

WHAT TYPE OF HEALTHCARE
PROVIDERS WILL WE NEED
IN THE FUTURE?

WHAT CARE MODELS COULD
PROVIDE BETTER QUALITY
AT LOWER COST?

HOW CAN WE MOVE
AWAY FROM A HOSPITAL-
CENTRIC MODEL OF CARE?

WHAT WORKS
INTERNATIONALLY?

The NHS
belongs to
the people

A CALL TO
ACTION

A CALL TO ACTION: TRANSFORMATIVE IDEAS FOR THE FUTURE NHS

A REPORT OF THE NHS FUTURES SUMMIT FEBRUARY 2014



A call to action: transformative ideas for the future NHS

Introduction

To mark the NHS' 65th anniversary in July 2013, NHS England published **'The NHS Belongs to the People: A Call to Action'** in collaboration with Monitor and the NHS Trust Development Authority.

The Call to Action describes how health needs are changing, especially with a growing epidemic of polychronic disease (patients with one or more chronic condition) and the specific needs that come with an ageing population. It also illustrates the economic gap that is expected to emerge over the coming years—estimated at approximately £30bn by 2020/21. To meet these challenges, the NHS needs to find new ways of delivering health and care that are more productive and better suited to what patients and the public will need in the future.

On 21 November 2013, the three national partners hosted the NHS Futures summit. The summit was designed to spark debate about how the landscape of health and care providers could evolve over the next decade to better

meet the challenges outlined in the Call to Action. Over 100 senior health leaders took part including commissioners, providers (including GPs), health policy experts, and patient and charity representatives. On behalf of the national partners, Monitor used new crowdsourcing technology to engage over 300 NHS leaders through an online debate on future provisions models, a summary of which can be **found here**.

This report summarises the ideas discussed at the summit. It is also intended to assist commissioners, providers and their local partners, as they look ahead. Commissioners, providers and their local partners have been asked to develop ambitious plans that look forward to the next five years, with the first two years mapped out in the form of detailed operating plans. Taking a five-year perspective is crucial, as commissioners and providers need to develop bold and ambitious plans rather than edging forward on an incremental basis one year at a time. This report

outlines just the sort of potentially transformative options that local health economies may wish to consider.

More detail about this strategic and operational planning process, including the guidance released alongside this report, is available on the websites of **NHS England, Monitor** and the **NHS TDA**.

Please note that NHS England, Monitor and the NHS TDA do not endorse any particular model featured in this report. Commissioners and providers need to decide for themselves what reforms are most appropriate for their areas and circumstances. The proposals contained in the report may not be relevant everywhere, nor are they the only options, but they do illustrate the type of bold vision that health leaders across the NHS will need to formulate if we are to meet the challenges that face us.

Six visions for the future NHS

Six visions for the future NHS

We asked a number of leading health policy thinkers and practitioners to develop future scenarios about the types and mix of health and care providers that could emerge given what we know about likely future health needs, economic constraints and other relevant dynamics (e.g. demographics, service user expectations, technology trends etc).

In developing their scenarios or strategic options, we asked contributors to focus on transformative ideas that could be implemented over the longer-term; in other words, ideas that would require fundamental change to the health and care services that we provide to patients and the public and how we deliver them. We also asked contributors to focus on the provider landscape rather than on, say, commissioning or national policy, although clearly these may be important enablers of provider reform.

However, we did ask contributors to assume that there would be no centrally driven, or top-down reorganisations. We also assumed that funding settlements would only grow inline with inflation despite increasing demand for services. These assumptions helped focus the scenarios on changes that could dramatically improve the value of the health service—delivering better outcomes and patient experience for lower net expenditure.

Six visions about how the landscape of provision should evolve were presented at the Futures Summit and are summarised on page 6 and 7. Further detail is available by clicking on the topic.

Six visions for the future NHS

Dr Jim Bonnette¹ described different care models emerging around the world aligned to specific population segments with different levels of risk. He explored in detail an **extensivist led approach**, in which a community-based doctor is responsible for wrapping services around the sickest patients no matter the setting in which they receive care. Dr Bonnette illustrated the model with respect to vulnerable older people.



Click the image to view or visit:

<http://www.youtube.com/watch?v=VqEIUHsC6oU&feature=c4-overview&list=UUI-kWXLNEK7rsBW9ZVCvPfg>

Instead of describing a particular care model, Professor Paul Corrigan² and Mike Parish³ developed an account of **how innovation could be diffused by encouraging new entrants**.

They cited a number of examples from other sectors such as the grocery industry. These industries have learned to 'co-produce' value with their consumers, transforming them from passive recipients of services to active elements of the value chain. Professor Corrigan and Mr Parish also suggested that lessons from other industries about how to convert fixed to variable costs could have a radical impact on productivity.



Click the image to view or visit:

<http://www.youtube.com/watch?v=JDXuH7suFZU&feature=c4-overview&list=UUI-kWXLNEK7rsBW9ZVCvPfg>

Bridget Fletcher,⁴ Aimee Chapple⁵ and Kipp Webb⁶ discussed **technology trends and disruptors** with the potential to reshape healthcare provision. Building on Airedale's ambition to provide much more care in patients' homes through data-driven, integrated services, this scenario identified ten key technologies that could transform how care is provided both to healthy populations and to polychronic and elderly patients.



Click the image to view or visit:

<http://www.youtube.com/watch?v=3nSzUYIfJs&feature=c4-overview&list=UUI-kWXLNEK7rsBW9ZVCvPfg>

Six visions for the future NHS

Dr Nicolaus Henke⁷ presented new models for providing **out-of-hospital services** that could be implemented in England. These included hospital led systems like Torrevieja Salud in Spain, which manage patients on a capitated basis in both primary and secondary care settings. He also described physician led networks, like ChenMed in the US, which cares for cohorts of high-risk patients again on a capitated basis, primarily in a home or community setting and with impressive results.



Click the image to view or visit:

<http://www.youtube.com/watch?v=U855tlayd4k&feature=c4-overview&list=UUI-kWXLNEK7rsBW9ZVCvPfg>

Dr James Kent⁸, Dr Graham Rich⁹ and Dr Detlev Loppow¹⁰ outlined a model of specialist **centres of excellence for planned surgery**, operating at high volumes and with strong transparency on outcomes. They illustrated this scenario with reference to the Martini-Klinik in Germany which specialises in prostate cancer. Martini-Klinik delivers such outstanding outcomes that a quarter of patients travel more than 300 miles for their care despite the availability of local providers.



Click the image to view or visit:

<http://www.youtube.com/watch?v=dlqpCPvNi8&feature=c4-overview&list=UUI-kWXLNEK7rsBW9ZVCvPfg>

Professor Terence Stephenson¹¹ looked forward to a future NHS that would provide **a seven-day-a-week, consultant present service**. Achieving this vision within economic constraints would require significant consolidation and reconfiguration of the current landscape of hospital provision. It would also require a flexible workforce able to provide care across primary, social care and secondary boundaries.



Click the image to view or visit:

<http://www.youtube.com/watch?v=2BrmFhZNHq&feature=c4-overview&list=UUI-kWXLNEK7rsBW9ZVCvPfg>

Achieving change: themes from the discussion

Achieving change: themes from the discussion

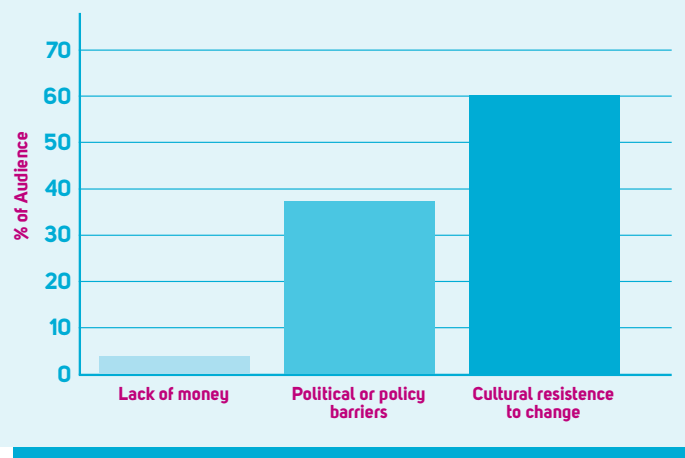
The agenda of the Futures Summit featured plenary discussions from the sponsoring organisations, including hosts Sir Malcolm Grant, Dr David Bennett and David Flory. Attendees also debated the visions that were presented on the day. Although the discussion was rich and varied, the following themes stood out for the frequency in which they were raised.

- There was a strong consensus for the need for bold and transformative change to respond to the challenges the NHS faces (see Figure A). Although many attendees expressed worry at how little time we have to effect change—particularly given the pressure on providers over the next two years—there was also widespread confidence that transformation could be achieved.

“I AM ALMOST PATHOLOGICALLY OPTIMISTIC WE CAN ACHIEVE THE CHANGE THAT’S NEEDED.”

GP leader at NHS Futures Summit

FIGURE A: BARRIERS TO CHANGE ACCORDING TO NHS FUTURE SUMMIT ATTENDEES



- Attendees stressed the need for local experimentation and a tolerance for taking risks. In this respect, initiatives like the **Better Care Fund** were supported despite being at an early stage. Experimentation and diversity of models should be a feature of the forthcoming five-year planning process since local circumstances vary substantially. Attendees also described the need for the ‘space’ to develop longer term planning and to ensure that short-term needs do not always trump strategy.
- However, this experimentation would need to be matched with better communication with the public and greater political skills. The reception of work like Sir Bruce Keogh’s recent first stage report on **Urgent and Emergency Care** showed that difficult messages can be communicated to the media and the public if they are deftly and sensitively handled.

Achieving change: themes from the discussion

“I’M STRUCK BY HOW FAR BEHIND THE MEDIA ARE, AND AS A RESULT POLITICIANS, IN UNDERSTANDING THE CHANGE THAT’S NEEDED.”

Jonathan Dimpleby, Master of Ceremonies, NHS Futures Summit

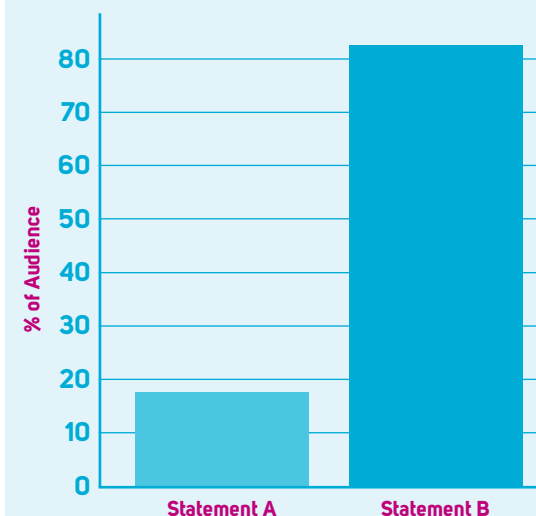
- Across the different visions discussed on the day, attendees raised the need for workforce change. To deliver new care models, we would also need new workforce models—and ones with much greater flexibility. Importantly, urgency demands not only that we reform how we train professionals in the future, but also support the NHS’ current workforce.

- Attendees cited many barriers to change, with culture perhaps the most common. Crucially, money was not regarded as an important barrier (see Figure B). Although investment is required to support new care models, this can be achieved by taking a longer term planning perspective—through the five-year strategic planning process—and by reallocating resources. ‘Double running’ new care models alongside old ones could also require funding.
- Many health leaders at the summit wanted to unlock patient and consumer demand to drive change. There was scepticism that large-scale reform could be achieved by national bodies, commissioners and providers alone: patients and the public need to be enlisted as agents of change.

FIGURE B: THE NEED FOR TRANSFORMATIVE CHANGE, ACCORDING TO NHS FUTURE SUMMIT ATTENDEES

WHICH STATEMENT DO YOU MOST AGREE WITH:

- A) Achieving greater commissioner and provider efficiency will enable us to meet future challenges both health and financial
- B) We need to fundamentally change how services are provided in order to meet future challenges



Achieving change: themes from the discussion

“WE NEED TO HAVE MORE DISRUPTIVE DEMAND IN THE FUTURE.”

Attendee, NHS Futures Summit

- Finally, the need for leadership was often raised. However, the point was not just about national leadership—and certainly not top-down leadership—but about a more distributed leadership that draws on health leaders from across the NHS and especially clinical professionals. Without active clinical leaders, many thought transformation unachievable.

“CENTRAL TO ACHIEVING CHANGE IS CONFLICT—CONFLICT BETWEEN THE CURRENT BUSINESS MODEL AND NEW BUSINESS MODELS DESIGNED TO REPLACE IT.”

Professor Paul Corrigan, NHS Futures Summit

Overall, perhaps the strongest message that emerged from the day is that how to achieve change is the biggest problem facing health leaders. Some of the ideas discussed on the day have been circulating in one form or another for several years, and yet transformative change has occurred only in isolated patches around the country and indeed internationally.

Conclusion and next steps

Conclusion and next steps

We hope that commissioners and providers will find the ideas summarised in this report helpful as they prepare their five-year plans, although the proposals may need to be adapted for local circumstances.

Of course, these are not the only viable options, nor will they be applicable everywhere, but they do illustrate new care models with the potential to deliver more value for patients and the public. The **strategic and operational planning** process, published by **NHS England, Monitor** and the **NHS TDA**, is a key opportunity for local health economies to develop their own ambitious

proposals. NHS England, Monitor and the TDA will also consider what further development of new care models could help commissioners and their partners. We will also be using the information gathered at the NHS Futures Summit to inform national action that may be required to remove obstacles to change and support the transformation the NHS needs.

For more information, please contact:

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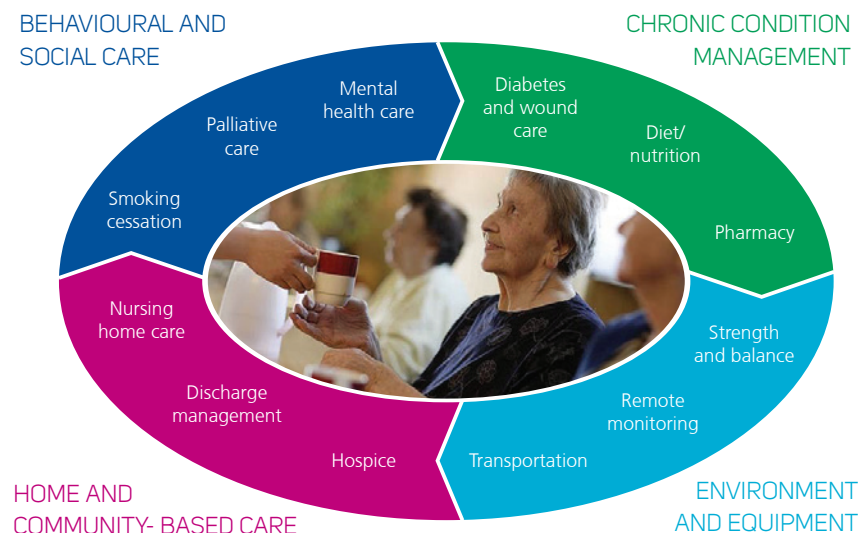
NHS TDA:
ntda.enquiries@nhs.net

Transforming the care of the vulnerable elderly

Summary of the presentation by Dr Jim Bonnette¹ to the NHS Futures Summit, 21 November 2013

THE EXTENSIVIST MODEL: VISION

- The Extensivist model focuses on the highest need patients at risk of catastrophic decline
- Care is reoriented around the needs of the patient, spanning primary, secondary and social care
- Each patient's care is led by a confident generalist doctor, known as an Extensivist, who has full accountability for their patients' outcomes and overall budget
- Designated Extensivist clinics act as the physical hub for the care programme, typically located in the community
- Each clinic with 2-4 Extensivists can care for ~1,500 high risk patients (from a catchment area of ~80,000) supported by multidisciplinary care teams including case managers, nurses, physiotherapists and social workers



HOW WOULD IT IMPROVE OUTCOMES?

- The holistic care system is designed to ensure proactive prevention and early intervention, breaking the cycle of reactive care provision
- Robust predictive modelling identifies patients at risk for enrolment into the programme before their health declines
- Each patient has a care plan tailored to their individual needs, with different programmes designed for different needs e.g. diabetic programme, chronic heart failure programme
- Care takes place at convenient locations for the patient, with significant home care and support for transportation to ensure high levels of compliance with treatment programmes
- Full authority over care decisions, and full clinical and financial accountability to ensure incentives are aligned to drive better outcomes for patients and commissioners

DEMONSTRATED CARE MODEL IMPACT

- 90% reduction in falls
- 80% reduction in amputations
- 50% reduction in mental health admissions
- 30% fewer bed days
- 60% of patients are able to die at home
- 80% of members refer friends to the programme
- 20% reduction in costs

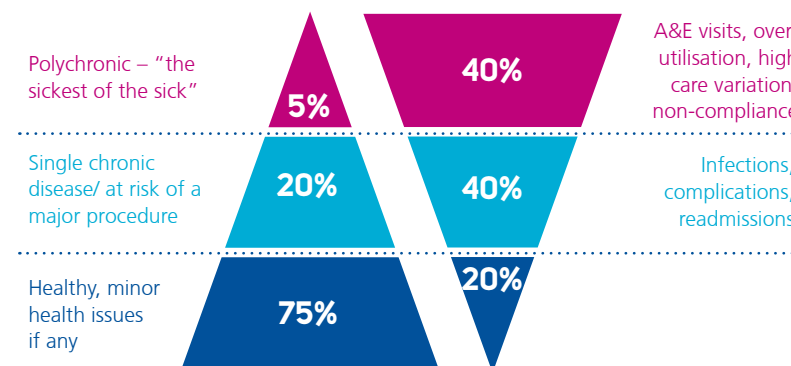
Transforming the care of the vulnerable elderly

Summary of the presentation by Dr Jim Bonnette¹ to the NHS Futures Summit, 21 November 2013

HOW WOULD IT ADDRESS THE FINANCIAL GAP?

- Reduced unplanned attendances of Accident and Emergency and Urgent Care Centres
- Decreased inpatient admissions and specialist utilisation (including reduced outpatient appointments)
- Shortened inpatient length of stay (enhanced recuperation and rehabilitation care at designated Extensivist step-down facilities)
- Reduced proportion of deaths in hospital (and increased provision of end-of-life care at home/ in hospices, aligned with patient choice)
- Release of GP time to address other patient groups

CARE FOCUSES ON THE 5% OF PATIENTS WHICH DRIVE 40% OF COSTS



HOW COULD IT BE ACHIEVED?

This model could be developed by any player in the health system for a given target population. Potential implementation steps include:

1. Local health economy mapping and feasibility study:

- Will it work in my area?
- For what population?
- With what impacts?

2. Developing the blueprint for the Extensivist model and implementation requirements:

- What will it look like and require? E.g. clinical model design; clinical quality metrics; governance; risk pricing; incentive and contracting model; investment and economics; site selection; IT systems

3. Shifting to implementation:

- How do I support potential partners to deliver the model?

KEY SUCCESS FACTORS INCLUDE:

Aligned Care Delivery Approach

- Meaningful population segmentation
- Coordination across clinical settings
- Impactful, patient-centric care model and care delivery redesign

Aligned Accountability and Incentives

- Single point of care accountability
- Clinical risk assessment infrastructure
- Financial upside and full control of funds

Supporting Capabilities

- Aligned clinical resources & competencies
- IT and systems to facilitate patient-centric care
- Partnerships to address capability gaps

Compelling Leadership

- Leadership by individuals not committees
- Alignment and promotion of end state vision
- Support of change management agenda

Ability to Scale and Replicate

- Upfront orientation towards scale and replication
- A model that is not built on specific local characteristics
- Development of standard processes

Consequences of disruptive market change for established businesses with predominantly fixed cost structures

Summary of the presentation by Professor Paul Corrigan² and Mike Parish³ to the NHS Futures Summit, 21 November 2013

NEW ENTRANTS DRIVE CHANGE

In other industries, new and disruptive business models have come from the entrance of new providers.

There is no need for the state to pretend it has the knowledge that allows it to specify successful business models; instead, commissioners need to commission health and social care outcomes for patients, policymakers need to focus on providing the space that will enable entrants, as well as ensuring that mechanisms are in place for failing business models to disappear rather than to subsidise failure.

In other industries successful new business models uncover new sources of value creation. In health care this will involve the co-production of value with patients and the public. As in other industries, this requires consumers being active in their experience rather than being passive recipients.

The new business model will recognise the home and not the hospital is the main location where healthcare takes place. The new business model will establish the home as a more efficient location for value creation in health care.

Given the unique and powerful status of the NHS, new business models will rarely be allowed to simply replace the old business model; rather the two are likely to co-exist—albeit in conflict—until the overwhelming benefits of the new technologically integrated model gradually, with the active demand from patient groups for new and better care, ‘out competes’ the old.

This mirrors the experience of other industries, and our hypothesis is that over time this will happen in healthcare.

THE PROBLEM OF FIXED COSTS FOR THE NHS

The very high level of perceived fixed costs in NHS hospitals restricts the belief of NHS hospitals that they can be agile enough to radically change business model.

Most acute NHS hospital trusts fixed costs are in real estate. Since healthcare property management is typically not entrepreneurial, the NHS assumes these costs to be totally fixed. Challenging this assumption is necessary if the NHS hospital is going to develop a new business model.

Other industries have addressed the problem by moving costs from the table of fixed to that of variable. They do this in order to exit fixed cost structures.

Since real estate is one of the main fixed costs, reducing the need for high acuity patients to stay in hospital would challenge the nature of this ‘fix’. If more high acuity healthcare could be delivered safely in the home this would shift the cost of a bed from the hospital to the home of the patient (where patients really want to be).

Consequences of disruptive market change for established businesses with predominantly fixed cost structures

Summary of the presentation by Professor Paul Corrigan² and Mike Parish³ to the NHS Futures Summit, 21 November 2013

Workforce costs are also seen as fixed in the NHS, in the context of national pay bargaining arrangements. If the patient pathway shifts from being fully delivered by one provider within one building, it is less appropriate for the clinical workforce to be all employed by that one provider. This is likely to result in workforce mobility unprecedented within the NHS.

OTHER INDUSTRIES HAVE MADE RADICAL CHANGES TO THEIR BUSINESS MODEL THAT THEN IN TURN BECOME 'NORMAL': THE EXAMPLE OF GROCERY RETAILING

In the 1970s the grocery industry developed a new business model which transformed the consumer experience of the industry.

Previously, retail outlets were high street based and fragmented. Outlets were serviced by dominant grocery manufacturers, who passed their distribution cost onto retailers and thus consumers.

New entrants developed larger retail outlets, improving their buying power, and built sufficient critical mass to create their own dedicated

distribution centres. Consumers could now buy all their shopping under one roof, with greater choice, reduced cost of sale and higher quality.

Because the new large format stores were designed for self-selection, they were able to reduce staff costs. This proved to be a win win – the shoppers enjoyed the shopping experience of browsing the aisles, the retailer employed fewer staff.

Unlike the current NHS, increasing the size of outlets was not the only way that high quality and low cost could be assured. We have seen large retailers return to local convenience stores, which are viable through supply chain efficiency and a large-scale distribution infrastructure. Similarly, home shopping has taken off because of the convenience with little additional cost.

One can imagine the NHS going through a similar transition, reducing its fixed costs, high overheads and moving towards a much flexible supply chain for delivering care with multi-channel access.

HOW COULD THE NHS ENABLE THE EMERGENCE OF NEW BUSINESS MODELS?

Key steps should include:

- **Reforming how organisations are measured and paid.** Outcomes should be worked out initially by the commissioner with patients' organisations and further developed with prospective providers in competitive dialogue. This would reward reductions in hospital beds and fixed costs.
- **Encouraging 'integrators'.** The organisational form that will pick up these contracts will be very different from a hospital or surgery. The new organisations will need to be incentivised to integrate services from multiple providers and will need skills from across the health and social care supply chain rather than in one form of provider.
- **Workforce, relationships and culture.** Over the next decade we need to retrain the workforce to play their role in delivering whole person care that enhances self-management.

Consequences of disruptive market change for established businesses with predominantly fixed cost structures

Summary of the presentation by Professor Paul Corrigan² and Mike Parish³ to the NHS Futures Summit, 21 November 2013

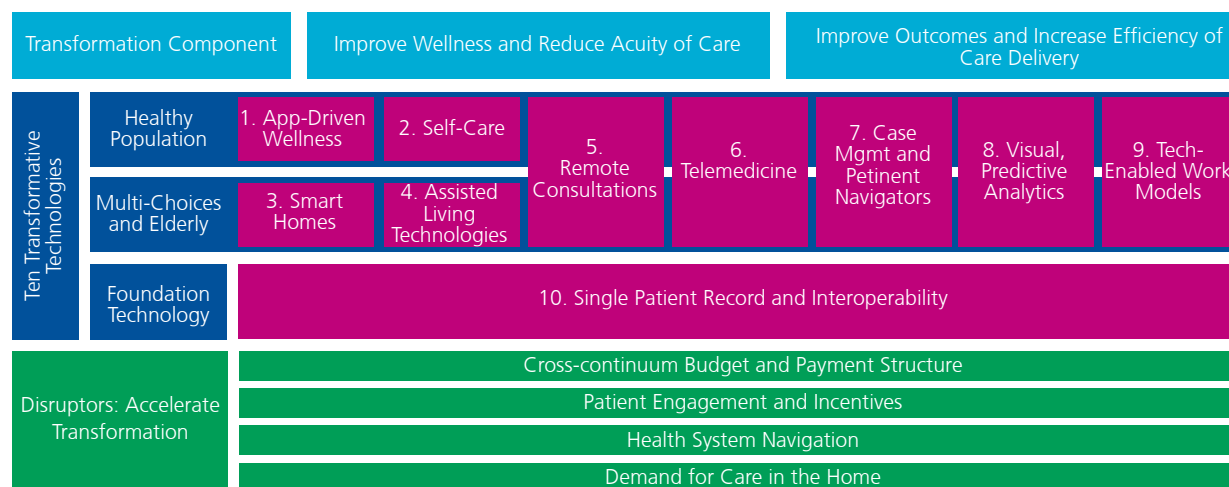
- **Reforming specialist care.** Specialist providers should become expert not only in the delivery of specialist, episodic care but also in the delivery of community level social and health across a wide set of geographies.
- **Long-term conditions (LTC) care.** The main site for the provision of health and social care for patients with multiple LTCs should be the home. Co-production and self-management, facilitated by technology, needs to be at the heart of this new model, enabling the home to safely be the location for higher acuity health care.
- **Outcome-based regulation and commissioning.** Regulators - both economic and quality - need to regulate outcomes and not processes. Monitor and NHS England should continue to encourage new forms of pricing which move away from episodic reimbursement. Commissioners should favour innovations by commissioning to outcomes and not to processes. This will develop new providers and markets.

Personalised and preventative care: technology trends and disruptors that will shape the healthcare transformation

Summary of the presentation by Bridget Fletcher⁴, Aimee Chapple⁵ and Kipp Webb⁶

PREVENTATIVE AND PERSONALISED CARE: THE VISION

- The preventative and personalised care approach focuses on structuring care provision proactively around patients' needs
- Aim is to engage with patients before they get seriously ill or if ill already, to tailor care to reduce acute episodes
- Accenture explored ten technology trends that will shape the design and delivery of the preventative and personalised care agenda over the next decade
- Main benefits of this approach is the shift to improved wellness, a reduction in the acuity of care and an overall improvement in outcomes and efficiency in care delivery



HOW WOULD THE VISION IMPROVE QUALITY?

- Driving a wellness agenda and treating patients proactively to avoid or delay acute episodes through app-driven wellness, self-care, smart homes and assisted living technologies
- Treating patients in the comfort of their homes, and tailoring care to individual patient's needs through telemedicine and remote consultations
- Greater efficiency in care delivery through the use of case managers, patient coordinators, predictive analytics, technology-enabled new work models and interoperability between care systems

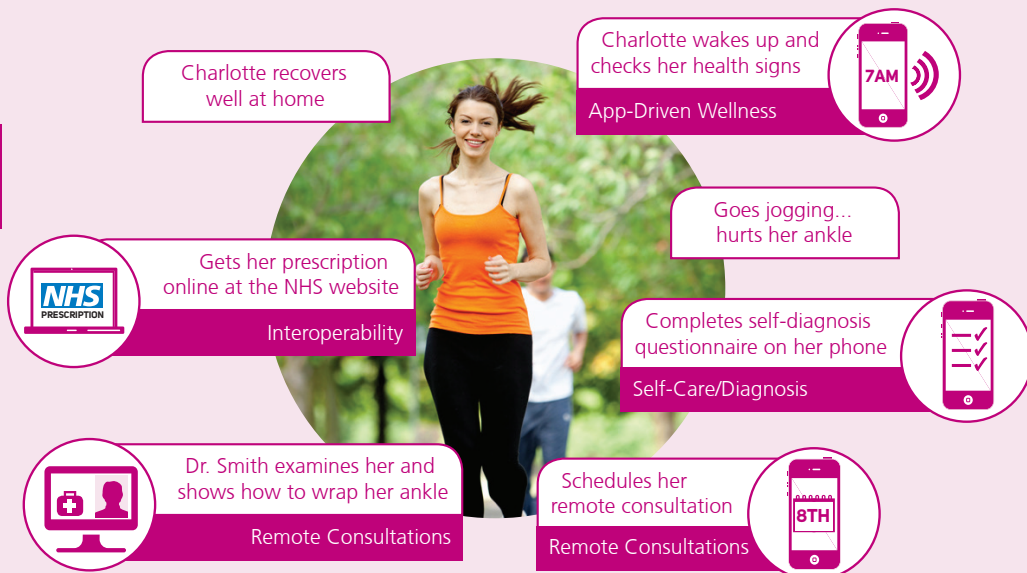
AND REDUCE COST?

- Whilst innovative technology can offer an incredibly robust platform for managing individual and population health, technology alone does not drive transformational change.
- There are four disruptors that will accelerate the move towards a preventative and personalised care approach:
 1. Creation of a cross-continuum budget and payment structure
 2. Relentless focus on patient engagement and incentives
 3. Health system navigation
 4. Increased demand for treatment outside of traditional care settings

Personalised and preventative care: technology trends and disruptors that will shape the healthcare transformation

Summary of the presentation by Bridget Fletcher⁴, Aimee Chapple⁵ and Kipp Webb⁶

CHARLOTTE, A HEALTHY 25 YEAR OLD...



MICHAEL, THE 80 YEAR OLD WITH DIABETES...



Personalised and preventative care: technology trends and disruptors that will shape the healthcare transformation

Summary of the presentation by Bridget Fletcher⁴, Aimee Chapple⁵ and Kipp Webb⁶

THE FUTURE IS ALREADY HERE: AIREDALE FOUNDATION TRUST

Airedale's Right Care programme uses technology and new ways of working to bring health and social care into patients' homes

OUR VISION: CARE IN PEOPLE'S HOMES THROUGH DATA DRIVEN, INTEGRATED SERVICES



AIREDALE NHS FOUNDATION TRUST © 2013

DISRUPTORS TO ACCELERATE CHANGE

Continuum of Care

Cross-continuum Budget and Payment Structure

Patient Engagement and Incentives

Health System Navigation

Demand for Care in the Home

Delivering care outside of hospital—Yes but how?

Summary of the presentation by Dr Nicolaus Henke⁷ to the NHS Futures Summit, 21 November 2013

NEW MODELS OF OUT-OF-HOSPITAL CARE ARE EMERGING ACROSS THE WORLD

- Many health systems trying to develop models that deliver services out of hospital
- Four types or options have emerged:
 - a. Virtual models which supplement traditional care with call centre services and structured protocols
 - b. Physician-led networks which care for cohorts of high-risk patients on a capitated basis
 - c. Hospital led systems that manage patients across both primary and secondary care settings
 - d. Specialist carve-outs that care for specific high-utilisation patient groups



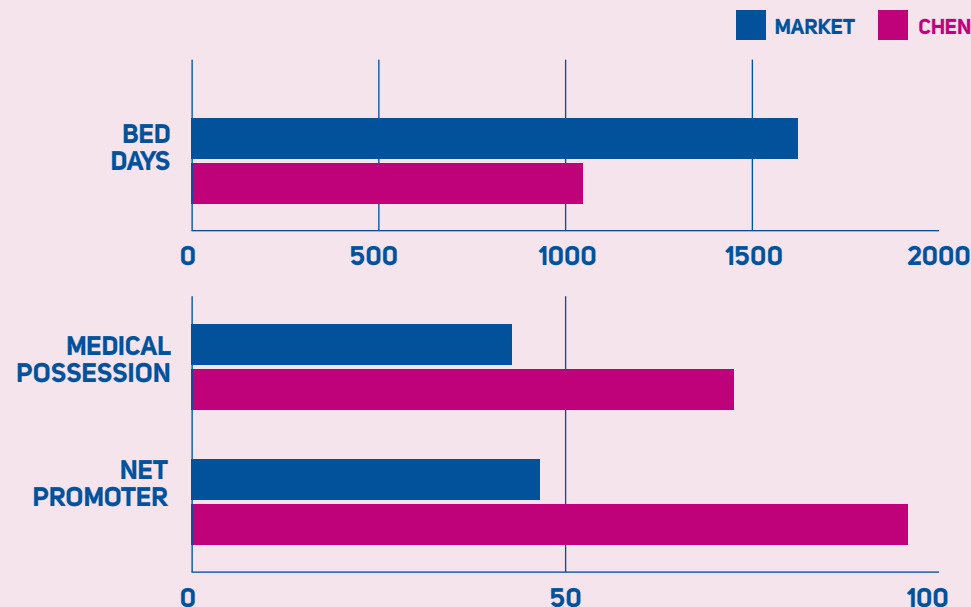
CHENMED SUCCESSFULLY CARES FOR SOME OF THE SICKEST PATIENTS AT LOWER COST

Approach

- Focus on older population with multiple conditions
- Primary care-led physician group with small list and intense care model
- Risk adjusted capitation
- Free patient transport to/from health centre
- 'Air traffic control' to minimise waiting times
- Mobile access to records and real-time information flow

Impact

- 18% lower hospitalisation rates
- 22% lower cholesterol levels for patients on statins
- 38% reduction in hospital days
- 100% increase in patient experience scores



Delivering care outside of hospital—Yes but how?

Summary of the presentation by Dr Nicolaus Henke⁷ to the NHS Futures Summit, 21 November 2013

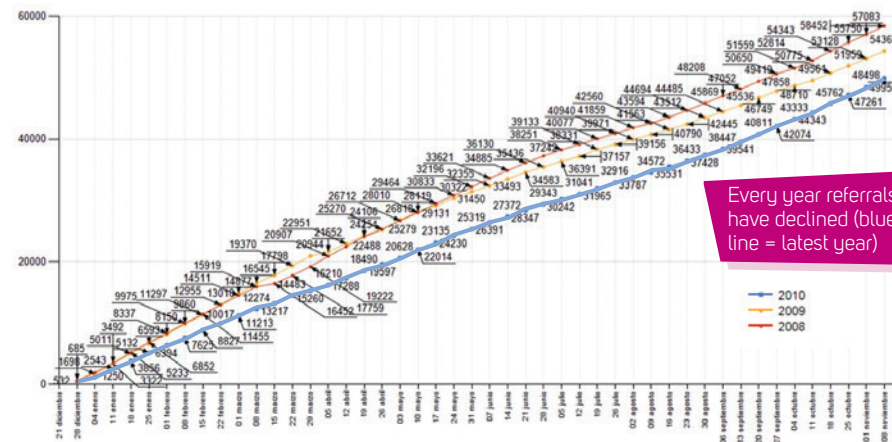
TORREVIEJA HOSPITAL HAS REDUCED DEMAND BY SETTING UP SERVICES IN THE COMMUNITY

Approach

- Medium sized hospital (about 260 beds) and primary care network serving a diverse elderly and immigrant population
- Single team runs the hospital and primary care centres located in the community around it
- Paid an annual fee per insured resident “Cápita”, covering comprehensive services offered
- EMR with mobile tools for physicians and patients

Impact

- Reduced emergency visits, outpatient referrals and surgical waiting lists
- Greater patient empowerment e.g., they can check waiting times for A&E and community care by phone



HOW COULD THE NHS IMPLEMENT VERSIONS OF THESE MODELS?

Take advantage of the new landscape

Specialise

- Specialist commissioning
- Accident & Emergency
- Quality inspection transparency

Reshape and integrate local care

- Reasons to integrate: demand, local hospital future, chronic care
- Health & Wellbeing Boards as vehicle
- Public health transparency investment

Develop enablers

- Health & Social Care Information Centre / care.data
- Future workforce / Health Education England
- Incentives/contracts



Remove barriers

Competition rules

- Enable specialisation
- Enable local integration
- Compete where competition adds most value

Local provider development – refocus CCGs?

- Management bandwidth
- IT integration

Strategic and implementation capabilities

- Discontinue under-investing
- Sort commissioning support one way or the other
- Celebrate and develop talent

Planned surgical care: driving higher volume through fewer centres

Summary of the presentation by Dr James Kent⁸, Dr Graham Rich⁹ and Dr Detlev Loppow¹⁰ to the NHS Futures Summit, 21 November 2013

EVIDENCE SHOWS QUALITY AND COST BENEFITS FROM CONCENTRATING SERVICES

International evidence shows that performing planned surgery in fewer, high volume centres provides better care for lower cost

- Systematic review of 163 articles covering 10m patients shows 93% positive correlation between quality and treatment volume¹²
- In England, consolidation of NHS stroke services in London demonstrated benefits of consolidation

The benefits are driven by three reinforcing factors

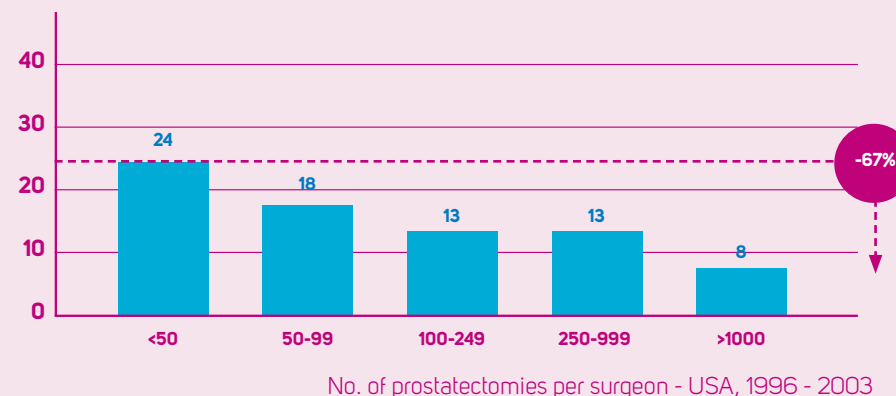
- Accumulated experience
- Focus on outcomes that matter to patients
- Transparency of volume and outcome data

Prostatectomy is an example of a service that could benefit from this approach

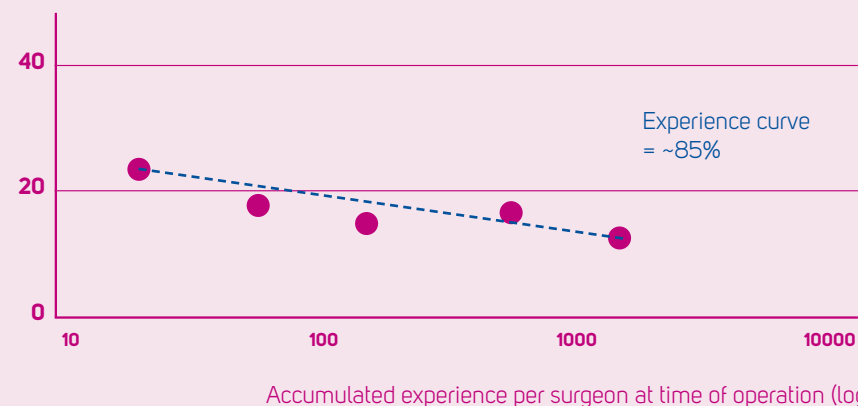
- 92 NHS trusts perform an average of 60 procedures a year
- 48 of these trusts perform <50 procedures a year (the minimum threshold set by NHS England)

EXAMPLE: PROSTATECTOMY IN THE US

Patients with incomplete resection, %



5-YEAR PROBABILITY OF RECURRENCE %



Planned surgical care: driving higher volume through fewer centres

Summary of the presentation by Dr James Kent⁸, Dr Graham Rich⁹ and Dr Detlev Loppow¹⁰ to the NHS Futures Summit, 21 November 2013

THE MARTINI-KLINIK...

The Martini-Klinik (MK), a specialist prostate cancer treatment centre in Hamburg, is a compelling case study on how this approach improves outcomes

Over the last 10 years they have grown to become the world's leading prostate cancer centre

- 5,000 patients a year
- 2,200 prostatectomies (~10x the leading NHS Trust)
- 20 years of data, including >18,000 follow-ups

9 dedicated surgeons with average experience of >1,000 radical prostatectomies each

On outcomes that matter to patients they are significantly ahead of other German providers

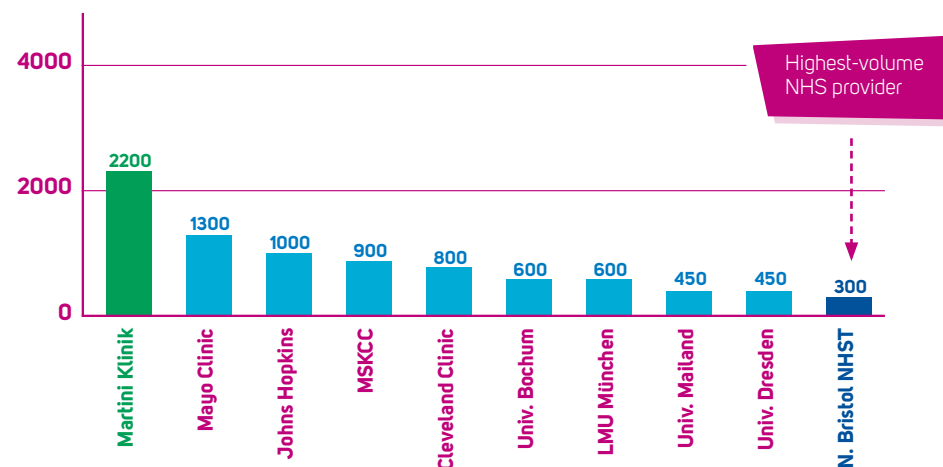
- As a result >25% of their patients now come from >300km away in order to receive their treatment

Process improvement has also resulted in higher productivity than the NHS

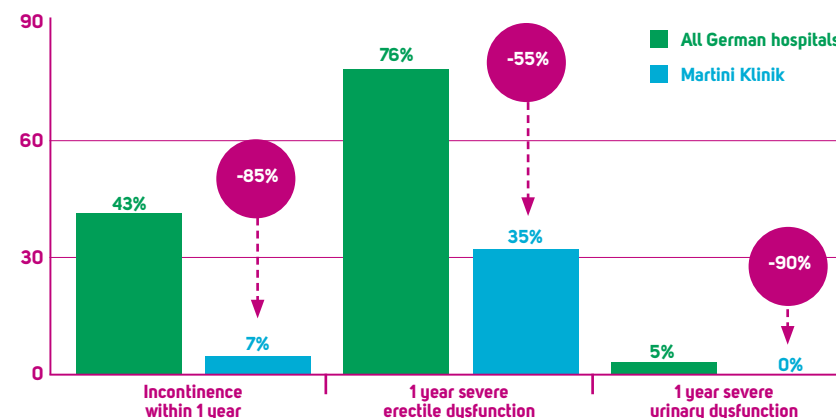
- 2.1 ops per day vs. ~1.6 in top NHS providers¹³
- Results in better utilisation of high-value fixed-costs

...A WORLD-CLASS PROSTATE CANCER CENTRE

Radical prostatectomies (2011)



Complication rate one year post-operation, in % of patients (2012)



Planned surgical care: driving higher volume through fewer centres

Summary of the presentation by Dr James Kent⁸, Dr Graham Rich⁹ and Dr Detlev Loppow¹⁰ to the NHS Futures Summit, 21 November 2013

WHAT WOULD IT TAKE TO IMPLEMENT THE MK MODEL IN THE NHS?

A common challenge to concentration of services is the trade-off with access, but for prostatectomy the number of providers could be reduced by ~66% with minimal impact on travel times

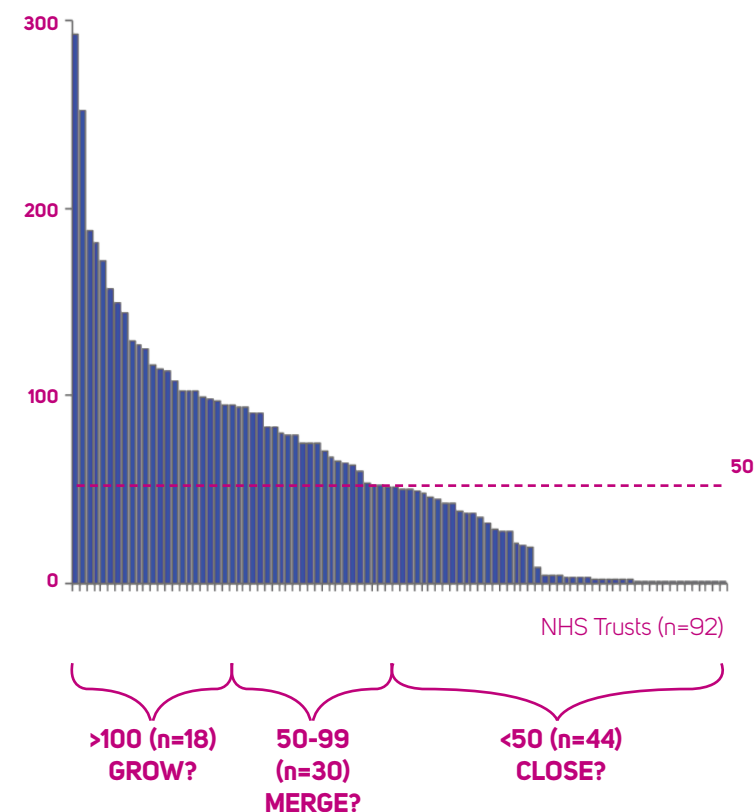
- Reducing from 92 to 33 centres would still allow >90% of the population to be within 60mins

Discussion at NHS Futures event identified several key components to realising benefits:

- Systematic collection and publication of comparable volume and outcome data
 - Including data that matters to patients
- Clear definition of minimum surgical volumes at both clinician & team level
 - Enforced by commissioners
- Allowing dialogue between providers to identify consolidation opportunities while protecting local pre and post op support for patients
 - e.g. specialist centres + more integrated community care
- Continue dialogue with general public about rationale for consolidation and trade-off with access (which is not always that significant – see above)

EXAMPLE OF POTENTIAL IMPACT ON CURRENT NHS PROSTATECTOMY PROVISION

Volume of prostatectomy procedures 2011/12²⁰



Right treatment, right place, right time

Summary of the presentation by Professor Terence Stephenson¹¹ to the NHS Futures Summit, 21 November 2013

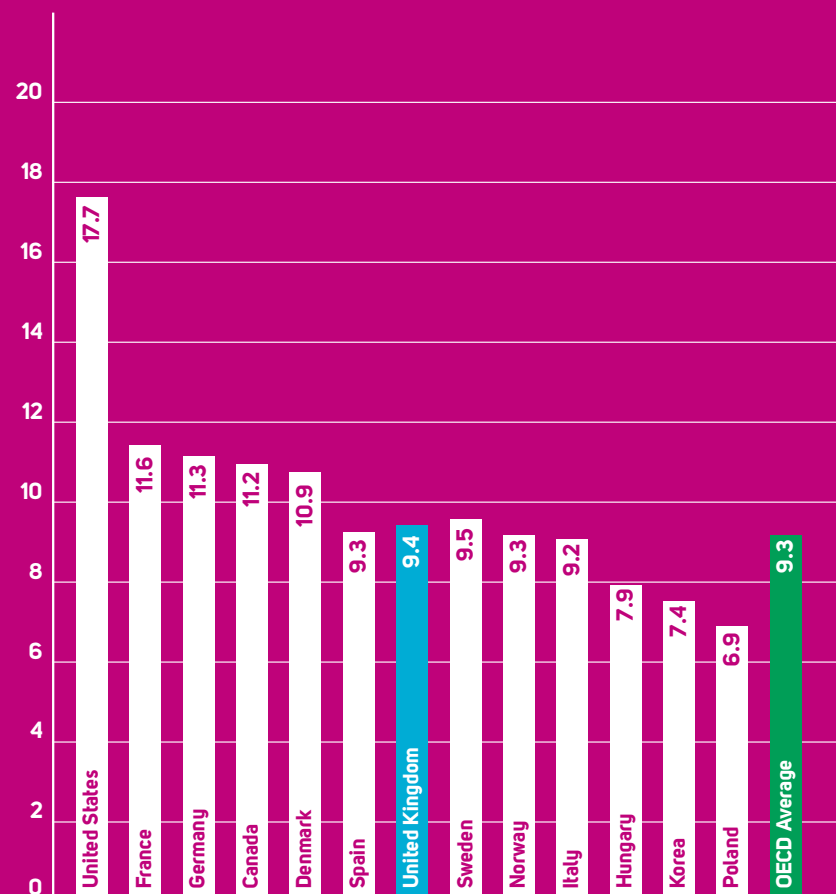
THE HEALTH AND CARE SYSTEM IN ENGLAND FACES SIGNIFICANT CHALLENGES

- The number of people over 65 years will increase by 65 per cent in the next 25 years. Nearly two-thirds of patients admitted to hospital are over 65.
- We are seeing increasing prevalence of long-term conditions as the population ages – half of those currently aged over 60 have chronic illness.
- We need transformational thinking and change if the system is not to fail – which means we need new approaches for the hospital, in the community and for the workforce.

Every 1948 hospital cannot provide everything in 2013. The NHS aspires to be the best in the world but to spend a smaller percentage of GDP than other countries we envy such as Holland, France, Germany and Denmark. The demand for health will increase with an ageing population and a 7-day consultant present service.

The UK has fewer doctors per 1000 population than those four EU countries and 30% fewer hospital beds per 1000 population than Germany. The UK also has fewer doctors per 1000 population than the Organisation for Economic Cooperation and Development (OECD) average.

UK HEALTH SPENDING 2011



Source: OECD¹⁴

Right treatment, right place, right time

Summary of the presentation by Professor Terence Stephenson²¹ to the NHS Futures Summit, 21 November 2013

WHAT WOULD SUCCESS LOOK LIKE?

- *Higher quality care*: a good start would be closing the gap between the best and worst performers across the country (see NHS Atlas of Variation for examples).
- *Improved training of NHS staff*: doctors, nurses but also health care assistants and other support staff.
- *More prevention and self-care*: smoking and obesity underlie half of avoidable deaths in UK men aged 35-70.
- *More sustainable, integrated services* and more patients cared for closer to home.

HOW CAN THE NHS ACHIEVE CHANGE?

- *Reconfiguration*: we cannot deliver every service everywhere.
- *'Scope of practice'*: – highly trained staff should be doing what they have been trained to do, not administrative tasks.
- *Work smarter*: IT can allow staff to spend more time on patients and less time on 'back office' activities.
- *Training a flexible workforce*: the new world will need fewer specialists and more 'generalists'. Some generalists would subsequently train further in a sub-specialty.
- *Blur primary and secondary care in both directions*: GPs can be very skilled at keeping people out of hospital and specialists can help manage more complex cases in the community.

WORKING SMARTER – WITH A MORE FLEXIBLE WORKFORCE - IS CRUCIAL

To boldly go from “computer says no” to an iNHS

It's IT, Jim, but not as we know it, reports **Terence Stephenson**

Captain's log. Stardate May 2013
 0830-0930: Consultant led handover as per Francis.¹ The cases are projected by the trainee, Dr McCoy, on to the screen of the NHS Enterprise. Mr Chekov says, “Let's just take a quick look at the chest x ray.” Bones has to come out of the current program, decline several on-screen queries, open a new program, and re-enter his username and password—only to be told that the x ray software won't open unless he begins again and closes the word processing program. Three minutes have elapsed, and we have 60 minutes to discuss 20 cases. We give up, noting the excellent radiologist's report but missing a valuable teaching opportunity. Thank goodness we didn't have to access anything as complicated as the tricorder or switch the phasers to stun.
 0930: Consultant led ward round² starts on ward A. The first patient has sickle cell disease and a fever and has been seen by another NHS hospital more than a year ago.
 0945: The general practitioner and St Elsewhere's Hospital are telephoned for past



Thank goodness we didn't have to access anything as complicated as the tricorder or switch the phasers to stun

1031: The “crash” team arrives within

Safety—General practices have been using e-prescribing and e-records for 30 years. Why are systems which avoid errors of calculation, drug interactions, and illegible prescribing not routine in hospitals? Drug errors are a common cause of negligence claims; as many as a quarter of all settled negligence claims are because of drug prescribing errors.³
“Outside-in” design—We need an end to 10 minute computer start-ups, clunking through multiple screens, and multiple passwords that have to be changed often. We need user friendly interfaces, designed with jobbing doctors in mind. Endless functionality that is rarely required is the enemy of rapid, intuitive use. Sometimes there seems to be no one who can find the zoom button on the x ray viewing software, but everyone can find it on Google Maps.
Efficient—There is a problem in paging someone, but, because you have been paged in the meantime, the phone is engaged when the person you've paged calls back. Could the NHS develop a secure instant

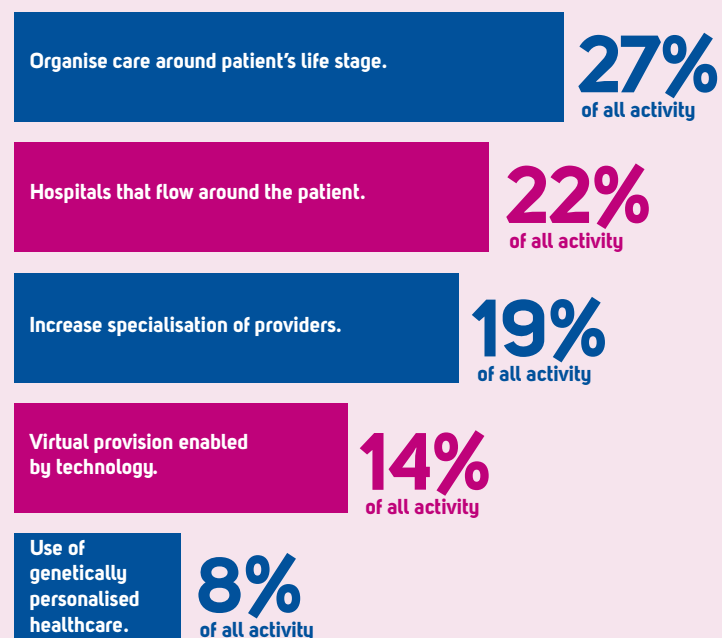
Source: BMJ¹⁵

Views from the online debate

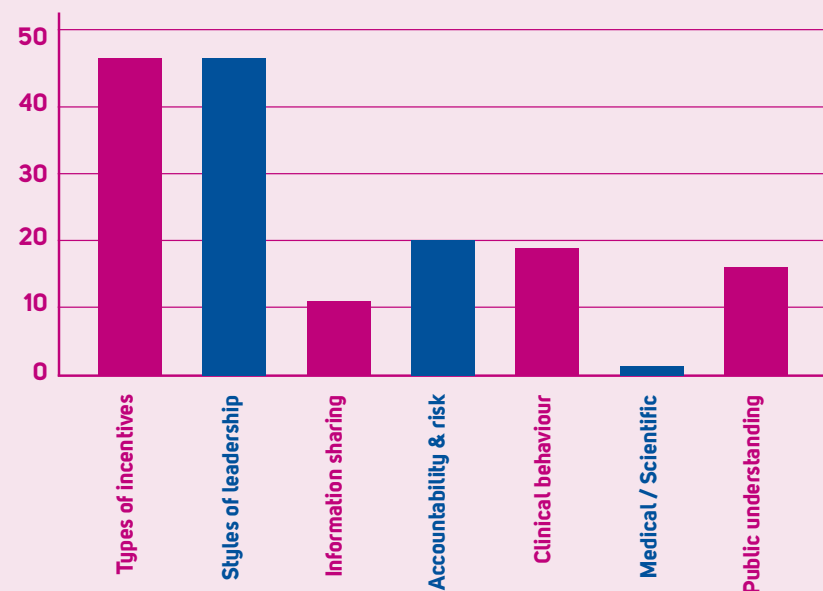
IN 21 DAYS, 324 NHS LEADERS LOGGED ON TO AN ONLINE PLATFORM HOSTED BY MONITOR AND COLLECTIVELY GENERATED 1,775 CONTRIBUTIONS:

- 165 ideas,
- 264 comments and
- 1,346 votes.

HOW SHOULD HEALTHCARE BE DELIVERED IN THE FUTURE?



WHAT WILL STOP OR ENABLE CHANGE?



References

- ¹ Dr Jim Bonnette, Partner and Chief Medical Officer for Oliver Wyman's Health and Life Sciences Practice.
- ² Professor Paul Corrigan, Independent consultant and executive coach.
- ³ Mike Parish, Chief Executive Officer, Care UK.
- ⁴ Bridget Fletcher, Chief Executive Officer, Airedale NHS Foundation Trust.
- ⁵ Aimee Chapple, Managing Director, UK Health, Accenture.
- ⁶ Kipp Webb, Managing Director, Accenture Health Clinical Services.
- ⁷ Dr Nicholas Henke, Director and Leader of the Healthcare Systems & Services practice in Europe, the Middle East, and Africa at McKinsey & Co.
- ⁸ Dr James Kent, Partner and Managing Director, Boston Consulting Group.
- ⁹ Dr Graham Rich, Director of health services, Boston Consulting Group.
- ¹⁰ Dr Detlev Loppow, Chief Executive Officer, Martini-Klinik.
- ¹¹ Professor Terence Stephenson, Chairman of the Academy of Medical Royal Colleges and Nuffield Professor, Institute of Child Health, University College London.
- ¹² Chowdhury et al., Br J Surg 2007 - Source: Vickers et al., J Natl Cancer Inst 2007; Health & Social Care Information Centre; BCG project experience; BCG analysis
- ¹³ Estimated number of prostatectomies per theatre day of 1.4 - 1.7 for two leading NHS Trusts vs. estimated 2.1 at Martini-Klinik - Source: Martini Klinik; BCG analysis; BCG interviews;
- ¹⁴ OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing.
- ¹⁵ BMJ, July 2013;346:f4028



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