Community Surgery

Tariffs for Safe and Sustainable services

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Pioneers

.. have established community surgical services are safe, sustainable and popular with patients.

A few examples:
– Bluesky Orthopaedics, Leics [1999]
– Independent Health Group [2004]
– Norfolk Surgical & Diagnostic Centres [1996]
– Probus Surgical Centre, Cornwall [1995]

Example 1 – Probus Surgical Centre

• Started 1995, only community provider in area
• 2 operating theatres
• 5,000 procedures pa
• 80% consultant performed, 20% GPwSI
  – One stop cataract service
  – Hernia repair
  – Hand surgery - CTS, trigger finger & thumb
  – Maxillofacial + skin surgery, vasectomy etc

Example 2 – Lincolnshire Primary Care Surgical Service

• 4 CCGs covering population of 755,000
• Pilot 2012 -14, AQP contract 2014 -17
  – Orthopedics – 27 types of procedure
  – Dermatology – 16 types of procedure
  – Hernias, Vasectomy, Eyes, Podiatry
• Volume 8,800 procedures pa
• 75% suitable for GPwSI, 25% need consultant
• Pilot had 14 CTS providers, of whom 7 were consultants

How to grow Community Surgery?

Some of the essentials:
– Commissioning
– A pioneering spirit
– Availability of premises
– A new skill mix with managers
– A fair tariff
– Good primary/secondary care cooperation
– Sensible regulation

How to grow Community Surgery? 2

Less essential are:
– Long term Investment Capital (~£100k / centre)
– Attractive financial returns
– Government grants

It would greatly help to have
An NHS national community surgical service
Commissioning ‘Care Closer to Home’
Long established aim but progress has been slow

2000 NHS Plan sets out policy
Good progress in moving in-patients to day-case units
Much less progress moving from day-case to community

2006/7 Care Closer to Home demonstration projects
in 6 specialties x 5 locations each; strong patient support

Follow up was overtaken by other priorities
95% of Acute Hospital Activity is still provided by NHS Trusts
(HSCIC data for England 2012-13)

What’s the scope nationally?
NHS trusts and NHS foundation trusts provide
12 million daycase & O/P procedures each year

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Total Value</th>
<th>Total Value</th>
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<tbody>
<tr>
<td>Day Case procedures</td>
<td>£3,486,477,856</td>
<td>£3,486,477,856</td>
</tr>
<tr>
<td>Out-patient Procedures</td>
<td>£911,473,610</td>
<td>£911,473,610</td>
</tr>
<tr>
<td>Total</td>
<td>£4,397,951,466</td>
<td>£4,397,951,466</td>
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Source: NHS National Schedule of Reference Costs 2011-12
Excludes First O/P and Follow-up appointments

What type of procedures could move to Community Surgical Centres?

In Extended Primary Surgical Centres
  – Assessment
  – Diagnostic
  – Surgical under local anaesthetic

In Community Hospitals & Treatment Centres
  – All above +
  – Surgical under general anaesthetic

Day case & O/P procedures suitable for Community Units

In total there were 1,764 HRGs listed in 2011-12 Reference Cost Schedule.
ASPC lists 31 high volume HRGs as potentially suitable for community provision:

<table>
<thead>
<tr>
<th>HRGs suitable for Community Units</th>
<th>£970,888,739</th>
</tr>
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<tbody>
<tr>
<td>% of total</td>
<td>22%</td>
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</table>

Premises - Where?

• GP practices in England 8,000
• Extended Primary Care Centres built since 2000, est 1,000 +

Capacity of an Extended Primary Care Centre
is 3,000 procedures pa

Typical utilisation is 5-15% ie 1 to 3 sessions a week

Premises - Where?

Extended Primary Care Centre comprises:
• Clean Operating Room
• Consulting Room
• Admin space

Additional investment, if needed, is relatively low:
• Cost of adding 15 air changes per hour air conditioning - £10,000
• Cost of adding laminar flow air conditioning - £30,000
Premises - Where?

Conclusion: First Order Approximation -

There is capacity to do 3,000,000 procedures pa in existing Extended Primary Care Centres

Much additional work to be done to refine the model.

How would a Community Surgical Centre work?

- Part of a network – typical CCG will need 5 CSCs
- Each CSC will cover limited range of specialties
- Minimum 2 clinicians per specialty, working 1-4 sessions per week.
- Some specialties all GPwSIs, others a mix of consultants and GPwSIs.
- Links with local hospital(s) to give seamless service to patients and to manage demand.

Development of National Tariffs

- Basic concept – Nationally determined currencies = unit of healthcare
- Tariffs = the set prices paid for each currency
- Based on NHS Reference cost data – collected from NHS Trusts since 1998/9
- Payment by Result (PbR) tariffs introduced 2003/4
- PbR covers admitted patient care, outpatients and A&E, mental health, chemotherapy, radiotherapy, ambulance services and some community services;
- PbR accounts for > 60% of the £61bn spent by NHS Trusts in 2012/13

Sources: DoH Annual report and accounts; A simple guide to Payment by Results DoH 2012

Healthcare Resource Groups

- Now on HRG4 comprising
  - 41 Sub-chapters
  - 1,764 groups
- Some HRGs are specific and relatively homogenous
  - eg Vasectomy
- Other HRGs are broad groupings
  - eg Intermediate Skin Procedures Category 2, without CC
- Average of 10,000 FCEs per HRG in 2011/12

Price Signals

- Tariffs have been rising on Complex HRGs
- Tariffs have been falling on Simple HRGs
- Efficiency Requirement means tariffs as a whole have fallen in last 4 years

Most Trusts make a loss on the 31 sample HRGs

<table>
<thead>
<tr>
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<th>Lower Quartile Unit Cost</th>
<th>National Average Unit Cost</th>
<th>Upper Quartile Unit Cost</th>
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</thead>
<tbody>
<tr>
<td>Per patient Income at 2013/14 PBR Tariff</td>
<td>£356</td>
<td>£256</td>
<td>£256</td>
</tr>
<tr>
<td>Unit cost</td>
<td>£199</td>
<td>£286</td>
<td>£342</td>
</tr>
<tr>
<td>Surplus/(Deficit) per patient</td>
<td>£57</td>
<td>£29</td>
<td>-£85</td>
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Total Deficit for 3,018,848 patients: £88,867,900

Problems with Tariffs

Poor Quality Cost Data
- Too little providers made a material error with the total amount of costs reported
- Too little providers made a material error in HRG costs
- Data quality on service not covered by PBR is particularly poor
- Accuracy of clinical coding has improved, but 9% of services are still coded incorrectly.

Leads to Volatile Tariffs
- Over 40% of PBR prices change by +/− 10% or more each year.
- Over 20% of PBR prices change by +/− 20% or more each year.

Poor price signals > Uncertainty on moving work
- NHS England lead on defining HRGs
- Monitor lead on collecting costs and setting tariffs
- It will take 3-5 years to fix the data quality problem

Community Tariffs
- Community tariffs currently set by CCGs
- Little or No negotiation with providers
- Range from ~35% to ~80% of PBR tariff paid to Trusts
- National Community Tariff not likely for some time
- Could be based on fixed % of PBR tariff but risk to Trusts left with complex work
- Monitor likely to want to collect cost data first
- Monitor issued guidance on local pricing - Dec 2013

Guidance on locally determined prices

Framework to facilitate constructive engagement between Commissioners and Providers:
1. Establish a working group
2. Define roles and responsibilities
3. Agree objectives, timescales and rules on information sharing, deadlines
4. Document progress and outputs

Promoting transparency is one of the three principles that apply to all local variations, modifications and prices.

Under the 2012 Act, CCGs must maintain and publish a written statement of an agreed local variation

CCGs must use Monitor template
Monitor will also publish agreement on its website

Even Trusts with lower quartile costs barely break even; 75% make a loss
Developing an NHS national community surgical service

For a clinician-led service we need:

1. A list of procedures that will be contracted out by all CCGs
2. Model patient pathways and service specifications
3. A standard community tariff at a level sufficient to attract investment into setting up a new service. This might be at 60 – 70% of the hospital tariff giving immediate savings to CCGs.
4. Adoption of Any Qualified Provider (AQP) contracting model
5. The right for patients to choose any Community Surgical Clinic across the country, just as they have the right to choose any hospital.
6. A national system for accrediting clinicians who deliver the service.
7. Encouragement for NHS hospital trusts to subcontract work and/or work in collaboration with Community Surgery providers to provide a seamless service.
Commissioning 'Care Closer to Home':

Long established aim but progress has been slow

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2006/7 Care Closer to Home demonstration projects in 6 specialties x 5 locations each; strong patient support

Follow up was overtaken by other priorities
- Political: changes of ministers, general election, re-organisation, resistance from Trusts
- NHS: Acute Trusts, shortages of consultant surgeons, National Guidance for Cancer Management, training and workforce issues, increasing specialisation within surgery

As of 2013 - 95% of Acute Hospital Activity is still provided by NHS Trusts (NHSCC data for England 2012-13)

Why? The patients’ view

- Strong patient support for improved provision & access to services in the community
- Shorter waiting times 4-6 weeks vs 8-12 weeks
- Shorter visit on day of procedure 1 hr vs 2-6 hrs
- Less congested access than at DGH and often free parking £0 vs £3-£5
- Inhibitors – None identified

Why? The commissioners’ view

- Lower costs help to manage financial pressures
  - Community tariffs 40 – 80% of National PBR tariff
- Increases patient choice to drive innovation and quality
- Inhibitors
  - elective surgery not yet a priority
  - duty not to destabilise local trust financially

Why? The clinicians’ view

- Opportunity to participate in clinician led service
- Ability to innovate faster in smaller, less bureaucratic organisation
- Opportunity for variety and job satisfaction
- Inhibitors
  - more travelling?
  - loyalty to own trust if in competition
  - private practice

Why? The NHS Trust’s view

- Opportunity to shed low tariff, loss making work
- Opportunity to maximise day-case work and reduce bed occupancy to <85%
- Opportunity to partner on community services
- Inhibitors
  - Complex change process
  - Need to manage reduction in overhead costs

How do I get involved?

1. Check local CCGs’ commissioning plans
2. Talk to CCG leaders
3. Identify current & potential community providers
Workshop discussion

Assume your local CCG is going ahead with a community surgical service -

• What would be the main attractions of a community service from your point of view?
• What would be the main inhibitors?
• What are the priority procedures in your specialty to assist patients? To assist your trust?
• Review Lincs list and proposed HRGs – what other HRGs are needed for a coherent service?