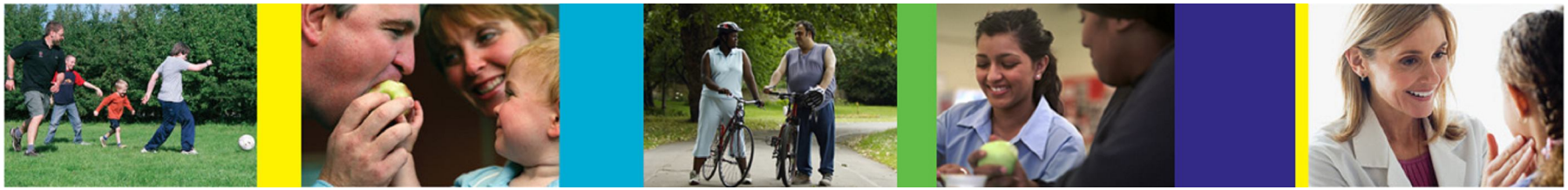
worldclasscommissioning

NHS



# Lessons from health: World class commissioning

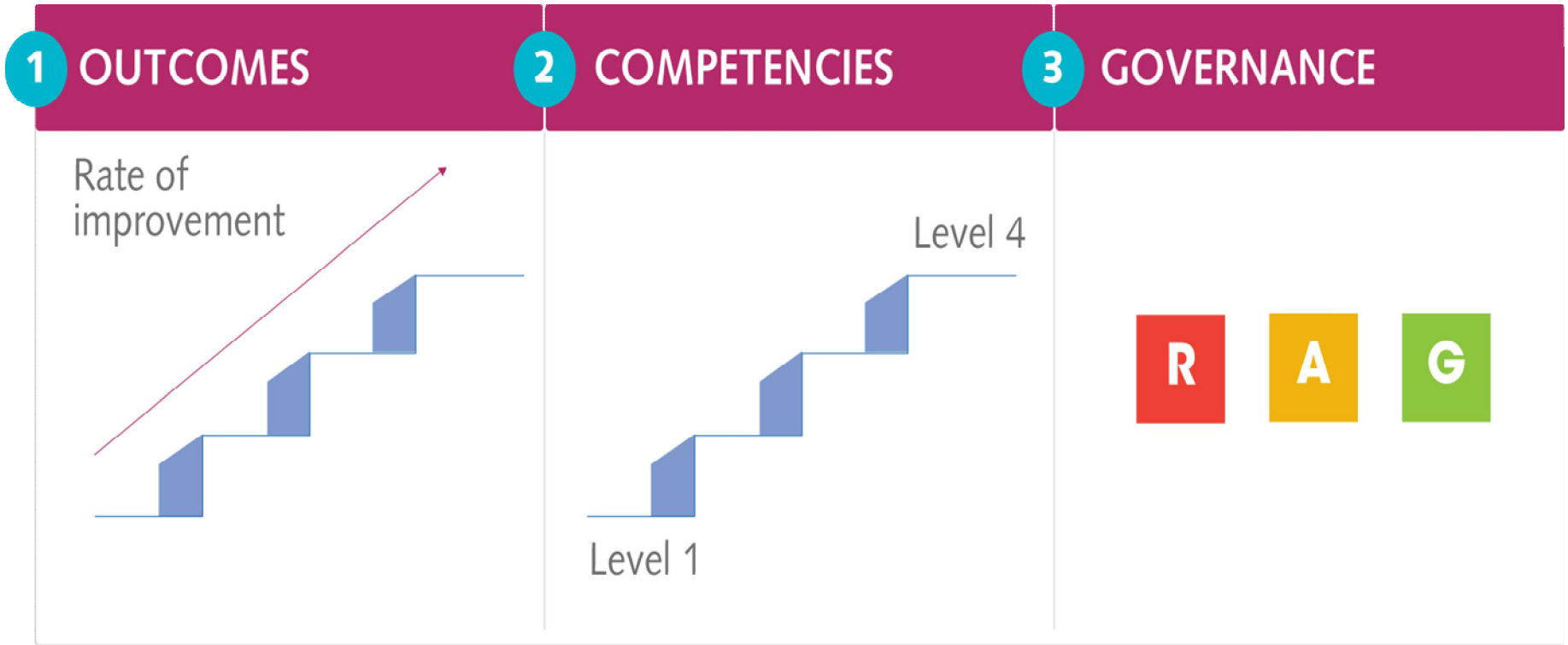
**Gary Belfield**
***Acting Director General***
***Commissioning & System Management Directorate***
*Department of Health*

# Context

- £80bn
- Focus on illness and short term
- Inequalities and unwarranted variation

# "The aim of world class commissioning, and therefore the ultimate test of its success, will be an improvement in health outcomes and a reduction in health inequalities"

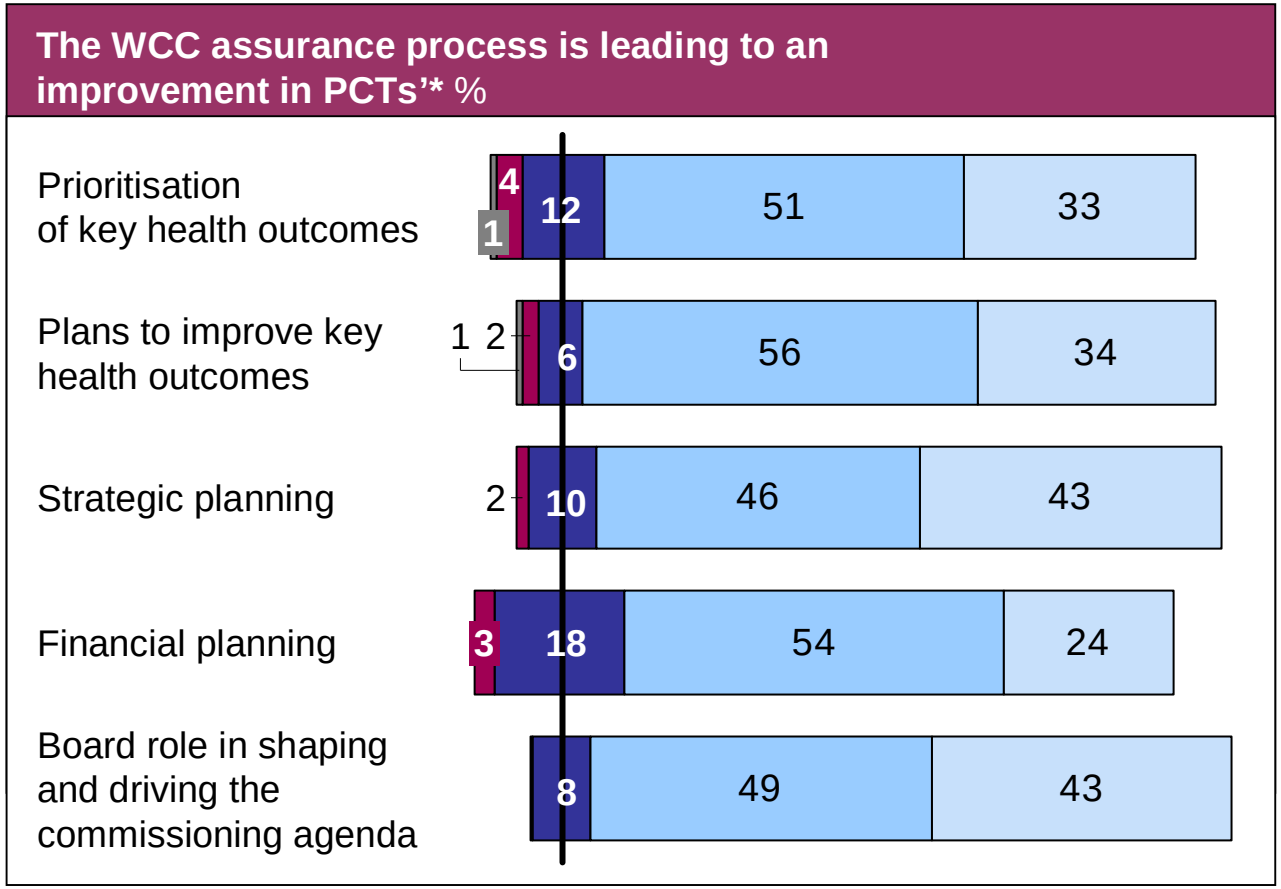
# 3 Key components: outcomes, competencies and governance



# 11 Competencies

1. Locally lead the NHS
2. Work with community partners
3. Engage with public and patients
4. Collaborate with clinicians
5. Manage knowledge and assess needs
6. Prioritise investment
7. Stimulate the market
8. Promote improvement and innovation
9. Secure procurement skills
10. Manage the local health system
11. Make sound financial investments

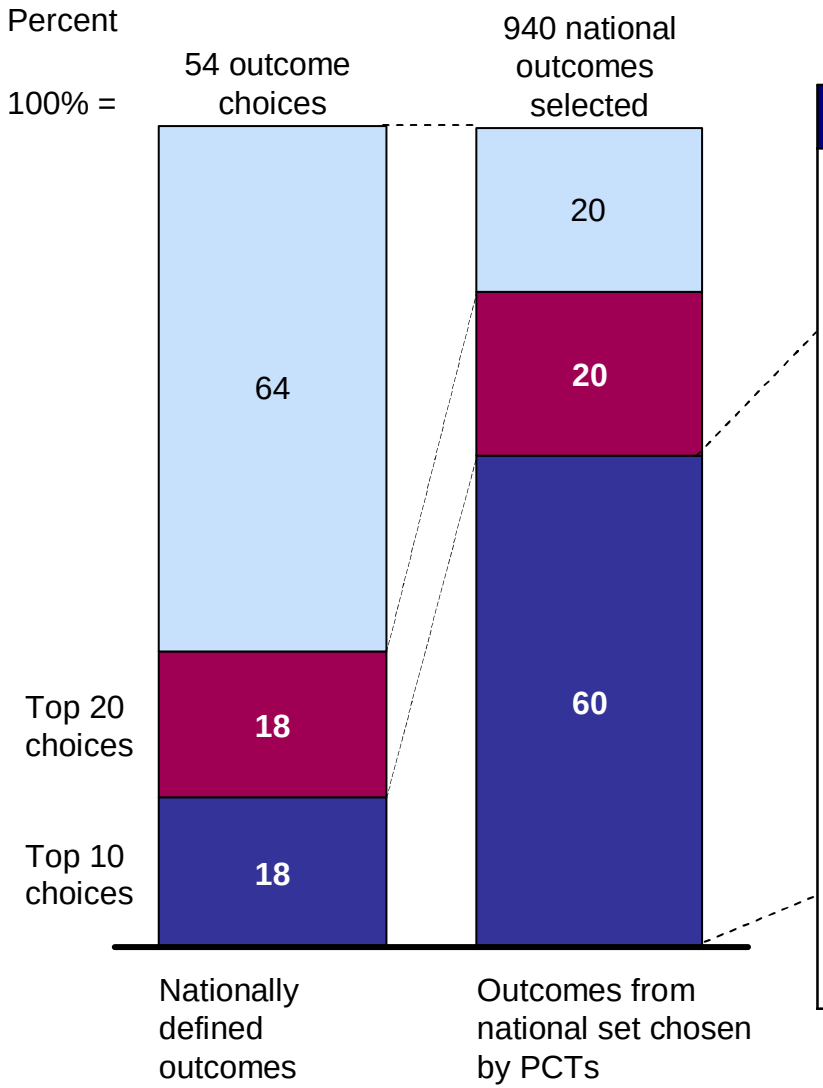
# 18 months on WCC is making an impact




* Results aggregated across PCT, SHA and Panel surveys (Panel survey N=71, SHA Survey N=29, PCT survey N=210)

Source: WCC evaluation survey, results from Jan 2009; SHA interviews

# The 10 most frequently selected account for 60% of all outcomes chosen by PCTs in the WCC assurance system




| | Top 10 measures nationally | #PCTs |
|---|---|---|
| 1 | Smoking quitters | 100 |
| 2 | Rate of hospital admissions per 100,000 for alcohol related harm | 75 |
| 3 | CVD mortality | 72 |
| 4 | Percentage of all deaths that occur at home | 69 |
| 5= | Under 18 conception rate | 53 |
| 5= | Childhood Obesity (locally-defined)* | 53 |
| 7 | Cancer mortality rate | 51 |
| 8 | Diabetes controlled blood sugar | 43 |
| 9 | Infants breastfed | 41 |
| 10 | Percentage of stroke admissions given a brain scan within 24 hours | 33 |

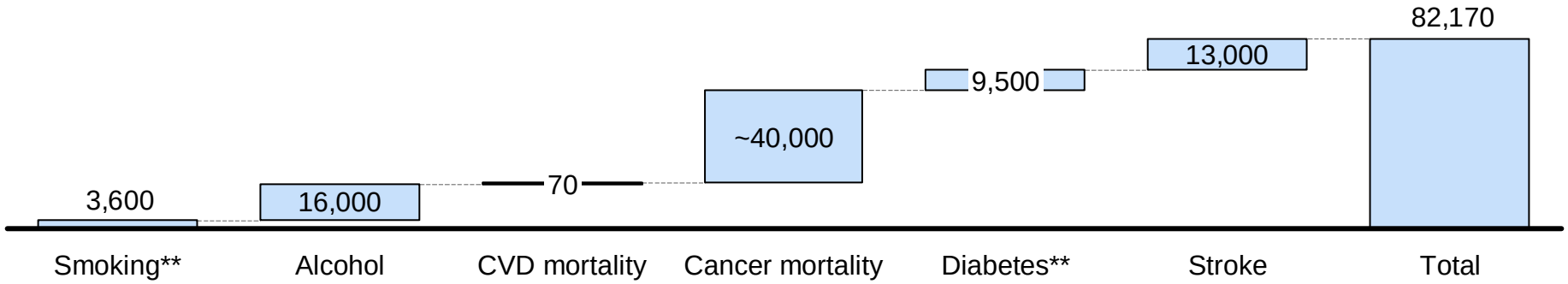
* Childhood obesity was the only locally-defined outcome among the top 20, and so is not included in graph on the left hand side of the page.

Source: 152 PCT submissions; DoH; team analysis

# Over 80,000 life years and about 60,000 QALYs can be gained over 5 years if PCTs improve their performance by a quartile

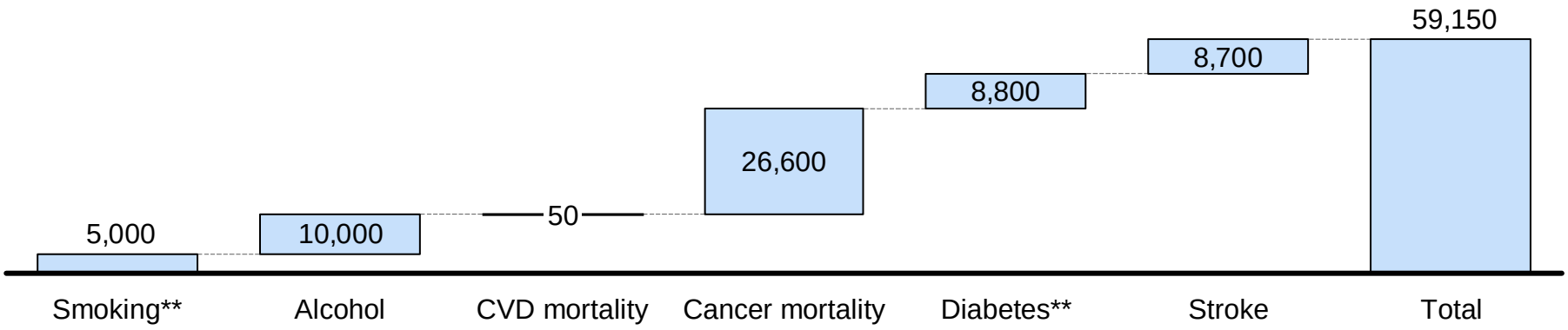
## Years to life….

Life years gained*




## Life to years….

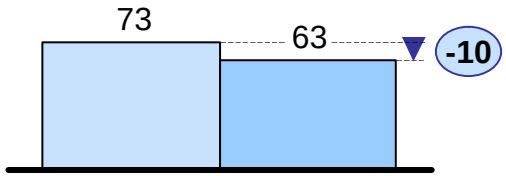
QALYs gained*



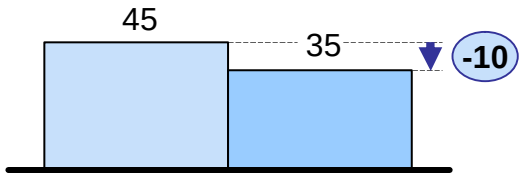

* By a one quartile improvement relative to historical baseline for PCTs selecting the outcome. PCTs in top quartile improve based on vital signs.
** 10 year time delay between intervention and full benefit capture
Source: Team analysis – details in appendix.

# A one quartile improvement in PCT performance for these outcomes would result in a 10-15% reduction in health inequalities* by year 5

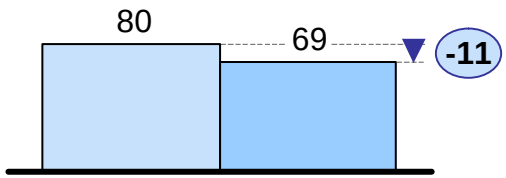
**Health inequality gap – rate of smoking quitters**
Percent gap*



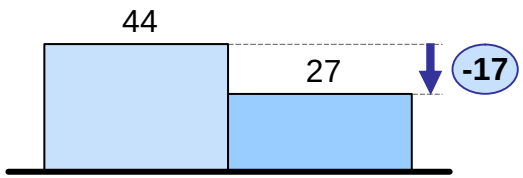

**Health inequality gap - Cancer mortality rate per 100,000**
Percent gap*



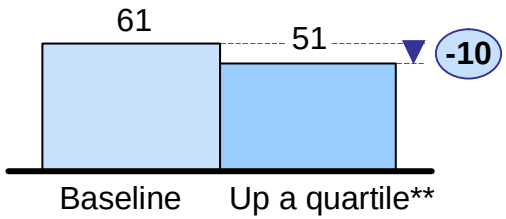

**Health inequality gap - rate of admissions for alcohol related harm**
Percent gap*



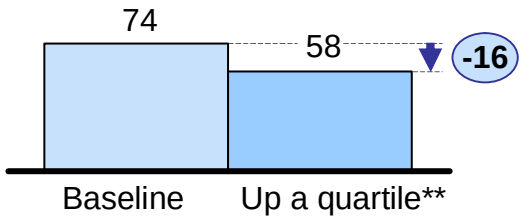

**Health inequality gap - Diabetes controlled blood sugar**
Percent gap*




**Health inequality gap - CVD mortality rate**
Percent gap*




**Health inequality gap - Stroke admissions given a brain scan**
Percent gap*




* Between top and bottom PCTs.
** PCTs in the bottom three quartiles move up a quartile whilst top quartile PCTs improve at the rate of their Vital Signs ambitions.
Source: 152 PCT submissions; DoH; team analysis

# The specific opportunities for improvement fall into four areas with a range of mechanisms to capture

✓ Mechanism applicable to capture the value

**Areas of opportunity**

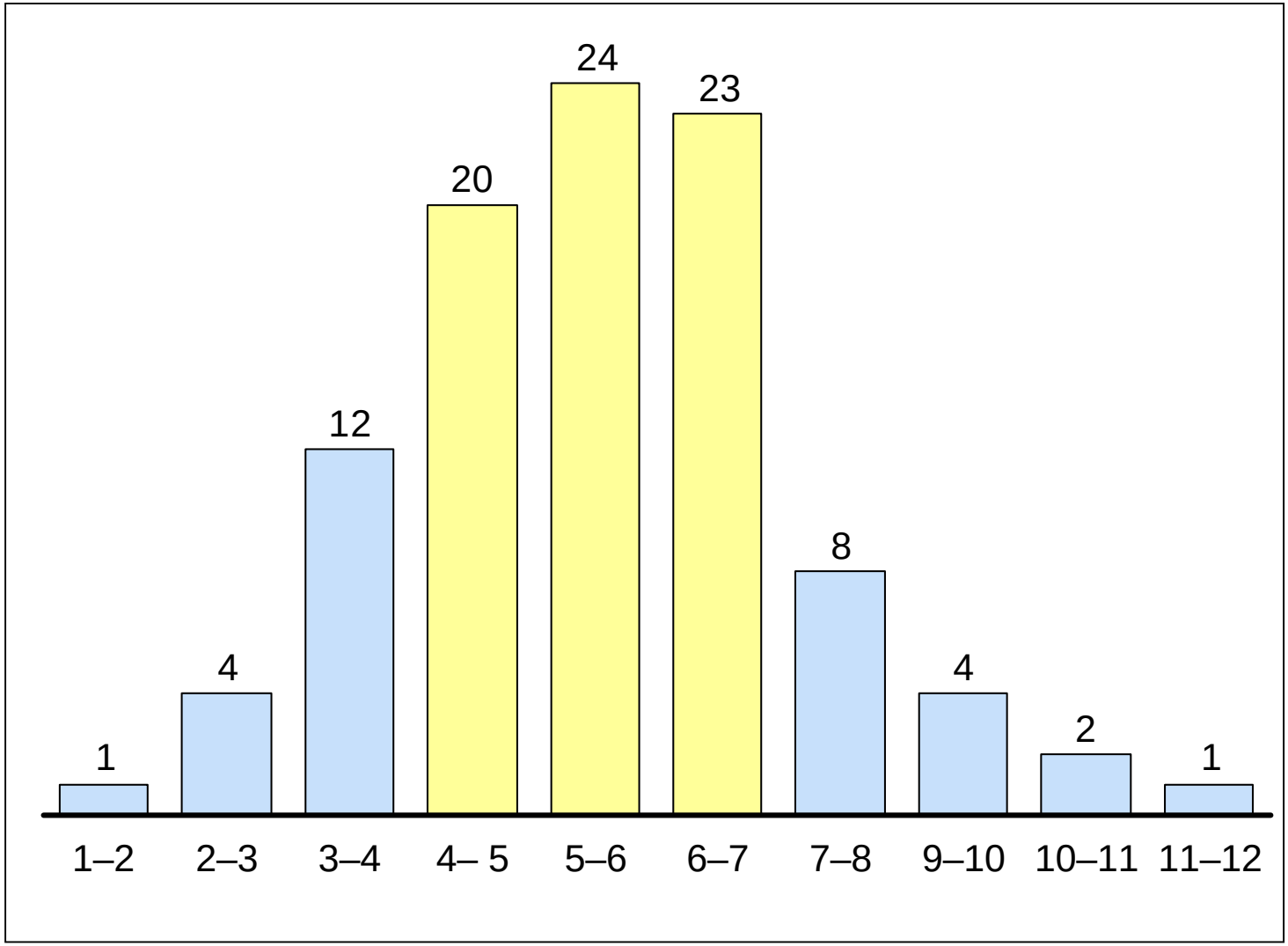
| Mechanisms to capture value | 1 Drive through cost efficiencies in all provider services | 2 Optimize spend and ensure compliance with commissioners' standards | 3 Shift care into more cost effective settings | 4 Prevent people from becoming ill through increased prevention |
|---|---|---|---|---|
| Market structure/ management | ✓ | | ✓ | ✓ |
| Pricing/ reimbursement | ✓ | ✓ | ✓ | ✓ |
| Contracting and setting/ enforcing standards | ✓ | ✓ | ✓ | |

**Technical efficiency**

**Allocative efficiency**

# Community services: 12-fold variation in productivity, starting from a low base

Average number of daily visits by nurse in specified period (%)



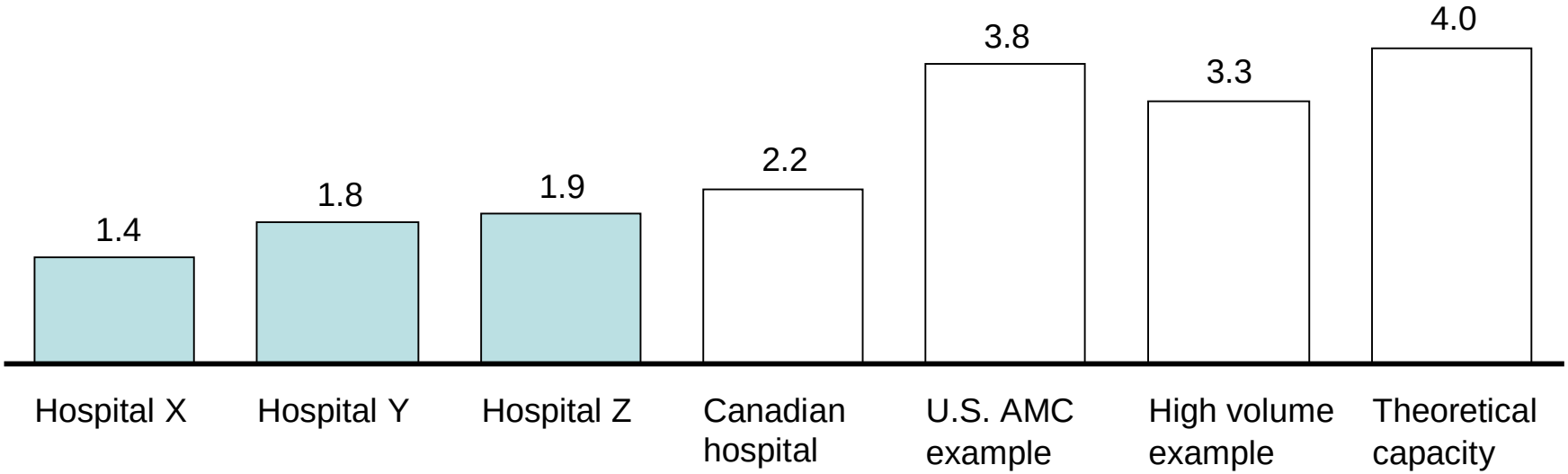

**Examples of key levers to increase efficiency**

- Streamline travel routes
- Replace night agency staff with permanent staff
- Adjust staffing levels to demand
- Standardize process/ interventions

Source: 3-month sample of district nurses in provider arm of a PCT

# Acute providers: potential to increase CT throughput by 50-100%

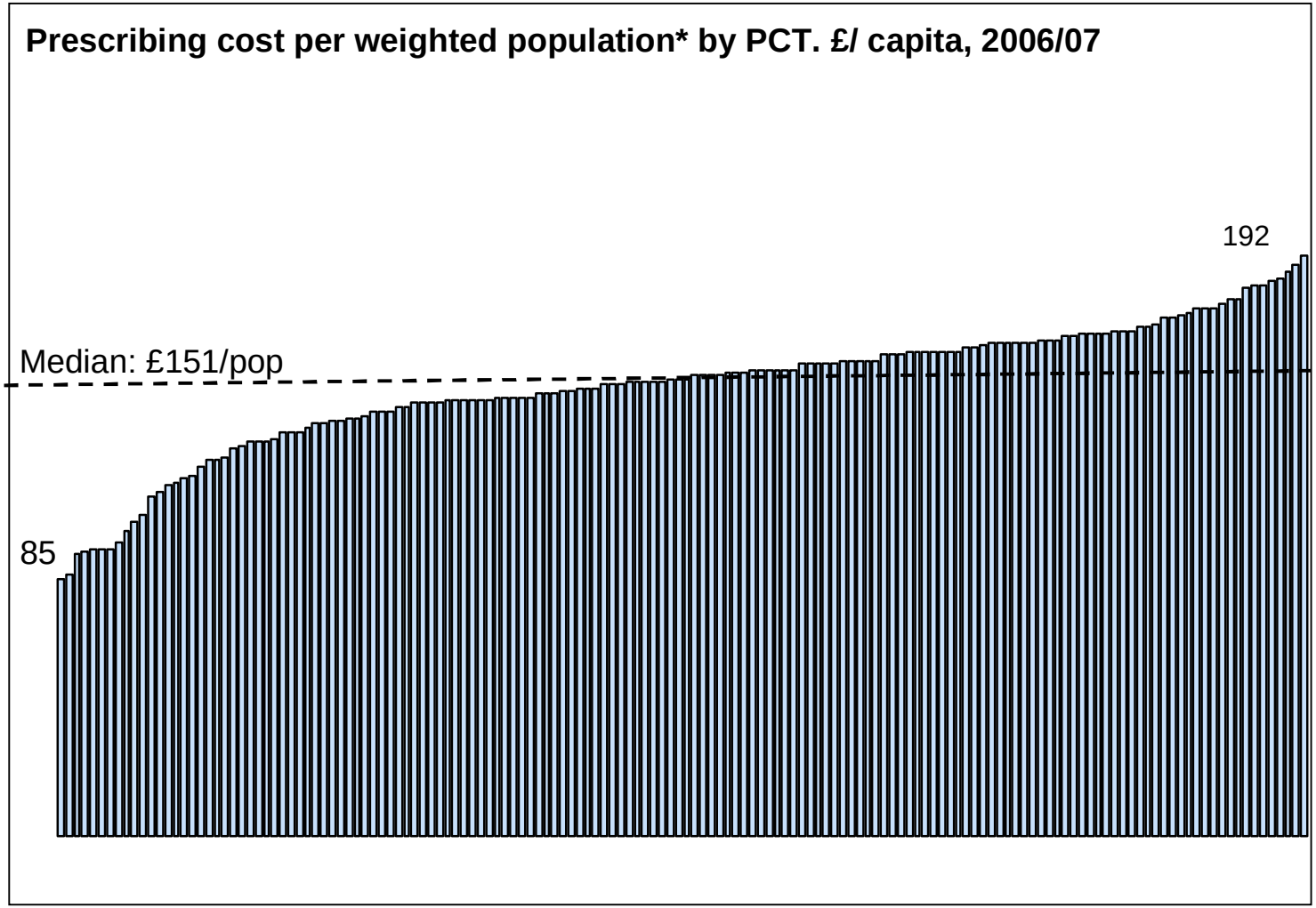
## Number of CT scans per machine per hour of operation. 2006




**Key levers to increase throughput**

- Reduce downtime e.g., scheduling, patient ready
- Reduce rework
- Standardize process e.g., consistent protocols

# 1b PCTs' prescribing costs: more than twofold variation in prescribing cost per weighted population*



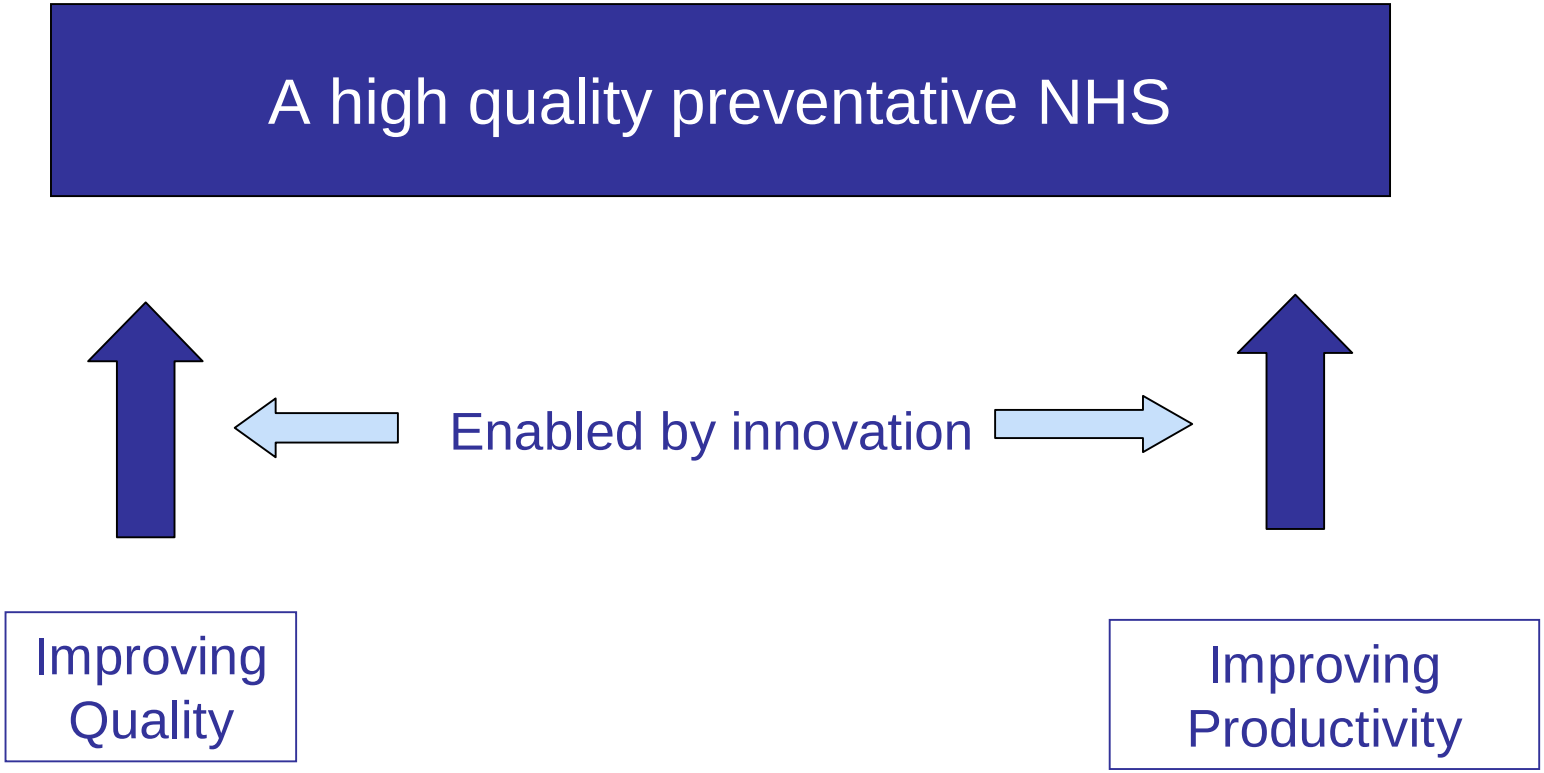

**Typical sources of inefficiencies**

- Unexploited switches to cheaper alternatives with identical outcomes
- Avoidable specialist and restricted drug spend
- Waste reduction
- Lack of formulary
- Supply chain inefficiencies

* Age and need weighted population

Source: PCTs spend, Mckinsey analysis

# Preparing for 2011/12



# Lessons

- Clear framework and expectations
- Co-production and "*movement*"
- Pace and purpose
- Great leadership
- Excellent communications