficits, PFI's , NpFit
- 2006-7 sees first full year of roll out of PbR across elective and non elective care, A&E, in patients, day cases and outpatients.

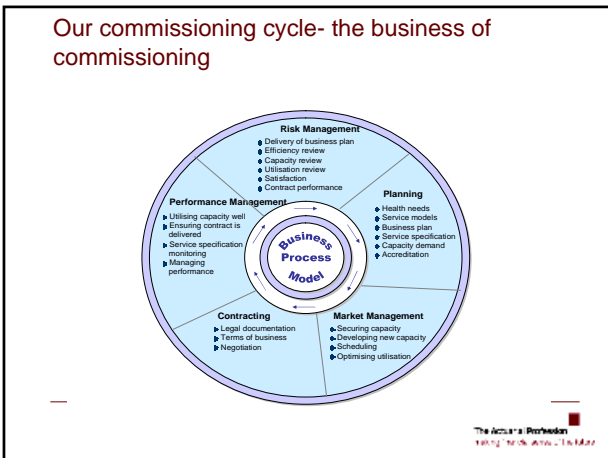


Commissioning

- What is it ?
- Maximising health care services available – choice and access
- Optimising health gain – best possible outcomes
- Reducing inequities- target the resources
- Within the money available

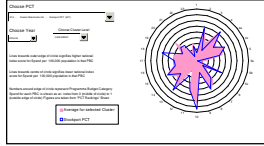


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Typical commissioning portfolio per head

- £1,295 per weighted head of population for all care 2006-7
- 'prospering towns cluster' –2004-5 average e.gs
 - Cancer £763
 - Mental health £1,301
 - CHD £1,256
 - Endocrine inc diabetes £330
 - National Average per head £1,195



focus for this presentation in the cycle

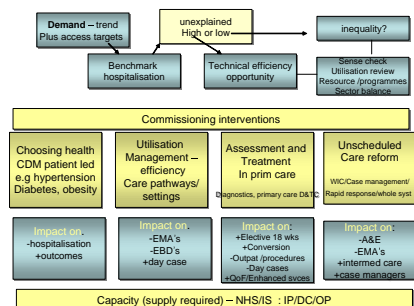
- **Planning** : tools for planning and targeting macro efficiency
- **Risk management**: tools for managing demand and incentivising change
- **Performance management**: utilisation management, planning and review

Section 1: planning

Tools for planning

- Evidence based pathways – evaluated with expected impact on hospitalisation rates – not available – Millimans care guidelines for uk
- Capacity/activity planning PbR and non PbR
- Plans based on mixture of activity /capacity and modernisation agendas. Based on national policy – but no real tools to give PCT’s planning guidance on expected return for these investments, impact on quality, health outcomes, access targets
- The best plans show how return on investments
- Programme budgets and planning

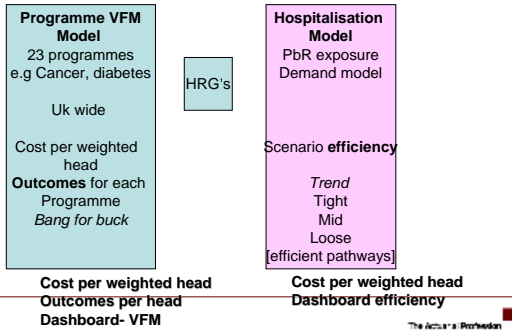
Scenario planning and efficiency



Capacity, activity and risk

- 3 year plans – model access and new pathways
- Trend
- Efficient
- Mid way
- Most PCT’s use central guidance rather than do detailed modelling e.g 3% growth

Developing models using actuarial skills- Efficiency and effectiveness



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Risk management

Planning for efficient pathways

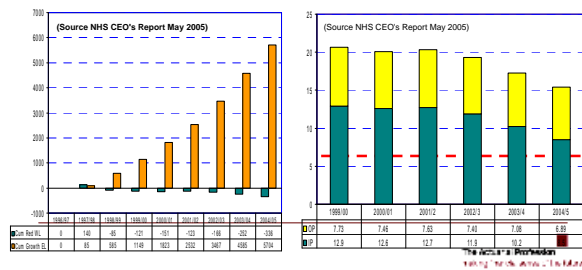
- More capacity and activity not the answer
- Reform or bust ?
- What will engage more reform/productivity ?

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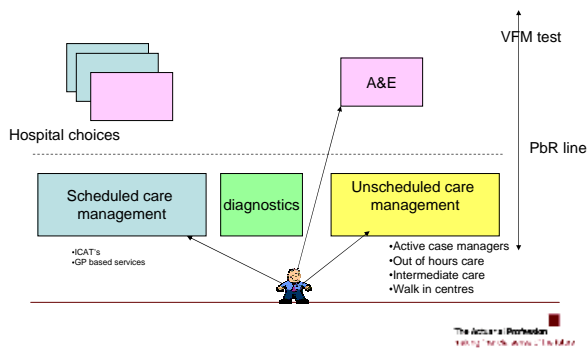
Doing more is not having the impact

17:1 ratio of activity to waiting volumes reduction

Median waits for OP and IP access have fallen ca. 4 weeks in 5 years



Management of pathways is the key



Hospitalisation for chronic conditions aged 65+

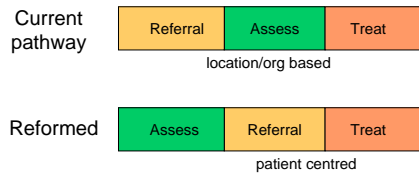
BMJ 2003	NHS	Kaiser
Stroke	823	788
COPD	699	558
Angina	783	152
Asthma	531	141

Active Case Management

- Pilot scheme for 12 months
- 44% reduction in emergency admissions
- Compared to a control group of like patients
- Significant (@95% confidence level) difference between the control and the pilot group
- Rolling out with 9 new ACM's and targeting a 10% reduction in risk group readmissions.

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Reforming the patient pathway in line with 18-weeks



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Total ICAT and Tier 2 05-6

13791 referrals received

2155 triaged to consultant

1113 seen and referred to consultant

3268

24%

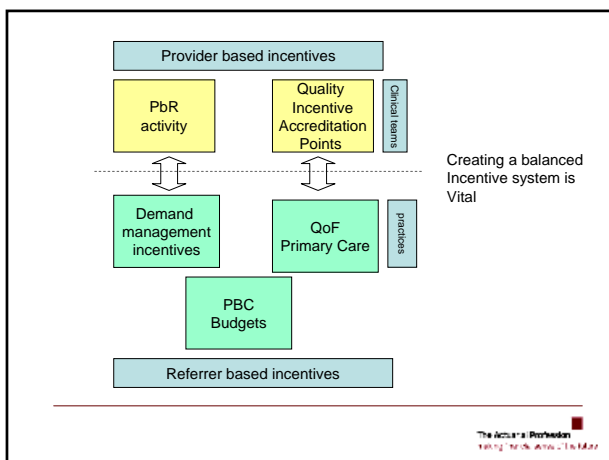
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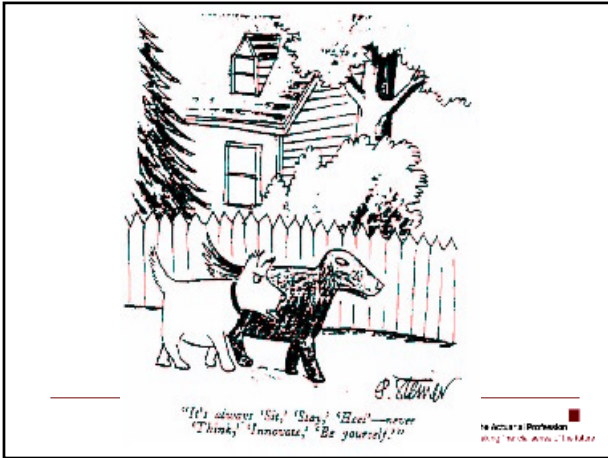
Cost - Evidence

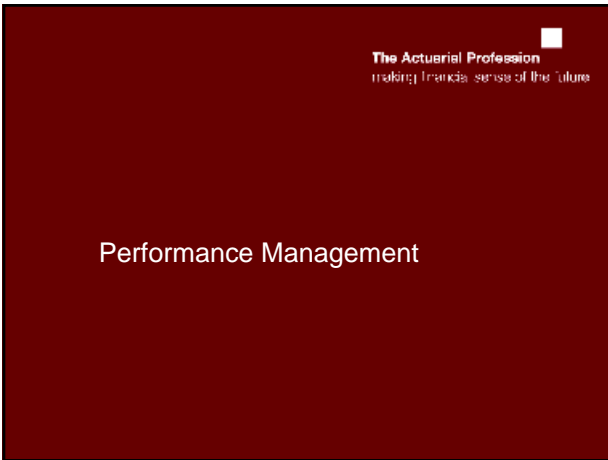
- 25-30% saving from PBR alternative
- calculated on total cost of activity in new 'ICAT'
- Plus cost of PbR onward referral
- compared to total cost of expected activity based on last year trend.

Incentives – work

- Organisational – quality improvement /process efficiency – reward for above tariff standards
- Clinician – for engagement – e.g PBC incentives for using efficient pathways and setting up new services
- Stakeholding in new services – engenders control and development







Managing success

lots more development in these areas

- Utilisation management
 - Case management – frequent flyers
 - Care managers – increasing risk
 - Self management + primary care
- Utilisation review
 - 2 studies per year benchmarked utilisation avge 30% in appropriate best in breed 15% now
 - Appropriateness of admission
 - Length of stay /appropriateness point prevalence

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Joint areas for work

- Planning tools – hospitalisation and VFM
- Evaluation of effective pathways and returns
- Utilisation management

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Thank you

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