

Quality and Cost Reductions

How do we exploit the opportunities for improving quality whilst saving costs?

United Kingdom Quality Collaboration
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What is this guide? Who is it for?

This guide, developed through multi-disciplinary workshops facilitated by the UK Quality Collaboration, is targeted at NHS board members and those planning and commissioning healthcare and improvement. It is intended to support debate around service quality, and to help ensure that at times when funding issues are critical that opportunities to at the same time improve service user experience and quality of care are not missed.

Healthcare quality and cost reductions

Poor quality care effects patient outcomes and costs money. Ensuring and improving the quality of care is a win win for both patient and the system. The Health Act 1999 applied a 'duty of quality' to all parts of the NHS and to all those who commission, provide or manage patient care. Under the Act, healthcare organisations must put in place arrangements for monitoring and improving the quality of care. Chief Executives are accountable for assuring the quality of healthcare services and must provide boards with regular reports and assurance on quality in the same way as they do for finance. Boards are likewise charged with a Statutory duty of financial balance.

Poor care certainly drains the healthcare system of resources, and has dire human (and often financial) consequences to patients and their families. Addressing patient safety and quality issues and at the same time reducing waste is, however, not a trivial matter and those leading healthcare systems need to be discerning about improvement plans put to them if they are to take this opportunity to both enhance patient experience and save lost resources. Increasing numbers of NHS boards are using the lens of patient safety to drive forward quality, effectiveness and efficiency in their

organisations. Quality is a prime duty of every healthcare board. Every director of every healthcare organisation should make it their job to be assured that improved quality and better patient safety practice is being systematically introduced and maintained in their organisation, and that this goes alongside a systematic programme to ensure the effective use of resources.

All NHS organisations are required to contribute to the national effort to ensure that the inevitable increased pressures on healthcare resources that arise from demographic changes, the changing burden of chronic illness within the population and new drugs and therapies becoming available are met from system efficiencies. QIPP (Quality, Innovation, Productivity and Prevention) requires all NHS organisations to identify sustainable programmes where improvements to quality also release resources for investment elsewhere. It is estimated that the NHS will need to make year on year cumulative efficiency savings through improved quality of at least 3–4% over the coming five years, amounting to some £20 billion of realisable resources.

Tried and tested approaches to reducing costs include:

- Improvement to care administration
- Better care solutions
- Reform of non-care bureaucracy
- Care setting substitution
- Not to fund decisions
- Benchmarking of resources, process and outcomes.

Quality management can contribute to ensuring that all these known approaches to cost reductions can be achieved while at the same time the quality of care is enhanced.

Supported by an educational grant

The benefits of a focus on quality

- 1 Focussing on better patient experience and improved service quality in ways that reduces the use of expensive acute interventions plays very much into the longer-term conditions agenda. Patients who are supported to manage their long term conditions are better able to maintain a healthy life without resort to emergency hospital admission.
- 2 Poor quality and unsafe care wrecks lives. Adverse events are estimated to claim around 38,000 lives a year in the United Kingdom. Even more patients will suffer further ill health or injury as a result of poor quality of care.
- 3 Care processes that fail leach valuable healthcare resources away. There is a significant body of evidence that demonstrates that poor quality increases healthcare costs, as well as placing additional financial burden on social care and patients and their families. It is harder to identify evidence that better quality produces realisable resources. However, better performing healthcare organisations tend to also be those which perform well against measures of quality.
- 4 Poor quality destroys public confidence in care services. Organisations that fail to properly address safety and quality issues lose the support of local communities, and face sanctions from the regulators.
- 5 Patient safety incidents can also ruin the careers and confidence of clinical staff. Adverse events are rarely the result of an error or malfeasance by one member of staff – most adverse events arise because of a combination of systems errors that conspire to cause harm to a patient.
- 6 NHS organisations, boards and managers are charged with a Statutory Duty of Quality. Ensuring patient safety and healthcare quality is integral to the good governance of healthcare organisations.
- 7 Poor handover at the boundary between teams or between organisations causes problems for the patient and effective sharing of patient information

Promoting quality care

The exam question for boards is currently about saving the money, while at the same time ensuring that potential damage is not done to long-term improvement by the need to save immediate money. Especially during tough times economically boards must ensure that they run safe, effective services, and that the right service is provided to the right patient in the right location at the right time.

The rest of this guide

Opposite is a series of assurance questions that board members might ask to ensure that they are addressing whether their organisation is properly exploiting quality improvement efforts to contribute to cost savings. The maturity matrix is a simple ‘ready reckoner’ that will enable the reader to help identify whether their organisation is meeting the guidance within this board assurance prompt.

Board Assurance Prompt

How do we exploit the opportunities for improving quality whilst saving costs?

	Questions	Plausible answers	Fob-off answers
1	How are we going about improving quality and better resource management?	When agreeing budgets we prioritise quality improvement. What our patients really think is really important, and we are acting on this. We have asked our staff what isn't working and what they would do about it.	We regularly do patient surveys. We believe that our quality problems will be solved through technology.
2	What are the costs of our poor quality? What harm are we doing?	We have set ourselves meaningful harm reduction targets, which we are monitoring through evidence-based means such as global trigger tools. We understand the proportion of our spend associated with episodes of care where there is a quality error, and are monitoring our plans to reduce this.	Quality is very important to this organisation and we do not tolerate unsafe or poor practice. The board receives an annual report on serious untoward incidents, and we have a quality policy in place. Quality monitoring is quite properly the job of our clinical governance committee.
3	Do we as leaders promote a culture of inquiry, reflection and improvement?	We review what we and others do, and learn from this. In this organisation we value staff who are prepared to implement what works – wherever it is invented. We give staff time to learn from other organisations and promote learning about the known high impact changes.	We value innovation above all else and we have our own way of delivering improvement. There is not much to be learnt from elsewhere and we don't waste resources on external seminars – we manage our learning in-house.
4	Do we know where we stand in relation to key metrics about quality of care?	Quality accounts that are shaped by patient views are helping us leverage improvement.	We are CQC registered. We aren't rewarded for change by either the tariff or the regulator.

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Note – the statements are incremental and so in order to score yourself towards columns on the right all preceding statements must be true also

To use the matrix: identify with a circle the level you believe your organisation has reached and then draw an arrow to the right to the level you intend to reach in the next 12 months.



Progress levels ▶	0	1 Basic level	2 Early progress in development	3 Results being achieved	4 Maturity – comprehensive assurance in place	5 Exemplar
Key Elements ▼	NO	Do we know what we mean by quality in our organisation?	Improvement plans are in place	Sufficient hard evidence to base investments and disinvestments. Data and evidence is triangulated	Responsibility to other health bodies – integrating efforts with the common aim of maximising opportunities for patients – joint responsibility to save whole system costs	An established exemplar of better practice, committed to sharing learning and helping colleague organisations improve
Commitment to quality	NO	We have developed, within sustained input from staff and service users, a quality strategy and we have adopted a linked savings aspirations to quality improvement. We can articulate our hopes for outcomes.	We are comprehensively measuring our progress towards our quality and savings targets. We give a consistent message about our commitment to quality to staff, patients and payers.	We have benchmarked our quality and savings progress with similar organisations, and where we find we are behind the game we are attempting to identify why and to learn from better practice elsewhere.	Our audit committee devotes time to evaluating progress with our quality strategy and is able to consistently confirm to the board that expected savings are being met, while at the same time we see quality improve.	We have been working with our partner organisations to ensure that our healthcare economy is in the upper quartile nationally for progress with QIPP, outcomes and reference costs. We have been actively promoting our achievements through various learning forums to others.
Focus on patients	NO	We have ensured we have evidence to better understand what improved care means from the point of view of our service users.	We have involved patients and service users in the co-design of services.	We are able to trace back some of our improvements to input or feedback from patients and service users.	We have achieved year on year improvements in terms of patient reported outcomes, and share clinical outcome improvement data with patients.	Our patients are advocates of our approach to quality within the local healthcare economy, and support the organisation in making changes to services.
Minimisation of effects of poor quality	NO	The board understand the cost base and has set targets for reducing both harm and waste. Targets have been explained to staff and commissioners.	Using established and reliable measurement approaches, we are systematically evaluating our progress towards harm reduction and eradicating waste. We have sought ideas for improvement from both staff and horizon scanning the efforts of others.	Our board and staff agree that efforts to reduce waste and realise cost benefits can at the same time be linked to quality improvement. We view poor resource usage as a quality as well as fiscal issue. Through the audit committee, the board reviews the effectiveness of our clinical audit programme.	We have met our harm minimisation and CIP targets for the past two years. Each year we refresh our targets to ensure that we are not lax about maximising improvement opportunities.	We are a track record in matching the best healthcare organisations in the country, in terms of outcomes and value for money. We have exceeded our targets for harm minimisation and cost effectiveness.
Reinvestment of resources	NO	We have established CIP targets and investment requirements. These have been included in our business plan.	We have looked forward at the risk environment, such as changes in the population profile, and are putting in place quality improvement plans to meet these needs.	We investment promises for the past two years from successful CIPs, and have at the same time reached our quality targets.	Our specifically designed quality programmes have met their savings targets, and we have been able to explain to staff, commissioners and service users how we have reinvested this money.	We have exceeded our targets for investment, and have been able to support capacity and capability development in other organisations.
Engaging frontline staff	NO	Our staff have contributed to developing both our quality strategy and our CIP. They can articulate the organisation's approach to quality and QIPP.	Resource decisions are as a matter of course considered by clinicians, and we have examples of CIP plans initiated by clinicians. We have rejected some CIPs on the basis of clinical advice.	Our culture rewards learning from elsewhere, and we actively encourage and facilitate our staff to learn from their peers and bring improvement lessons back to our organisation.	We can route back successful cost improvement programmes to initiatives developed by clinicians and other staff.	Our staff are actively involved in supporting other organisations learn from our experience, in terms of both our successes and our failures. We recognise clinical commitment to spreading better practice by making time and resources available to staff who do this.
Use of metrics and transparency	NO	We have identified a range of evidence-based metrics for understanding both quality and cost effectiveness. We have set out criteria for any disinvestments we may need to make.	We use a combined quality and resource dashboard to openly report to the board, management and staff. We solicit feedback on the validity of metrics from staff and service users.	We view transparency as a way of improving our data and its use. We make our performance and improvement data available and actively solicit feedback.	Our data on quality improvement is holistic, and shows improvement in terms of patient reported outcomes, resource usage, clinical outcomes, our place in national audits, etc.	Our experience with metrics has been recognised as useful to other organisations, and we have actively contributed to enabling learning from our experience. Metrics are audited for data quality.