Chartered Institute of Marketing

*Opportunities in the Changing NHS **2012***

The Wellards Academy

Opportunities in the Changing NHS

"The relentless pursuit of an almost familial bond between customer and product."

"The management process responsible for identifying, anticipating and satisfying customer requirements profitably."

'exchange relationships'.

The NHS care challenge

- *An 'aging' nation (people living longer)*
  - ✓ *By 2020 the number of people over 85 will double*
  - ✓ *Fewer taxpayers post-baby boom decreasing revenue*
  - ✓ *Loss of 1/4 healthcare staff to retirement in next 3-5yrs*
- *A third of the population with ongoing health needs*
  - ✓ *15m people identified with long-term needs*
- *The poorest areas with the poorest access to care*
- *A system which channels people into high-volume, high-cost hospitals where people become more sick or die*

NHS Funding Crisis by 2014

- *3 Scenarios: Tepid Cold, or Arctic*
  - *NHS funding will be in real terms, arctic*
- *The gap under current scenarios is big!*
  - *by 2014 would be nearly £40bn at 2010/11 prices.*
- *2011–17, the NHS productivity gains needed:*
  - *between **£21.6 billion** and **£47 billion***
- *The NHS message is one of:*
  - *MORE for LESS*

What have policymakers done to address this?

- *Introduced heavyweight levers:*
- *Structural reforms:*
  Attempted to make local NHS more accountable to populations and remove unwanted tiers of management
- *Quality and Productivity reforms:*
  Attempted to spend its money more wisely, reduce all possible waste, save all possible bed days, prevent complications and improve recovery
- *Market reforms:*
  Attempted to introduce choice, capacity, a range of providers, competition, tariff system of payments, commercialise procurement

What are the implication for companies?

- *Structural reforms:*
  - This means engaging with some new customers, networks, lines of accountability, processes and purchasing points
- *Quality and productivity reforms:*
  - This means ensuring our products align with the agenda of our customers, eg, QIPP, CQUIN
- *Market reforms:*
  - This means understanding who new providers will be – *Any Qualified Provider* – and the implications of the payer/provider split; financial, contractual or local health economic barriers, and how to overcome them, engaging with commercialised procurement

Where to begin and end?

The beginning……

- *Health and Social Care Act 2012*
- *NHS structure*
- *Payers and providers*
- *Procurement - National, Regional, Local*
- *QIPP/Cost- and Value-based efficiencies*
- *Enhanced recovery*
- *CQUIN/Hospital finance*
- *Clinical outcomes, COF and the ‘five domains*

Where to begin and end?

So by the end you are more aware of ……

- *Who the new types of customer are*
- *What are the pressures and priorities of these customers*
- *Procurement customers and processes and how they fit into all this*
- *How to begin to align your sales strategy with this environmental knowledge*

The health and social care bill?

- *2011 was the year of the social care bill.*

- *Gets rid of SHAs and PCTs*
- *Introduces NHS commissioning board and clinical commissioning groups*
- *Introduces any qualified provider*
- *Gives new freedoms to foundation trusts to make profits*
- *Removes barriers to local competition for service contracts*
- *Introduces various quality and outcomes frameworks for providers and commissioners*
- *Makes all NHS trusts foundation trusts*

- *2012 is the year of the Health and Social Care Act*
- *Which will give us a new NHS structure….*

NHS payers and providers?

***Payers** are the NHS commissioning board, specialist commissioners, and the PCT clusters now moving to the clinical commissioning groups. They decide how to allocate funds.*

***Providers** are foundation trusts or other qualified providers of healthcare (private hospitals, independent diagnostic and treatment centres, social enterprises, voluntary groups, etc)*

Providers have their own money to spend but are ultimately accountable (by contract) to the payers.

New customers?

The two most important customer groups for companies on these previous diagrams are foundation trusts and clinical commissioning groups.

Foundation trusts *will be using the products.*

CCGs *will be paying for them.*

So a bit on both of these.

Clinical commissioning groups?

- *Clinical commissioning groups are the big payers in the new system. They will control up to £80bn of NHS money.*
- *They are the replacement for the primary care trusts.*
- *They are supposed to be taking over from them in around 2013.*
- *Have a look at this interactive map of CCGs.*
- *In the meantime, PCTs have had to form clusters and increase in size whilst shedding staff…*

Clinical commissioning groups: scope

- *There are now 257 groups of GP practices from across the country, covering around 97 per cent of the population*
- *The average consortia population size is approx 190,000.*
- *It is unlikely that consortia with populations of less than 500,000 will find it easy to manage financial risk, while they may not have sufficient management resources to function effectively nor take advantage of the economies of scale necessary to ensure that commissioning is efficient*
- *expect mergers and takeovers*

Why engage with CCGs?

- *They set the terms of the contract with providers.*
- *They can specify a CQUIN (quality payment) for operations being done in a certain way.*
- *They set the QIPP plan for an area and will be looking to see how they*
- *can reduce bed days, waste, need for certain staff, shortening recovery time. If your product can help with any of these it will help CCG staff*
- *They control the pathway. They can remove providers (and thus whole purchasing points) from the pathway at will*

Foundation trusts – what are they?

- *Part of the NHS but independent from the DH*
- *Have to apply to become a foundation trust based on quality of service and financial stability*
- *Accountable to local populations via an executive board*
- *All trusts now have to be FTs. If they can't they will be taken over or shut (up to 48 might face this fate)*
- *Will be allowed to act as a social enterprise and make profit under HSC Bill*

The private sector – any qualified provider?

New in town are the private providers tendering for contracts with NHS commissioners for diagnostics and elective surgery, and in the future, all kinds of other services. Here are some of the key players:

- *Alliance*
- *Assura*
- *Bupa*
- *Circle*
- *Nuffield*
- *Ramsey*
- *United Health*

Full list of 'NHS partners'

Procurement

Restructuring and competition means a new set of purchasers

- *All NHS trusts will become foundation trusts*
- *Some super-trusts* ***super-customers***
- *Powerful procurement and supplies departments*
- ***Vertical integration****; trusts buying different products than would normally be used in secondary care.*
- ***Any willing/qualified provider*** *model: private companies will take a greater market share*

Procurement

There are three procurement levels:

- *National (NHS supply chain, the government)*
- *Regional (Procurement hubs/supply confederations/Private buying agencies)*
- *Local (Trust-level procurement)*

- *All potential customers, navigating them can be a minefield.*

QIPP: what is it?

- *The Department of Health's (DH's) quality, innovation, productivity and prevention (QIPP) programme aims to tackle the problems of rising cost pressures, brought about by a growing, ageing population, long-term condition epidemics and a slowdown in real terms growth.*
- *At the same time, the government has demanded that the NHS must make efficiency savings of £20bn by 2015.*
- *QIPP involves NHS clinicians, managers, commissioners and other staff making decisions to save money while maintaining quality.*

Cost and value based efficiencies?

How can industry assist productivity?

- *Save a trust money – **simple cost-based efficiency***

  The product is simply cheaper than the one they are currently procuring but does exactly the same job

- *Save a trust money – **value-based efficiency***

  The product is priced comparably, or costs more than the one currently used, but offers the customer better value through other means

CQUIN?

- *CQUIN is the main mechanism for rewarding hospital QIPP practices*
- *CQUINs are locally negotiated and can affect a variety of clinical areas*
- *they are worth 2.5 per cent of a hospital contract's value in 2012/13*
- *An example could be: to get the CQUIN payment, the hospital has to implement an enhanced recovery programme for trauma surgery*
- *CQUINs can be agreed with ANY QUALIFIED PROVIDER*
- *CQUINS can be agreed with COMMUNITY PROVIDERS*

HRGs and the tariff?

- ***What are HRGs?***
- *healthcare resource groups*
- *costed bundles of all the healthcare resources (staff, materials, procedural costs, overheads) required to do a particular intervention or deal with a particular diagnosis*
- *an English national reference cost for the intervention*

- ***What is the tariff?***
- *the tariff is the price list of the hospital payment system currently known as payment by results*
- *it attaches prices to HRGs*
- *it gives information on the devices and interventions whose use is excluded from the HRG, ie, paid for separately from an HRG price*
- *it forms a comprehensive price list for interventions and operations performed in NHS hospitals in England*

Encouraging use of Standards in the NHS

National Outcomes Framework

- Adherence to Quality Standards will help improve local performance against relevant national outcome indicators

Local provider payment mechanisms

- **QS will inform:**
- Best Practice Tariff
- Commissioning for Quality Improvement Initiatives (CQUIN)
- Quality Outcomes Framework (QOF)

Local commissioning mechanisms

- **QS will inform the:**
- Indicators for local use
- Commissioning Outcomes Framework (COF)

Clinical outcomes, COF and the five domains

In order to achieve successful sales a company must prove that its products provide value to the NHS. What does this mean and what's the best way to do that now?

In the new NHS,

VALUE = Clinical outcomes/cost (Maxine Power, DH)

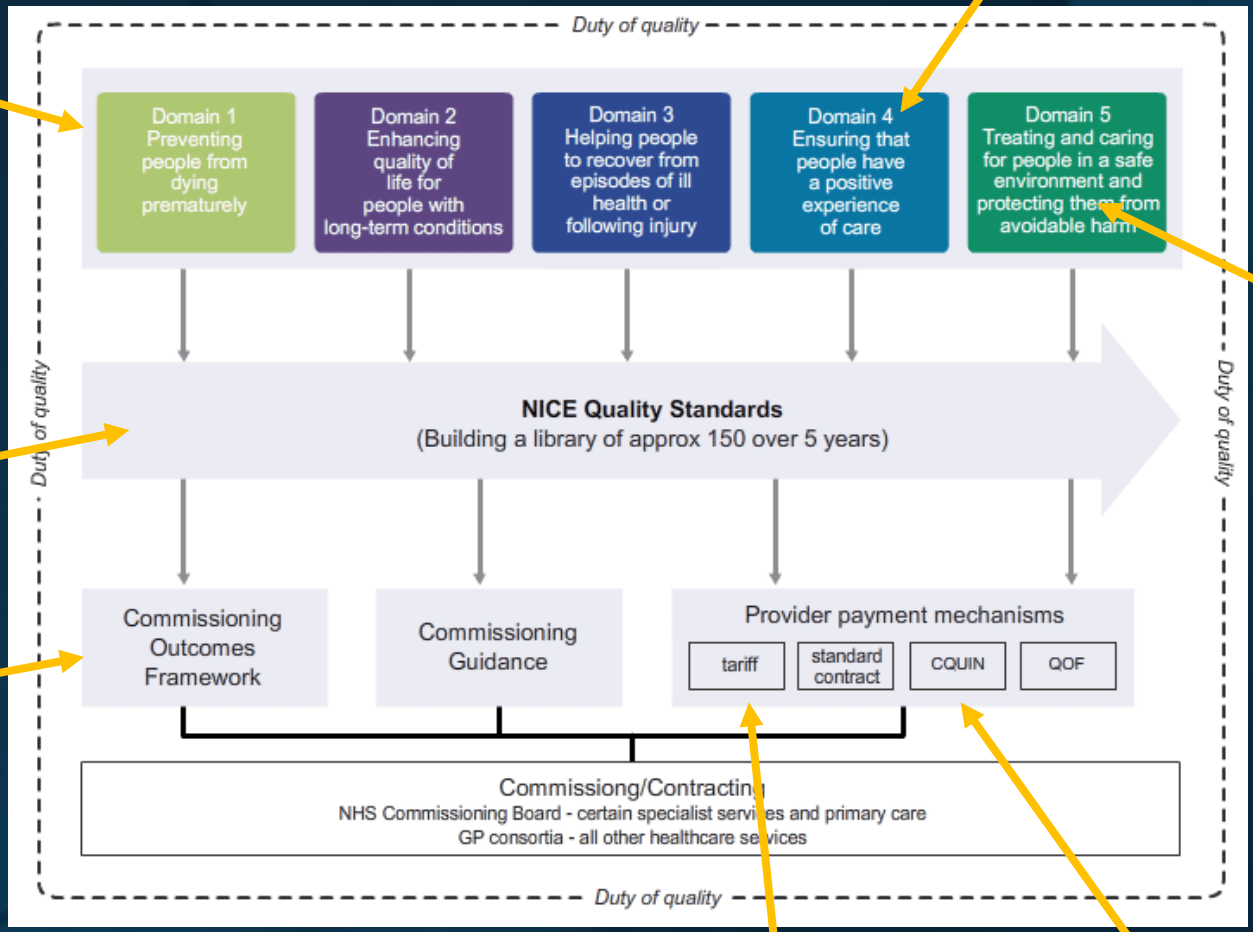
*The NHS outcomes framework sets out a **duty of quality** that NHS services must provide, and holds authorities and providers accountable for improving healthcare outcomes. For the industry it provides indicators that their products need to address.*

Matching the outcomes required to a cost-effective value proposition makes your product or service a potential solution for the NHS.

Clinical outcomes, COF and the five domains

Where is your entry point to the quality and outcomes agenda?

How have you communicated your solution to commissioners, providers and local authorities working under the COF?



Local authorities – a wild card?

Industry has never before paid much heed to local authorities – now might be the time

- *Local authorities (LAs) are also subject to the outcomes framework*
- *Much public health work will the responsibility of local authorities (LAs), which will complete joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (JHWs) with CCGs and others to set the direction of public health.*
- *LAs will have a budget for public health*
- *And there will be a health premium, to reward local NHS organisations that progress against elements of a public health outcomes framework. This will take into account the five domains mentioned previously.*

Summary: the wider value proposition

- *Looking at your product or service portfolio, how does it bear up against the NHS relentless drive for value?*
- *Will it enable your customers to get 'more for less'?*
- *Will it enable your customers to maximise their revenue through the quality and outcomes indicators system?*
- *How does it enhance the use of resources and reduce waste?*
- *How does it mesh with the prevention agenda, either through effective diagnosis, harm-free care, reduction of complications, reduction of acute admissions or reduction of readmissions?*
- *How does it fit into the best practice agenda of BPTs, CQUIN, enhanced recovery and the NICE quality standards?*