

Next Stage Review and a vision for the future

Donal M Hynes

NHS Alliance

Somerset PCT

Next Stage Review

- Where we are in the Darzi Review
- LTC South West

How to plot out a future NHS

- Why we need to change in the present NHS
- What do we want to keep
- What would it look like in reality
- How would it be funded

NHS Next Stage Review timeline

- Review announced: Secretary of State in the House of Commons, 4 July 2007
- Stakeholder forum: introductory presentation, 12 September

NHS Next Stage Review timeline

- Consultative events: over 1,000 people attend events around the country, 18 September 2007

NHS Next Stage Review timeline

- Interim report: published by Lord Darzi, 4 October 2007

NHS Next Stage Review timeline

- Clinical working groups: local clinicians and others in each Strategic Health Authority
 - Maternity and newborn care
 - Children's health
 - Planned care
 - Mental health
 - Staying healthy
 - Long-term conditions
 - Acute care
 - End-of-life care

NHS Next Stage Review timeline

- Clinical summit: at London's ExCel Centre, 21-22 November 2007
- Local engagement events ensure the views of local staff and patients feed into clinical working groups
- Reconvened consultative events discuss models of care developed by local working groups, 24 January 2008

NHS Next Stage Review timeline

- Local visions: SHAs to develop local models of care for the next decade
- Final report: Lord Darzi's nationwide vision for next decade, June 2008

His Vision

- **Fair**
- **Personalised**
- **Effective**
- **Safe**

His Vision

- **Fair** – equally available to all, taking full account of personal circumstances and diversity
- **Personalised**
- **Effective**
- **Safe**

His Vision

- **Fair**
- **Personalised** – tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice
- **Effective**
- **Safe**

HisVision

- **Fair**
- **Personalised**
- **Effective** – focused on delivering outcomes for patients that are among the best in the world
- **Safe**

His Vision

- **Fair**
- **Personalised**
- **Effective**
- **Safe** – as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive.

Interim Report

- **Government should invest new resources to bring at least 100 new GP practices, including up to 900 GPs, nurses and healthcare assistants into the 25% of PCTs with the poorest provision**

Interim Report

- **We should invest new resources to enable PCTs to develop 150 GP-led health centres, situated in easily accessible locations and offering a range of services to all members of the local population (whether or not they choose to be registered with these centres), including pre-bookable appointments, walk-in services and other services**

Interim Report

- PCTs will work with all new and existing GP practices in their areas to develop greater flexibility in opening hours – our aim is that at least half of all GP practices will open each weekend or on one or more evenings each week. Where existing GPs do not start to offer these extended services, PCTs will be able to use the funding we make available for this to commission new services from other GPs, GP federations or other providers

The Need for Change

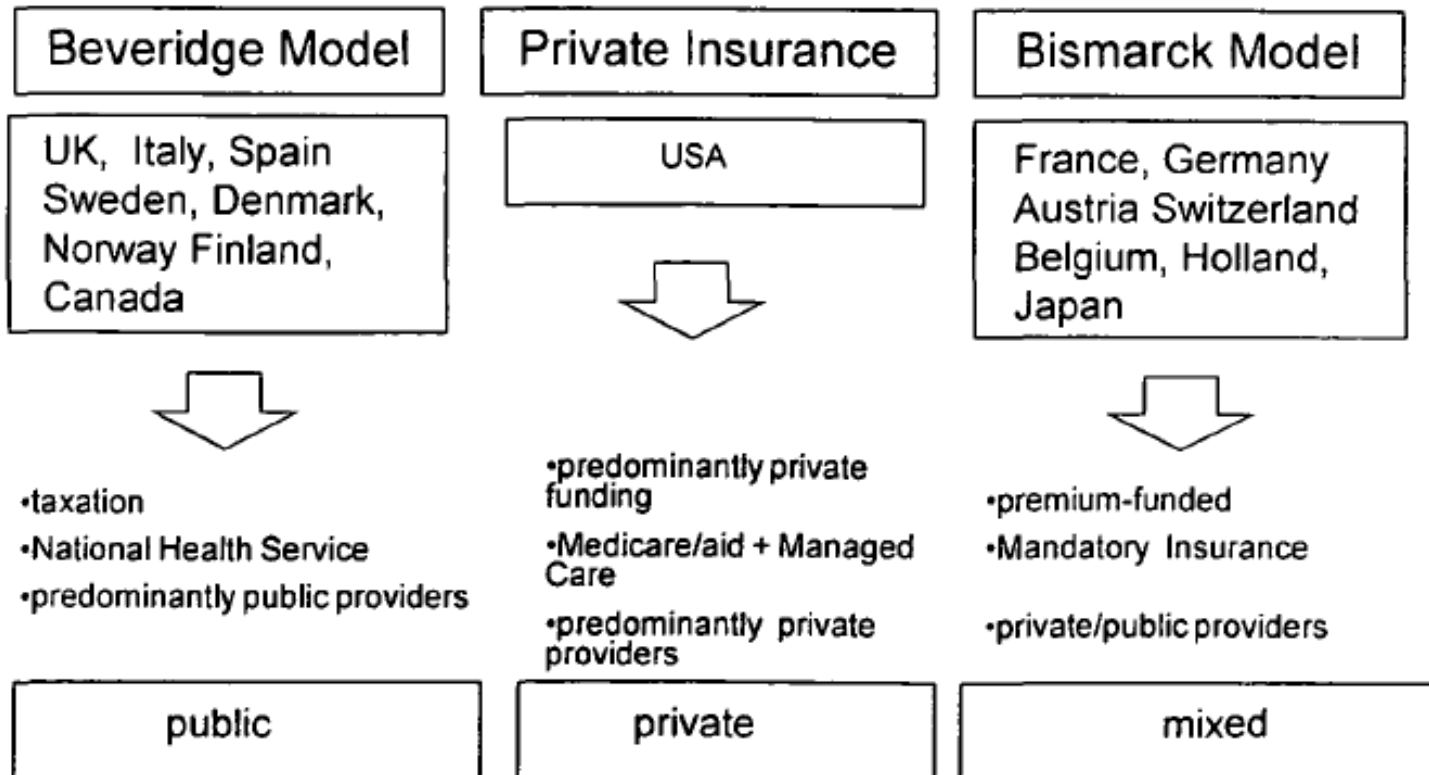
- Why we cannot stay the way we are....

Drivers 1

Financial

- Ambulance at the bottom of the cliff
- Cost of advanced care
- Apply business techniques

Business Model of Healthcare



Business Model



Service
Provider



Currency



Customer or
Commissioner

Business Model



Service
Provider



Currency



Customer or
Commissioner

Service Providers

- Hospitals
- Trusts –
 - Acute NHS Trusts
 - Foundation Trusts
 - Mental Health Trusts
 - Community Trusts
 - Social Care Trusts
- Independent Providers
- General Practitioners
- Social Enterprise Groups

Currency -HRGs

- ***Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatments which use comparable levels of healthcare resource***
- In their most basic form HRGs are groups of ICD-10 diagnoses and OPCS procedures that have similar resource implications
- Cost per HRG identified and allocated
- No deviation from tariff

Admitted Patient Care Mandatory Tariff							
HRG code	HRG name	Elective spell tariff	Elective long stay tripoint (days)	Non-elective spell tariff	Non-elective long stay tripoint (days)	Per day long stay payment (for days exceeding tripoint)	Reduced short stay emergency tariff (@40% non-elective tariff)
3	A01	Intracranial Procedures Except Trauma - Category 1	1580	5	4194	21	223 yes
4	A02	Intracranial Procedures Except Trauma - Category 2	3456	14	4922	30	234 yes
5	A03	Intracranial Procedures Except Trauma - Category 3	4849	21	6084	42	244 yes
6	A04	Intracranial Procedures Except Trauma - Category 4	7126	26	8272	46	230 yes
7	A05	Intracranial Procedures for Trauma w cc	5640	46	5640	46	249 yes
8	A06	Intracranial Procedures for Trauma w/o cc	4285	26	4285	26	180 yes
9	A07	Intermediate Pain Procedures	491	1	953	2	116 no
10	A08	Percutaneous Image Controlled Pain Procedures	518	1	518	1	176 no
11	A09	Peripheral Nerve Disorder w cc	1542	17	3101	49	161 yes
12	A10	Peripheral Nerve Disorder w/o cc	647	2	1767	17	181 yes
13	A11	Muscular Disorders	996	10	3354	39	184 yes
14	A12	Disorder of Balance aetiology unknown w cc	2862	27	2677	44	162 yes
15	A13	Disorder of Balance aetiology unknown w/o cc	810	7	1122	11	154 yes
16	A14	Brain Tumours or Cerebral Cysts >69 or w cc	2225	32	3676	51	182 yes
17	A15	Brain Tumours or Cerebral Cysts <70 w/o cc	760	2	2269	24	186 yes
18	A16	Cerebral Degenerations >69 or w cc	2008	32	4366	76	172 yes
19	A17	Cerebral Degenerations <70 w/o cc	778	5	1807	18	186 yes
20	A18	Multiple Sclerosis or other CNS Demyelinating Conditions	585	5	2683	37	199 yes
21	A19	Haemorrhagic Cerebrovascular Disorders	3036	71	3216	51	163 yes
22	A20	Transient Ischaemic Attack >69 or w cc	1047	31	1535	18	155 yes
23	A21	Transient Ischaemic Attack <70 w/o cc	753	8	753	8	165 no

Transactional Arrangements

Payment by Results

- Funding follows activity
- The more patients you treated the more money you get
- The more people chose your hospital the bigger your hospital gets
- To longer your waiting times, the less people you attract and the less money you get

Commissioner

- Direct or indirect Sales

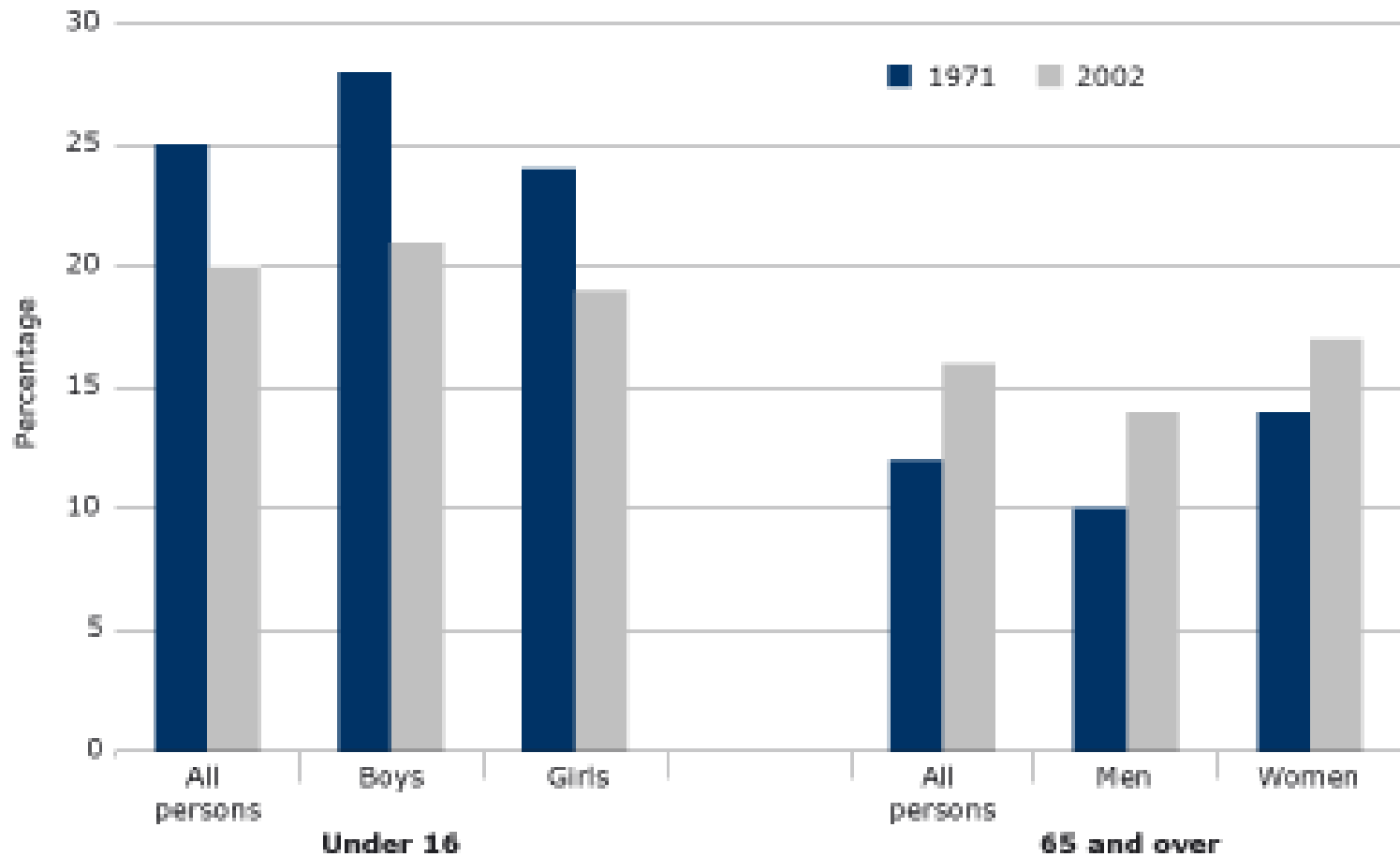
Patient

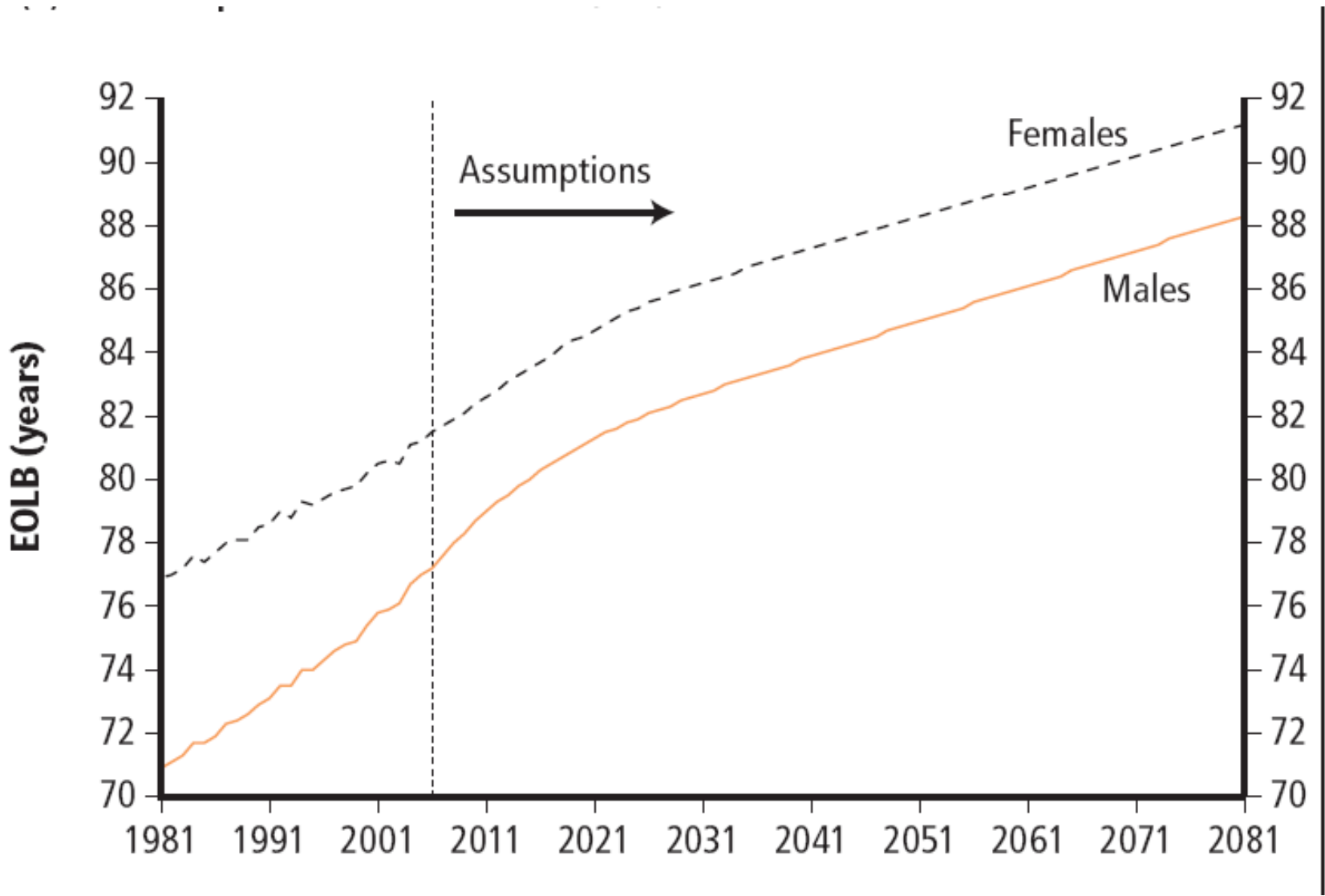
or

Primary Care/Local Authorities

Demographics

Drivers 2





Drivers 3

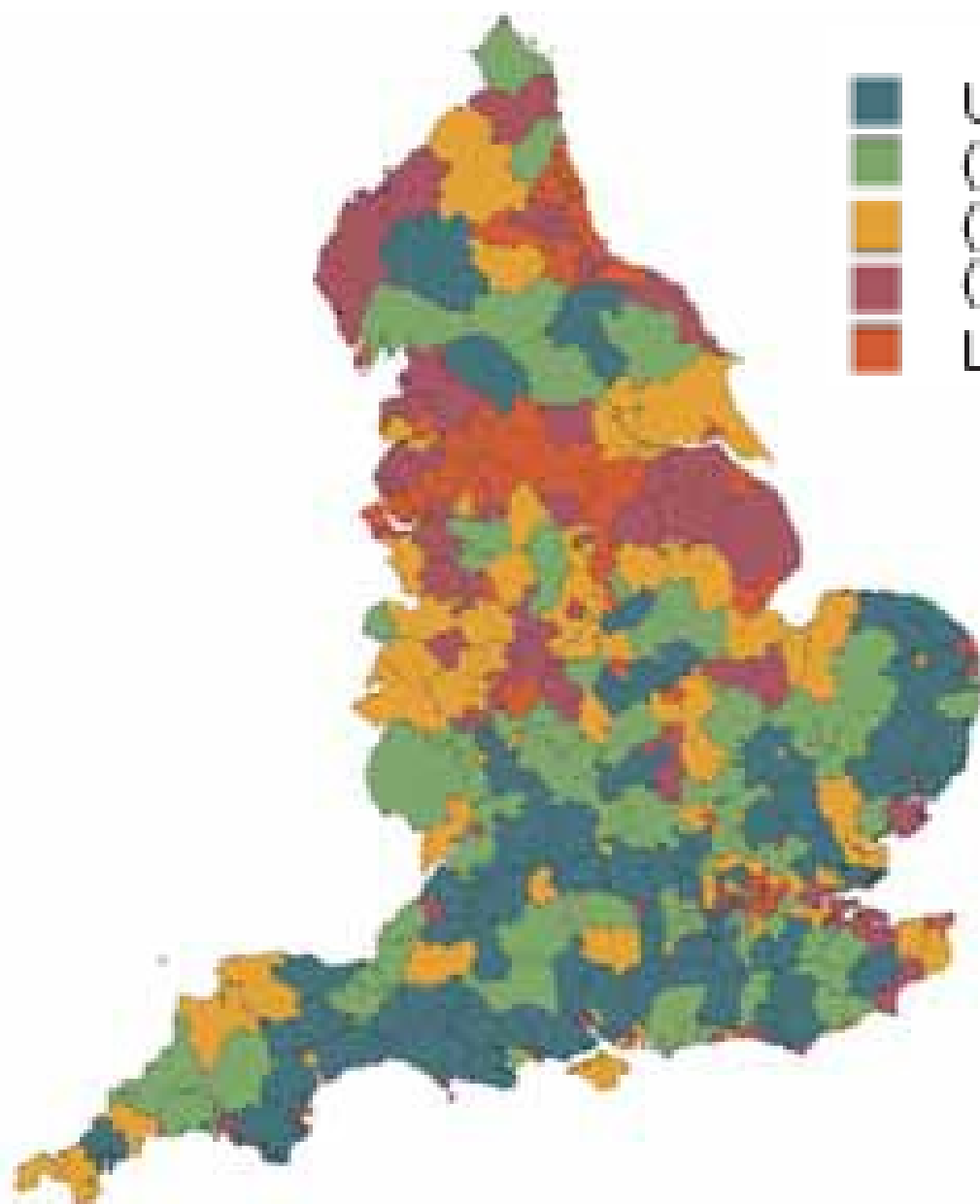
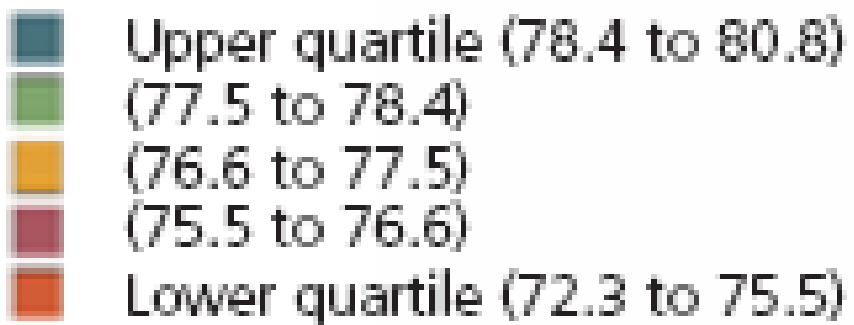
Expectations

Partnership – not subservient

Service to fit lifestyle

Drivers 4

Inequalities



We need to change

What do we value

- Continuity of Care
- Proactive Care
- Integrated Care
- Holistic Care

What does it look like

- Registered with one Primary Care provider
 - Multiple outlets of care
 - Multiple access points
 - Coordinated onto single record

What would it look like

- Fully aware of [Health inequalities](#)
- Practice fully aware of their population
- Shared with community

What would this look like?

- Risk stratification for health
- Community awareness and community engagement
- Fitness, smoking, pedometers,

What would it look like

- Risk stratification for ill-health
- Sickest 500
- Care plans, escalation packages etc
- Proactive care
- Transport into centre
- Social, financial and personal

What would it look like

- Tracking
- Retain responsibility 24/7
- Retain responsibility regardless of site of care
- Follow into hospital
- Review each unscheduled event

What would it look like

- Real-time information systems
- Unscheduled care requests
- Medication concordance
- Care coordinators or Community Matrons

What would it look like

- Integrated Care Models
- Specialist care provided in community setting
- Specialist services designed through community
- Specialist care provided to support ongoing care

What would it look like

- Comprehensive Care
- Hard-to-reach groups
- Transport to health centre
- Benefit Agency, CAB, Social needs, Voluntary sector

What would it look like

- Family Approach
- Partnership
- Population advising on commissioning
- Much of the services laicized
- Patient Orientated Outcome Measures

The Structure

- Practices working together
- Sharing estates and buildings
- Comprehensive 'Community Hospitals' either virtual or real
- Clinically-lead Integrated Care organizations (GPs and Specialist together)
- 24/7 access to care

- Specialist Centres only for Specialist Procedures that cannot be provided in community

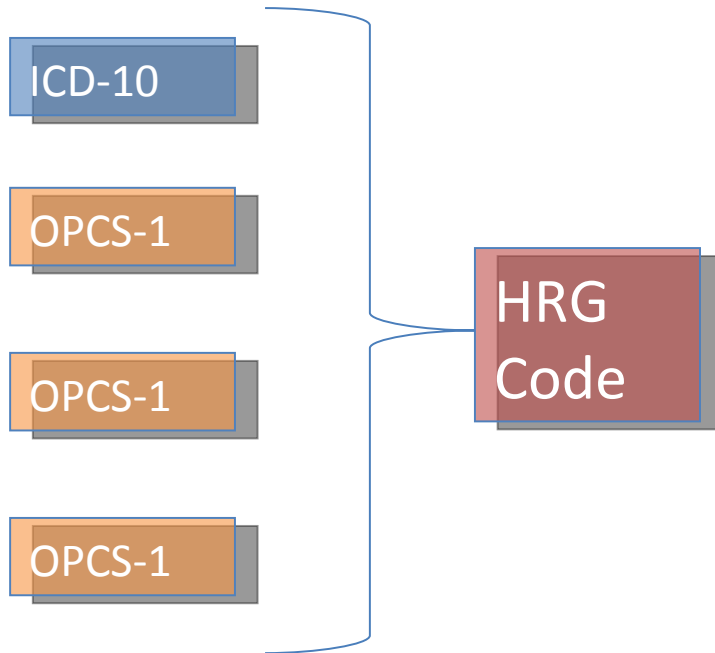
Funding

- Payment by Results (PbR)
- Needed a currency to put a price or tariff on healthcare provision
- Used the records already in place

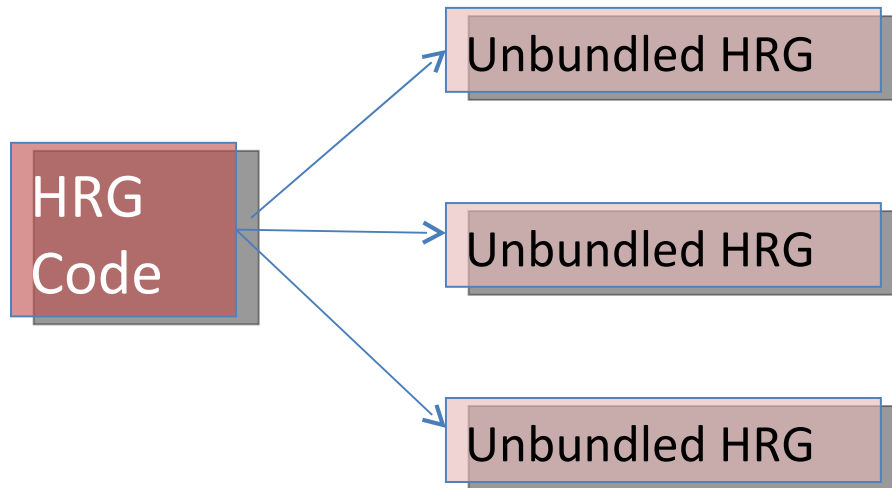
Intervention Codes (OPCS codes)

Diagnosis Codes (ICD-10 codes)

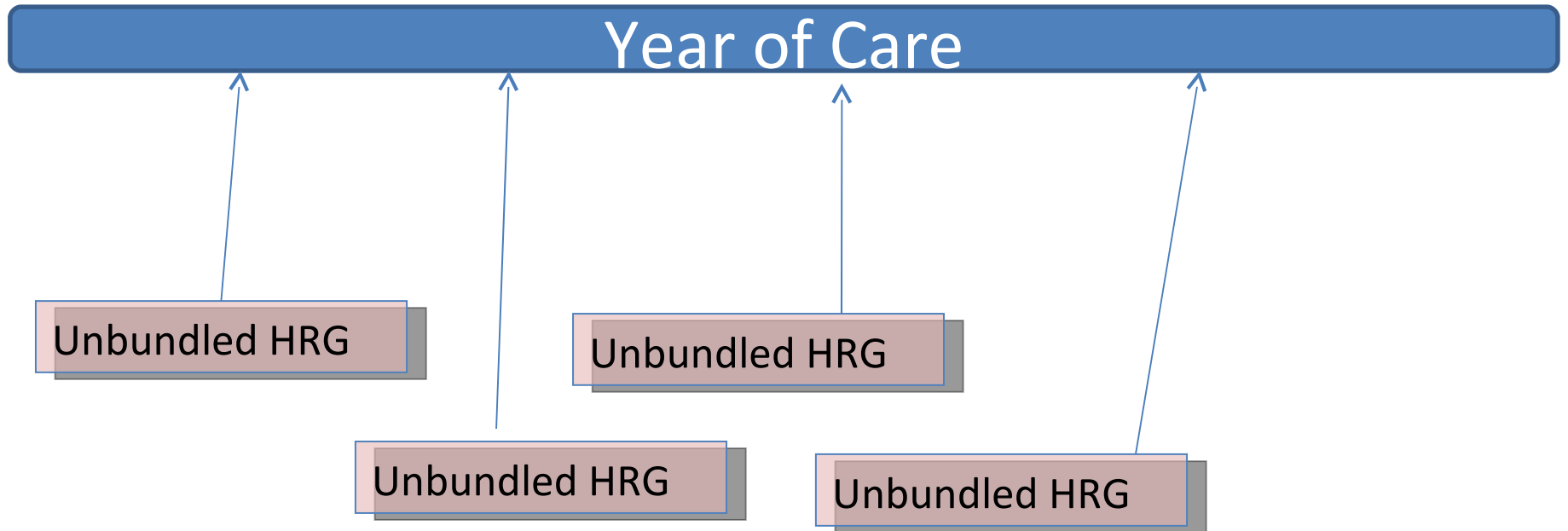
PbR Tariffs



Unbundling of Tariffs



Year of Care



Personalised Year of Care

Weighted according to disease state, geography, co-morbidity, individual circumstances

Year of Care

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graph BT; HRG1[Unbundled HRG] --> YOC[Year of Care]; HRG2[Unbundled HRG] --> YOC; HRG3[Unbundled HRG] --> YOC; HRG4[Unbundled HRG] --> YOC;
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The diagram illustrates the components of a personalised year of care. At the top, a blue horizontal bar is labeled 'Year of Care'. Below this bar, four light brown rectangular boxes, each labeled 'Unbundled HRG', are arranged in two rows. Blue arrows point from each of these four boxes up to the 'Year of Care' bar, indicating that these individual components contribute to the overall year of care.

Unbundled HRG

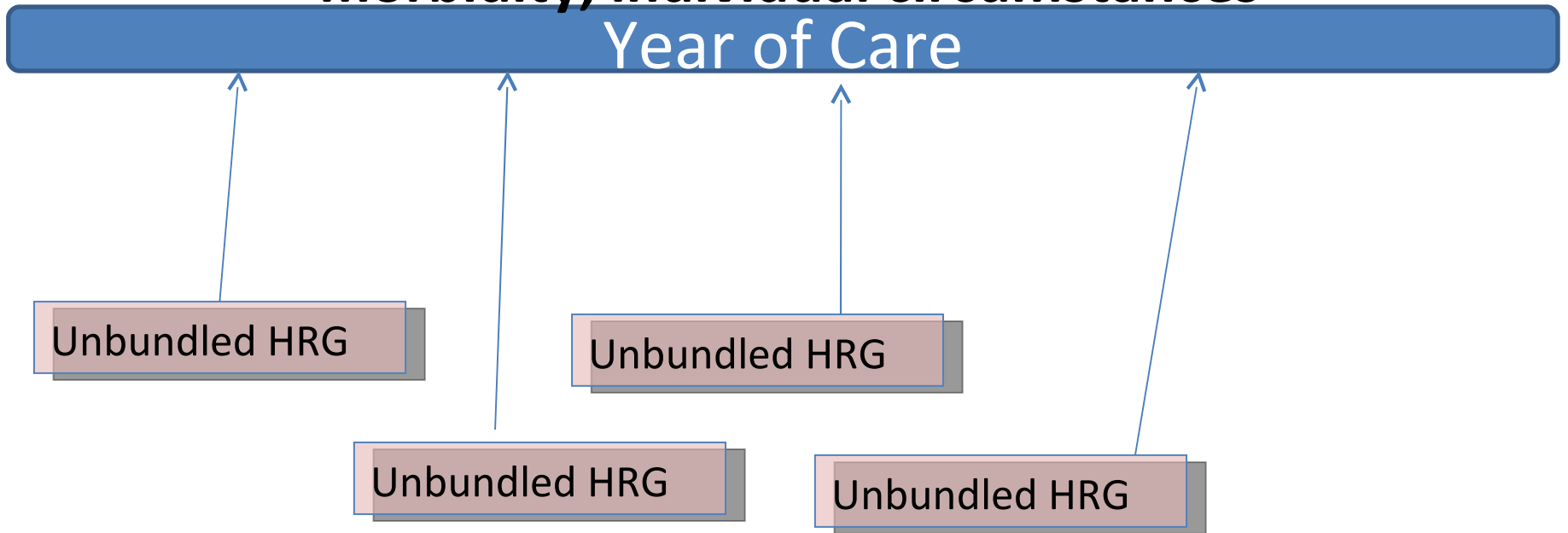
Unbundled HRG

Unbundled HRG

Unbundled HRG

Personalised Year of Care

Weighted according to disease state, geography, co-morbidity, individual circumstances



Give money to the individual themselves

What do we value

- Continuity of Care
- Proactive Care
- Integrated Care
- Holistic Care

