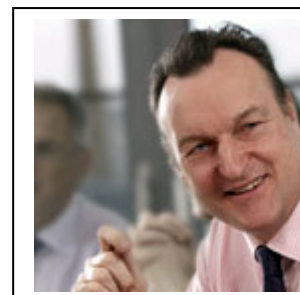


Mike Farrar



Mike Farrar is the Chief Executive of the NHS Confederation. He joined the organisation in May 2011.

Mr Farrar was chief executive of the North West England SHA from May 2006 to April 2011. He was previously chief executive of West Yorkshire and South Yorkshire Strategic Health Authorities, chief executive of Tees Valley Health Authority and head of primary care at the Department of Health. During his time at the Department of Health, he was responsible for establishing primary care groups, primary care trusts and Personal Medical Services (PMS).

Mr Farrar chaired the Strategic Health Authority Chief Executive's Group from 2002 to 2009. He chaired the NHS Confederation GP Contract negotiating team that successfully negotiated the new General Medical Service contract. He also worked as the national programme director of NHS Live. He previously chaired the Office for Life Sciences Innovation Delivery Board.

Mr Farrar is also a board member of Sport England, where he has also acted as interim chair, and in August 2009 was appointed as National Tsar for Sport and Health. Mike was also awarded the CBE in 2005 for services to the NHS and is an honorary fellow of the University of Central Lancashire.

Presentatie

Reforming Healthcare

- All 'mature democracies' experiencing significant cost and quality challenges
- Search for efficiency leads to the same sort of solutions (Pay for Performance; Competition; Shift from Hospital to Community solutions; use of technology etc)
- Importance of solutions matching the cultural and value base of different countries
- Learn from failure as well as success

Responses from Other Industries to Similar Challenges

- Consolidate
- Reduce Unit Costs of Labour
- Pull Technological Change
- Use competition to drive efficiency

- But in terms of healthcare, all of these are more difficult

Why is the rational thing to do harder in healthcare ?

- Consolidation often means fewer local hospitals – which usually lacks political and public support
- Unit costs of labour are often tied in in national contracts with well supported trade unions (Nurses and Doctors)
- Technological phobia in senior management ranks and aspiration outstrips state of the technology (eg. interoperability of EPR)
- Competition polarises the performance spectrum and in healthcare its difficult to manage the ‘lower end’ (Service failure in health is a matter of life and death)

But its essential to remain optimistic.....

- Necessity is the mother of invention
- Public attitude post economic collapse may be shifting on what they expect from healthcare systems
- Better sharing of good practice and learning
- Evidence that some solutions are emerging
- ‘Olympic spirit’ – challenge is inspiring not daunting

Evidence from the NHS in England

- Commissioning for Quality Examples -
 - > Primary Care (GMS Contract)
 - > Reduction in Healthcare Acquired Infections (National Operating Framework)
 - > VTE reductions (CQUIN Payments)
 - > P4P in Acute Services (Advancing Quality in the North West of England)
- Major Strategic Change

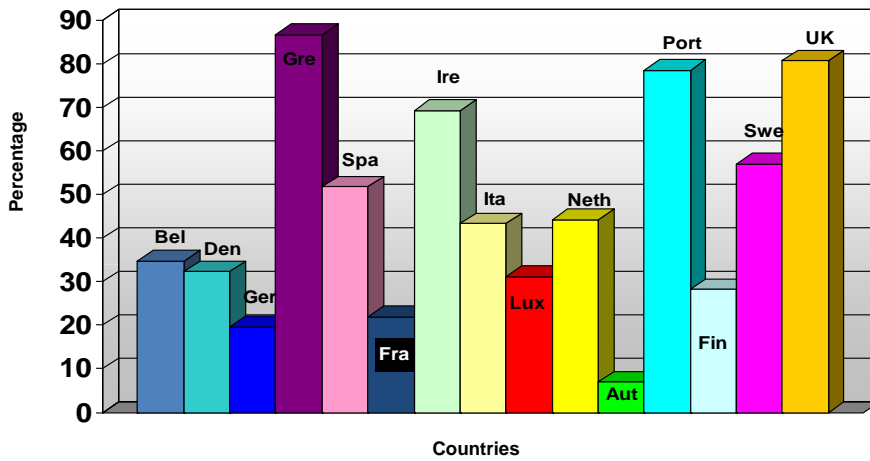
The English Health System

Nuts and Bolts in a Nutshell...

- Population based commissioning and allocation of resources on a needs weighted formula to 50 Clustered Primary Care Trusts ('payers')
- General Practice System offering cradle to grave primary care management and a gate-keeping role to secondary care through single registration of patients with one provider
- Competition for the right to provide acute care for patients based on free choice of any provider
(comprising 34% NHS trusts; 54% Foundation Trusts; 12% Independent sector organisations in market share)
- System Management by 10 Strategic Health Authorities and 2 Independent Regulators to ensure delivery of national and local targets and standards
- Major Set of Controversial Reforms (clinical commissioning; system management replaced by regulated market)

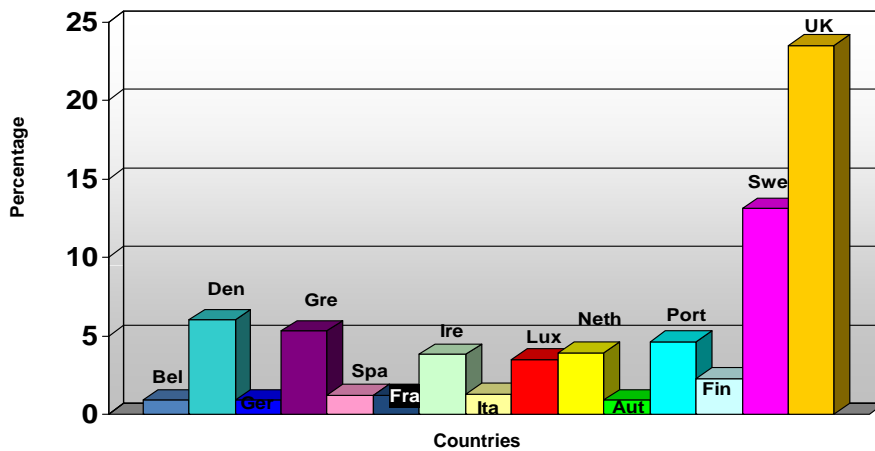
Historically, most people in Europe support increased spending on healthcare, but

Support for an increase in healthcare spending (% , net in favour)



People in the UK seem remarkably willing to put their tax money behind the NHS

% willing to pay more taxes for healthcare (% , net balance)

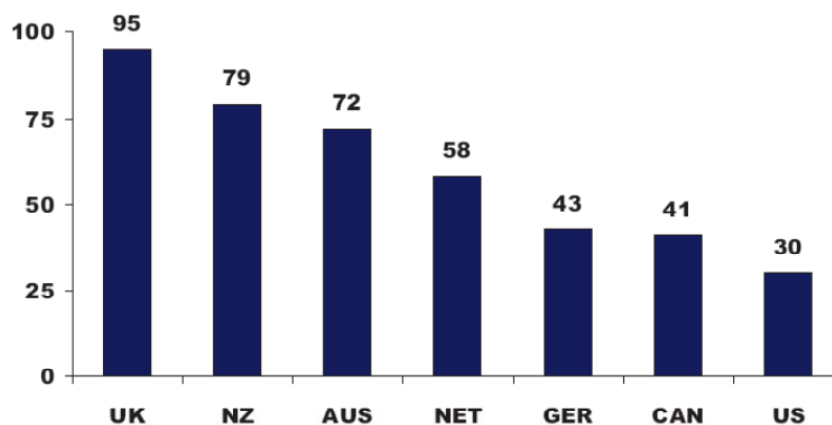


General Medical Services Contract

- Negotiated in 2004
- Largest systematic P4P system in the world
- Capitation based global sum (65%)
- Quality and Outcome Framework (25% income)
- Enhanced services and miscellaneous payments (10%)

Primary Care Doctors' Reports of Any Financial⁵⁰ Incentives for Quality of Care Improvement, 2006

Percent of physicians reporting any financial incentive*

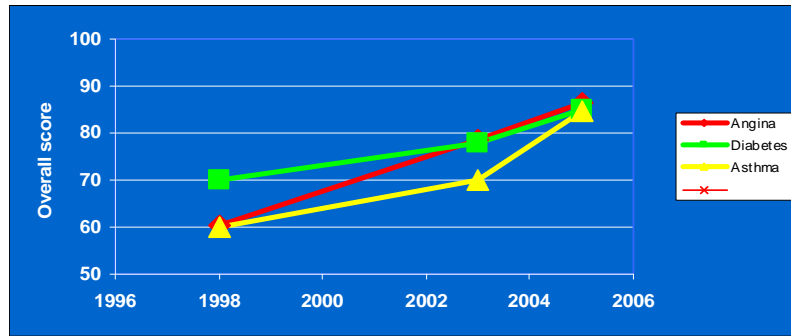


*Receive or have potential to receive payment for: clinical care targets, high patient ratings, managing chronic disease/complex needs, preventive care, or QI activities

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians

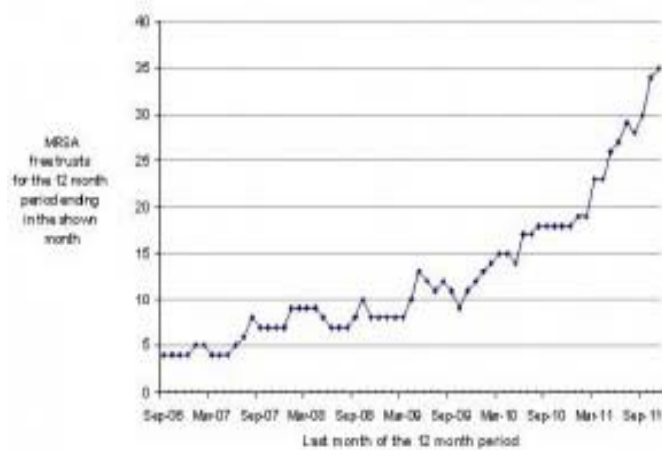


Quality of care improved between 1998 and 2005 more rapidly following the introduction of financial incentives



Campbell et al. Improvements in clinical quality in English primary care before and after the introduction of a pay for performance scheme. *New England Journal of Medicine* (in press)

MRSA Free Trusts for the 12 months ending in the shown month
Period covered October 2005 to November 2011



Primary Care Trust Network THE NHS CONFEDERATION

briefing

FEBRUARY 2010 ISSUE 15

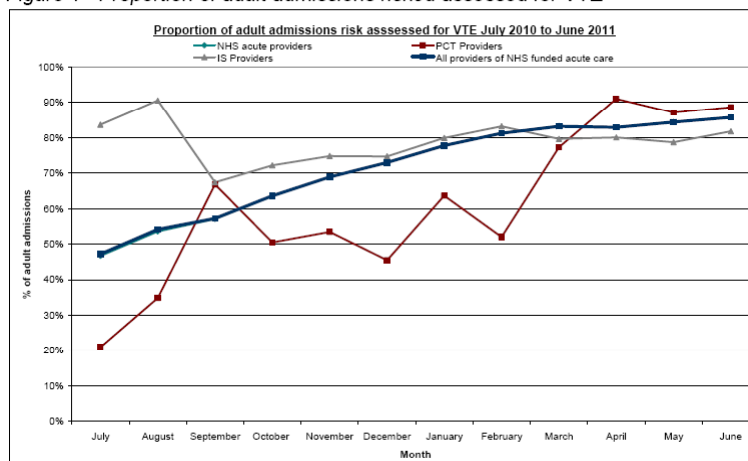
Commissioning for quality – delivering national priorities

The demands on commissioning are greater than ever before as primary care trusts are relied upon by policymakers and taxpayers to improve health and health services, assure quality and deliver value for money in an NHS faced with more stringent financial circumstances and increasing public scrutiny.

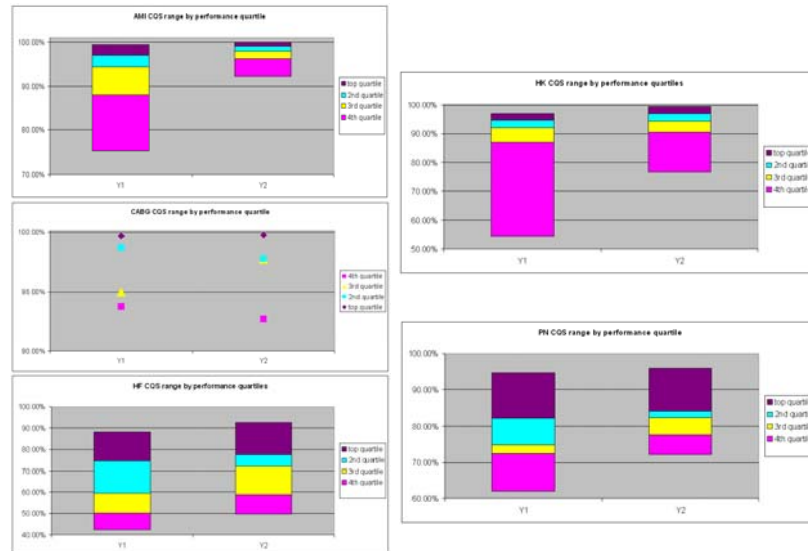
This *Briefing* highlights some actions commissioners can take to ensure they secure best value for patients and taxpayers when commissioning for two NHS priorities in 2010/11: delivering care for accommodation (DSCA) and...

Quality Improvements following the introduction of CQUIN Payments

Figure 1 – Proportion of adult admissions risked assessed for VTE



Comparison of Year 1 & 2 clinical process and outcomes



AQ : A Progress Report



Clinical Area	UK Year One Position*	UK Year Two Position**	US Year One Position***
AMI	92.55%	96.89%	89.31%
CABG	96.76%	96.94%	87.34%
HF	62.11%	69.95%	69.60%
HK	88.97%	92.73%	87.52%
PN	76.32%	81.55%	73.72%

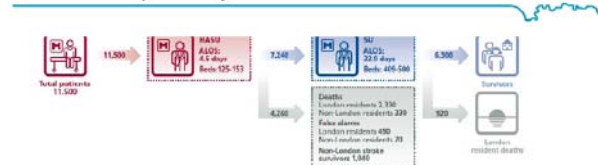
Interim findings from an independent evaluation indicate that the Advancing Quality (AQ) programme is leading to fewer deaths from congestive heart failure and pneumonia across the region.

Major Strategic Change

- Not created by commissioning for quality
- Almost always created by quality failing
 - Maternity changes in Greater Manchester
 - 13 Obstetric led sites to 8 sites
 - 2 neo natal sites to 3 sites
 - Population of 2.5m affected
 - Future proofed for staffing levels
 - Took 7 years from consultation to implementation
 - Saving 30 babies lives per year

Reorganisation of stroke services in London was the most controversial reconfiguration of services in the UK

New stroke pathway

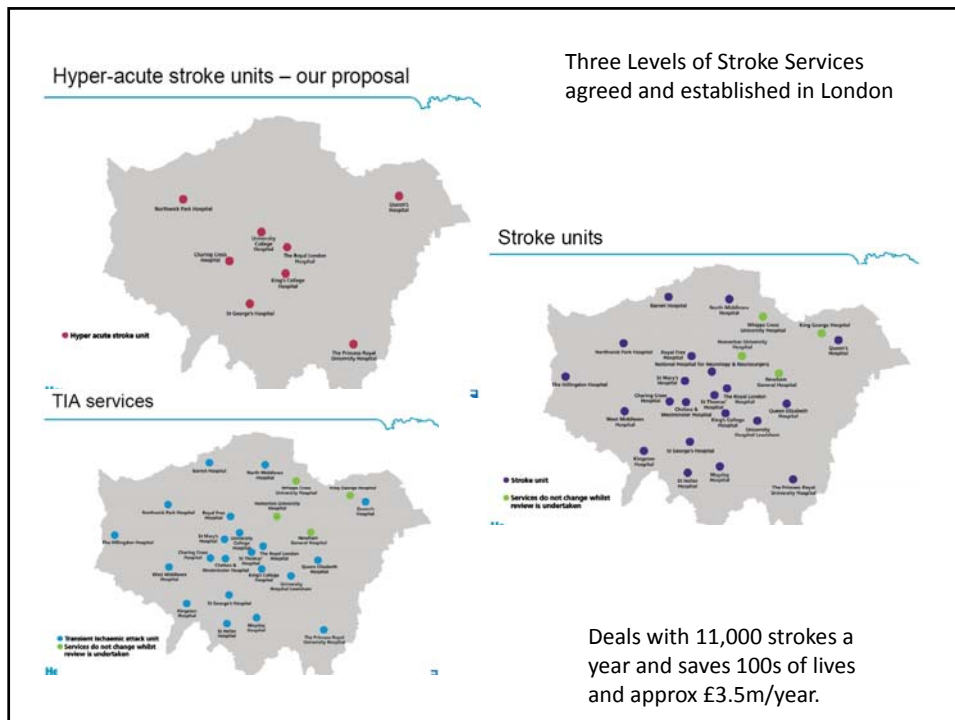


'Hyper-acute stroke units' (HASU)
 Eight units proposed
 Immediate response to stroke
 Stabilise
 Primary clinical interventions
 Thrombolysis if appropriate
 Length of stay us. less than 72 hours

Healthcare
for London

'Stroke units' (SU)
 20+ units proposed
 Inpatient care following a patient's hyper-acute stabilisation
 Multi therapy rehabilitation
 On-going medical supervision
 Varied length of stay (until patient well enough to be discharged from an inpatient setting)

NHS



Replacement of System Management with Market Ideology

- Current UK reforms move away from strategic system management
- Expectation is that quality incentives will be in contracts and primary care based commissioners will create 'small capacity opportunities'
- But the market will allow service failure and promote *unplanned* consolidation rather than system managers promoting aggregation and *planned* consolidation