How best to meet the challenges created by the need to contain costs whilst improving the quality of healthcare delivery:

Reflections and recommendations from two UK Quality Collaboration (UKQC) seminars held on 24.09.10 and 19.10.10.

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About the UK Quality Collaboration

The UK Quality Collaboration (UKQC) is a multi-professional working group of independent specialist organisations, bodies representing healthcare professionals and individuals working collectively to improve healthcare quality practice. UKQC exists to represent, inform, sustain, improve and champion healthcare quality improvement, to share best practice and to drive up standards in service delivery through individual, professional and organisational practice change. In this paper UKQC focuses on developments in England but also recognises the parallel issues in the now distinctive health areas of Wales, Scotland and Northern Ireland.

Aim of this paper

The **aim** of this paper is to offer a potential consensus framework on how to deliver quality improvement in an environment of cost containment. The UKQC brought together a group of experts and practitioners to share and debate views and ideas. The paper is informed, but not driven by, the emerging new national policy for health. UKQC's many years' collective experience in managing the delivery of services and promoting quality improvement also helps us contribute to developing this consensus framework.

UKQC developed this paper from two multi-disciplinary workshops held in the autumn of 2010. In parallel, we have also produced a board assurance prompt focusing on the same issues to help boards and/or executive staff in healthcare organisations understand their progress towards improving service quality at a time when costs need to be driven out of the system.

Summary of recommendations

This paper recognises the experience of those providing and managing NHS services year on year whilst being required to make efficiency savings. Many excellent ways of both improving quality and at the same time reducing expenditure have been found and implemented. These savings include those opportunities arising from the interface between different organisations through which the patient passes on their pathway of care. These reductions in cost should result in benefits to the patient.

A similar consideration would be to think about the patient's engagement with services. Patients should have clear information to manage their own care, with the result that they can avoid engaging with services where there is no clinical or patient advantage; but know if they need support, they can access the right treatment at the right time, in the right place, by the right people.

This paper also recognises the importance of appropriate involvement and ownership by management teams, boards and commissioners. Their involvement can help create a culture in the organisation that supports effective management to bring about long-term and ongoing improvement.

Finally, it is important to highlight some of the pitfalls to be aware of, particularly noting that there is still not enough evidence of a thriving culture of sharing or working together between NHS organisations. This has been exacerbated by the confused application of 'market forces' twenty years ago. Ongoing sharing by senior managers and clinicians of what they have found to work well is critical to encourage.

Introduction

At a time when cost efficiencies are imperative, the UKQC believes it is vital that quality improvements gained over the last few years are not lost, and that momentum is maintained. We need to ensure that quality improvement programmes are not seen as a 'nice to have' sideline, to be sacrificed in times of economic crisis. In order to meet this challenge new approaches and attitudes are needed to ensure that the business case for quality and safety is made, and improvement programmes protected. We support the argument that we can save money in the long term, *and* improve quality.

The white paper 'Equity and Excellence: Liberating the NHS' (July 2010) has three headline themes:

- Increasing accountability to patients;
- A focus on the outcomes of care, and;
- Empowering health professionals to support their patients.

Since the late 1980s the NHS has striven to manage itself more effectively and to embed more broadly the many quality initiatives that have taken place on a local scale. Much of the earlier work took place in the setting of central demands for year-on-year efficiency savings. Despite all the investment and dedication towards this goal, the results have been, on the whole, disappointing. John Ovretveit (Health Foundation 2009) concluded that while it is possible for providers to realise savings from improving quality, this is difficult, complex and is hampered by a lack of understanding of the true costs of health delivery. Leatherman and Sutherland (Nuffield Institute 2008) concluded that overall quality had improved in the previous ten years, but questioned both the return on investment and the way improvement initiatives have been organised and shared within the NHS.

Against this backdrop the Quality, Innovation, Productivity and Prevention (QIPP) challenge, launched in August 2009, is being implemented throughout the NHS, headed up by the National Director for Improvement and Efficiency, and supported by the NHS Institute for Innovation and Improvement (NHSIII). This aims to meet the anticipated funding gap of some £20 billion for the NHS in England through the means of better care services, rather than cuts in healthcare provision.

Approach

In the autumn of 2010, the UKQC brought together a group with a wide variety of experience of healthcare management, policy development and direct responsibility for clinical care. The aim was to create a comprehensive perspective which fully took into account the views of the stakeholders involved. The group met, not as representatives of their organisations, but as a collaborative group, using expertise culled from working in such settings over many years. The organisations they came from included the Nuffield Trust, the Health Foundation, The Healthcare Quality Improvement Partnership (HQIP), the Royal College of Psychiatrists Research unit, the Royal Society of Medicine's quality and patient safety sections, the Institute of Healthcare Management (IHM), the Good Governance Institute (GGI), the NHS Confederation, the Health and Social Care Advisory Service (HASCAS), National Voices, The Royal College of Nursing and the European Society for Quality in Healthcare (ESQH), together with colleagues from community, acute and mental health provider services.

Method

This group explored collective tacit assumptions by creating an affinity diagram (a tool that gathers large amounts of language data -ideas, opinions, issues- and organises them into groupings based on their natural relationships), shared experience and debated the principles from which consensus recommendations could be derived. Practical examples of successful organisational programmes as well as some recognised pitfalls or 'what to avoid' were discussed. As an aid to the process GGI used the model of Board Assurance Prompts with an example previously developed for patient safety for the group to use. This enabled the group to develop a template in this same series to challenge boards and/or executive staff on their approach to the cost/quality issue, which is being published alongside this discussion paper. Finally, how best to promote and achieve buy-in for the quality/cost message within the system was considered.

Observations

The 'Better Value Better Care' indicators for providers issued by the NHS Institute (2009) offer twelve key ways that high performing organisations can benefit their stakeholders, but it is quite clear that the 'Productivity Opportunities', i.e. cost release benefits, are 'guestimates'. When the QIPP measurement for quality and cost group ran a web seminar in April 2010 on 'challenges, examples of success and working collectively' a central question was 'why measurement represents a challenge to so many NHS organisations and staff'. Scrutiny of the 'success examples' subsequently posted on the internet 'ideas channel' since July 2010 reveals that few of the fifty or so examples so far developed actually involve evaluation of impact on cost.

There are very real **challenges** to all concerned when addressing this crucial issue. Contributions from group members helped illuminate these:

David Somekh (**ESQH)** offered as a reflection on the paradoxes of cost and quality in the NHS, four distinct themes:

- Cost cutting may often unwittingly be cost creating;
- New ideas and initiatives continue to flow, but their impact on either cost or quality is rarely properly evaluated;
- There is the inherent paradox that the management style necessarily adopted when the system is under pressure is in fact that least conducive to innovation, and finally;
- The evidence shows that the necessary timescales for effective change in organisations are inevitably longer than is demanded of them.

Andrew Corbett-Nolan (GGI) identified ways that providers might make cost savings, with cost saving potential, timescale and 'do-ability' guides.

- Reducing non-care bureaucracy e.g. by reducing the number of arms-length bodies could produce low but meaningful savings, quickly and simply;
- Improving care administration e.g. lean systems approaches to care pathways could produce significant resources, but in a three year or more timescale and with medium difficulty;
- Better care solutions, e.g. thrombolytic therapy with streptokinase in acute ischaemic stroke may also give significant savings, but the evidence base for this is less strong and the timescale and difficulty is as the previous example;
- Care setting substitution e.g. telemedicine care for chronic patients has a high resource release potential but an even longer timescale (five years onwards) and medium difficulty in achieving, and finally;
- Not to fund decisions e.g. tattoo removal or fertility treatment may be simple to achieve but although cost saving in the short term may cost more in the longer term or simply involve cost shifting.

Factors that aid good practice

The group identified what approaches support improvement *and* cost savings, and alongside this what approaches might hinder these processes. An **affinity diagram** was drawn up which identified three or four overlapping areas. On the 'support' side, there were clusters which related to:

- Good corporate governance (e.g. culture of enquiry within the organisation, standard operating procedures, IT systems driven by clinical staff, shared understanding about purposes of procedures and supportive and forward looking organisational culture);

- Leadership and motivation (e.g. incentives that benefit the whole group, linking reward to investment, top of the shop support and 'plagiarise with pride'), and;
- Tried and tested improvement strategies (e.g. reducing drug error using IT, use of decision aids, using nationally agreed set of standards (e.g. for cancer pathway), productive ward series and substituting home treatment for hospital beds).

Factors identified that hindered the process were clustered in a similar way. They were:

- Poor corporate governance (e.g. top down targets, cutting study leave and training budgets, cutting early intervention strategies (too unfamiliar), short-termism and good enquiries not being disseminated because they brought bad news);
- Human factors (e.g. being proprietorial with improvement ideas, professional tribalism, the 'not invented here' syndrome and lack of incentives for good practice (even cost savings)), and;
- Opportunity costs (failed improvement initiatives) (e.g. not recognising complaints as information, major restructuring without pilots/evidence base, disincentive of tariff or other economic issues, introducing change without enabling staff to work in new ways or adequately covering risk to patients during the process and internal investigations of incidents without adequate systems to ensure implementation of recommendations).

Some of the challenges that boards and executives need to understand are:

- Is there a means of getting an accurate picture of staff morale (over and above sickness rates)?
- What is understood by 'quality' by staff in the organisation?
- Is it possible to systematically triangulate data, evidence and decisions?
- Does this provide strong enough grounds for investments or disinvestments?
- Are opportunities maximised for patients by integrating efforts with other services or relevant partners, and is there joint responsibility to save whole system costs?

The need for guidance and recommendations

Taking these issues into account, the group felt there was a need for recommendations and guidance to help providers make decisions from an informed standpoint. Any recommendations should reflect these considerations:

- Any recommendations should not be sector specific;
- Making sure that the questions are not focussed on general quality improvement but on the nexus with cost savings;
- Seeing the patient as the common factor in all approaches;

- The principle of *the right service to the right patient in the right location at the right time*;
- Stressing the over-arching importance of measurement as the means whereby people know they are doing what they aim to do.

It was agreed that the **focus** of possible recommendations needed to be associated with three related tasks:

- Reducing obvious waste;
- Avoiding having quality harmed by cost reduction, and;
- Improving quality within a context of less resources.

In terms of the **target audience** for recommendations, three were identified:

- Boards and the new GP consortia, challenging how well developed these ideas were in their organisations and thinking;
- Middle managers and clinicians, on what works and what doesn't, helping providers see patient pathways through the eyes of the user;
- Patient groups, to enable them to inform service users and to monitor the performance of commissioners and providers.

Conclusions

It was accepted that the task facing both commissioners and providers was an unenviable one. Any recommendations and guidance to help better decision taking needs to be meaningful and have resonance. Nevertheless, recommendations need not involve some kind of 'magic bullet' or profound new insight. Ovretveit's headline observation 'poor care is both common and costly' is still a guiding principle. If the measures taken to deal with the pressures to cut costs involve measuring the effects of the actions taken, then quality can be evaluated and remedial action taken to ensure that quality is not being sacrificed (i.e. closing the loop).

Two main risks were identified:

Firstly, it is tempting to cut either frontline staff or those supporting their efforts (so-called salami slicing) but there is always a hidden cost to this (increased stress and staff sickness, delayed discharges, clinical staff drawn into administrative duties, etc.);
Secondly, if staff who manage services are reduced beyond a certain point the opportunity to stimulate and support improvement and then monitor the effects of what is being done may be compromised.

Similarly, it was felt that there need be no new gimmicks to enable effective management of delivery. Experienced senior managers know that there will always be savings to be made from a series of familiar actions such as:

- Vigorously policing delayed discharges;
- Preventing re-admissions by comprehensive information to patients on discharge including offering telephone support;
- Using telephoning or text messaging to reduce DNAs;
- Scrutinising staff sickness rates minutely to try and understand what messages this heralds;
- Ensuring that generic medicines are being used wherever possible if appropriate;
- Having on-ward pharmacy scrutiny (prior to complete IT management of prescribing).

Further, the management of the care environment to ensure that patients do not experience iatrogenic harm whilst receiving care and attention to patient's diet and general well-being should be as rigorous as the attention given to their drugs and other treatments. Finally, effective implementation improves when there is patient-public feedback. Feedback drives development and implementation.

However as much as the specific details of possible cost saving methods most likely to make sensible impacts, the need is for the culture to be right amongst those responsible for making such changes. This requires a whole system approach to quality improvement, including visible commitment from the top team.

One final observation can be made regarding current NHS culture. The group commended the notion of benchmarking and 'constructive plagiarising'; in other words, using other people's good ideas. The problem is that there is still not a sufficiently thriving culture of sharing or working together and this is believed to have been exacerbated by the introduction of 'market forces' twenty years ago. Nor is there a culture of searching for these better ideas, and rewarding those who successfully introduce ideas developed elsewhere. It may be that this is still a new idea that simply has not yet fully taken off. It may be that some modelling needs to be done by senior personnel (e.g. a group of CEOs publicly sharing their good ideas). Simply publishing a compendium of good practices is unlikely to be effective on its own. Indeed, many such efforts in the past have had negligible benefit. There is still a challenge to be met in translating our good intentions into products that people will want to use within a culture of improvement.

The take up of and the successful implementation of ideas is therefore still very variable. What is needed is the assurance that the organisation and its partners are striving both to bring their delivery up to the best possible standard and to innovate. There is much work that needs to be done to enable decisions on cuts to be made from a sensible starting point that will not jeopardise the gains in quality already achieved. The development of detailed recommendations and guidance for sensible ways forward will take time. This paper has only sketched out the principles on which these should be based. These include the following:

UKQC Principles

The UKQC believes that to successfully meet the current economic challenges these principles should underpin any programme. These principles should be considered in the round as each impacts on the others:

Enquiry: Creation of an environment that allows time and encouragement to look for better practice, both from within the UK and elsewhere;
Empowerment: Building expectations that front line staff have permission and indeed are expected to make improvements;
Assurance: Building confidence and support to seek independent assurance that quality improvement and cost reduction are embedded in the organisation, and are successfully adding value to patients;
Engagement: Using customer engagement as a tool for improvement and cost saving; valuing and taking action on users' views and experiences;
Recognising opportunity cost: Understanding the costs and potential benefits of an option that must be forgone in order to pursue a certain action;
Boundary busting: Not limiting our improvements or assurance to the activity that our organisation is responsible for. Patient pathways exceed organisational boundaries and may often fail at those boundaries. Making explicit the expectation that partners and suppliers deliver their obligations.

The UKQC will follow up this paper with further work on this theme, bringing together similar groups of informed stakeholders to turn these principles into detailed guidance and recommendations.

This will include the following:

1. **Recommendations to various key groups, as above, starting with a Board Assurance Prompt to help meet the specific needs of boards;**
2. **Work on an overall Quality Framework for Health Services – developed from previous models.**

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