

IMPROVING QUALITY AND PRODUCTIVITY IN THE NHS WHILST FACING THE FINANCIAL PRESSURES

A JOINT STATEMENT FROM THE ACADEMY OF MEDICAL ROYAL COLLEGES, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION AND THE NHS CONFEDERATION

Context

The NHS has had a decade of record growth and has seen a significant return in improved quality, massively improved access times and increased activity. But the national economic position means that these levels of spending growth cannot be sustained and whilst the Government has guaranteed to protect NHS funding from 2011/12 there will be very modest real terms growth in NHS spending.

In the White Paper *“Equity and Excellence: Liberating the NHS”* the Government has set out a clear and welcome commitment to putting the needs of patients and the public at the heart of the NHS and to improving healthcare outcomes. But the Government recognises that in order to maintain and improve services in line with its objectives there will have to be significant savings made in current expenditure to release the necessary resources to reinvest.

The purpose of this joint statement from the Academy of Medical Royal Colleges (the Academy), the Healthcare Financial Management Association (HFMA) and the NHS Confederation (national organisations which together represent the interests of the NHS medical, finance and managerial communities) is to acknowledge publicly the issues that the NHS faces and set out what we believe are the principles, approach and behaviours that should underpin the drive to address the issues at both a local and national level.

We recognise that the NHS across the UK is facing financial pressures of an unprecedented scale over the coming few years. But despite this tougher financial environment we believe that the NHS needs to maintain and improve the gains achieved in quality, access and activity – without threatening the service’s financial health. The drive to put quality at the heart of *everything* the NHS does – to make quality the organising principle – has to continue.

Coping with these pressures, whilst maintaining and improving quality healthcare and preventative services for patients and the public will be a real challenge for governments, commissioning and provider organisations (in whatever form they may take) and clinicians alike.

As the NHS prepares to meet this challenge the Academy, the HFMA and NHS Confederation are committed to:

- Protecting the quality and standards of care for patients
- Promoting equity of access to services
- Maintaining a focus on quality and effectiveness in disease prevention
- Delivering improved cost effectiveness in the provision of clinical services.
- Ensuring that necessary measures to improve productivity and efficiency support and improve, rather than undermine, the quality of care and services
- As part of that commitment to quality, maintaining the standards of education and training for current and future health professionals
- Ensuring that change is managed sensibly and sensitively in a way that does not damage patient care, the integrity of effective services and does not increase the public's risk of ill-health.

Quality and productivity

Quality should be the driving force for everything the NHS does and the Academy, HFMA and NHS Confederation recognise that efficient use of resources is the ally not the enemy of good quality services. It is possible to improve productivity and quality at the same time.

The patient – and improving health and healthcare – is the focus for all NHS staff. Improving quality means improving safety, clinical and patient reported outcomes and patient experience without losing equity of access. We welcome the Government's clear commitment that clinical outcomes should be the core measure of success.

The best quality care can often be the lowest cost care as costs are eliminated associated with waste, rework and unnecessary steps in a pathway, that at best add no value or at worst inconvenience the patient.

There are significant opportunities to improve the quality of services and cut costs and these will have to be grasped, although a simplistic division into frontline and back office services can be unhelpful. There can clearly be savings in support areas, through improved efficiency and the sharing of best practice. However maintaining good management and administrative support and meaningful information are vital for an efficient and well run health service.

Alongside what can be achieved by clinicians and managers within their own organisations the NHS must not shy away from addressing the overall cost of the external regulatory and administrative burden placed on NHS organisations. The White Paper the Government has set out proposals for cutting bureaucracy and administrative costs and we welcome the commitment to review existing data returns to the Department with the aim of culling returns of limited value. The Academy, HFMA and NHS Confederation are very willing to engage in discussions with government on these issues.

However, as the White Paper acknowledges *“large cuts in administrative costs will provide an important but still modest contribution”* to delivering the economies needed across the whole budget.

More of the productivity improvement will need to be through the reduction of variation in clinical practice, better and faster adoption of 'right first time' interventions, ensuring the appropriate use of procedures of limited clinical value or through better design of patient pathways and the application of Lean management-style principles.

It is unclear how much of the required savings will be met from changing services and doing things differently and how much through general efficiencies. Estimates of the savings that could be released through the latter route vary from 10-50% of the required £20bn. It will be crucially important for there to be clear joint understanding at local level as to how required savings are to be achieved without damaging quality.

The process of managing change

The NHS must resist the indiscriminate tactics of the past for delivering savings and look to find true efficiencies that deliver improved quality, maintain patient safety and are sustainable in the long term. An indiscriminate approach to reducing services, staffing and education and training will alienate the public and staff and cause long term damage.

We recognise that there has to be a strategic approach to change. Short term gain for long term loss will not benefit the NHS or patients. In this context the NHS must not lose sight of the value of investment in prevention as a method for medium to longer term savings. However, nor should it be overlooked that many preventive strategies can bring quite rapid returns, particularly those concerning contraception, antenatal care, childhood immunisation, accident prevention, cancer screening; cardiovascular risk assessment and smoking cessation.

It is also important to recognise that there are necessary costs associated with the process of change which cannot be ignored. Reconfiguration of services, even when delivering improved patient outcomes, can entail short term costs before benefits are fully realised.

Taking a whole health economy approach is essential to ensure that services are seamless, joined up and duplication of effort and costs is avoided. It is also essential that, in taking a whole health economy approach, efficiencies in one organisation do not simply 'cost shift' costs into another part of the NHS, social care or wider public sector.

At the same time it is vital that the levers and incentives in the NHS system are aligned to support, rather than inadvertently inhibit or block change.

Crucially, the Academy, HFMA and NHS Confederation recognise that identifying opportunities for improvements and efficiencies and then realising them can only be achieved through a partnership between clinicians (doctors, nurses and other clinical practitioners) and general and financial managers.

It is essential that the medical profession is positively engaged in the process of both deciding and implementing strategies for tackling the issues at local and national level.

Reconfiguration of services

We believe that if the NHS is to cope with the financial pressures without resorting to indiscriminate and damaging service and staffing cuts, large scale planned service redesign and reconfiguration based on clinical evidence will have to play an important part in the strategy.

The Academy, HFMA and NHS Confederation welcome the Government's recently stated criteria that any service change should:

- Focus on improving patient outcomes
- Consider patient choice
- Have support from GP commissioners
- Be based on sound clinical evidence.

Indeed the Academy, HFMA and NHS Confederation recognise that if such a process is managed well and properly involves doctors, other healthcare staff and the public, appropriate service redesign and reconfiguration can improve and not damage patient care. A reduction in hospital capacity can be a consequence of improving quality, patient safety or cost-effectiveness and not simply a contraction in service.

There has been a wealth of clinical evidence for many years that specialist clinical services such as stroke, trauma and heart surgery should be concentrated in centres of excellence, and in some conurbations this may mean in fewer centres.

This would allow the latest equipment to be sited with a critical mass of expert clinicians who regularly manage these challenging clinical problems, and are backed by the most up to date research. The greater volumes of patients mean that doctors are better at spotting problems and treating them quickly. Survival and recovery rates would improve markedly with many lives saved. As techniques and technology have developed over recent years specialty rather than proximity has become the key for patient safety. So increased patient safety and improved care must be the major drivers of any reconfiguration. At the same time economies of scale should bring financial benefits.

The benefits of this specialisation are often accepted; but the logical consequence, that other hospitals would then lose services to those which become specialist centres, is then ignored or refuted. Patients may indeed have to travel further for some specialist care, but if it is significantly better care and readily accessible then we believe that centralisation is justified.

It is important to recognise that a single model will not suit all locations. Services will be still required in geographically isolated areas and solutions in rural areas may be very different from those in urban areas.

However, at the same time there is also strong clinical evidence to support a large amount of more routine care, currently taking place in hospitals, being carried out in other settings closer to where patients live in the community with GPs playing a crucial role in the delivery of such services. We do recognise, however, that moving care closer to home, while providing benefits for patients, will not always automatically lead to reduced costs.

Managing this whole reconfiguration process effectively demands a forensic approach to service improvement and transformation of the way we deliver services – both how they are delivered and potentially where they are delivered. Any reconfiguration of services will demand close working between clinicians and managers locally and the involvement of patients in making the case for change and managing the process.

We recognise that this level of change often causes anxiety and indeed disagreement. However that should not stop the NHS from undertaking such change where it is in the interests of patient safety and service improvement.

Delivering this requires strong leadership and brave decision-making from doctors, managers and politicians at local and national level. Clinicians and managers have a major role to play

side-by-side in articulating the case for change and addressing local concerns. There is also a role at a national level for their representative bodies in helping the public to understand the need for change.

In 2007, the Academy produced a report¹ on the redesign and reconfiguration of acute care which set out principles for the design of services and management of change. The Academy has agreed to refresh the findings and promote them again to the service.

Conclusion

The Academy, HFMA and NHS Confederation all acknowledge that the NHS is now facing huge financial challenges of an unprecedented scale. It is crucial that these challenges are now approached and tackled in ways that are constructive rather than destructive.

As national representatives of the NHS medical, finance and managerial communities we believe it is possible to do this. We believe that the following principles should underpin the strategies adopted by the NHS nationally in the four countries of the UK and by local NHS organisations:

- Maintaining the quality of care to patients must be the overriding priority
- Equity of access to services must not be lost
- Improved clinical outcomes have to be a core driver for change and measure of success
- Delivering improved cost effectiveness for taxpayers in the provision of clinical services
- Productivity and efficiency improvements must be designed so they maintain or enhance and not reduce the quality of services
- An indiscriminate approach to achieving efficiencies in services, staffing and education and training will alienate staff and the public and cause long term damage
- The medium- and longer-term gains from effective prevention should not be sacrificed to short-term budgetary expediency
- The medical profession and other clinicians need to be engaged and play a central role in devising and implementing strategies for addressing the problems faced
- Well managed and clinically driven redesign and reconfiguration of services will be essential and can both produce efficiencies and improve services
- The levers and incentives in the system must support not inhibit considered approaches to change.

The Academy, HFMA and NHS Confederation have agreed to:

- Promote these principles and methods of working amongst their members and encourage local co-operation
- Work together to highlight good practice in delivering high quality, cost-effective care
- Work together to make the debate around service reconfiguration more informed.

September 2010

¹ Acute Health Care Services. Report of a Working Party September 2007. AOMRC

Notes

The Academy of Medical Royal Colleges

The Academy's role is to promote, facilitate and where appropriate co-ordinate the work of the Medical Royal Colleges and their Faculties for the benefit of patients and healthcare. The Academy comprises the Presidents of the Medical Royal Colleges and Faculties who meet regularly to agree direction.

Note: This paper reflects the broad view of the Academy of Medical Royal Colleges. It should not be assumed that each individual College or Faculty has considered or adopted every specific issue.

www.aomrc.org.uk

NHS Confederation

The NHS Confederation represents more than 95% of the organisations that make up the NHS. Its members include the majority of NHS acute trusts, ambulance trusts, foundation trusts, mental health trusts, primary care trusts, independent providers of NHS services, special health authorities and strategic health authorities in England; trusts and local health boards in Wales; and health and social service trusts and boards in Northern Ireland.

www.nhsconfed.org

Healthcare Financial Management Association (HFMA)

HFMA is the representative body for finance staff in healthcare. Its members work predominantly in NHS finance but a growing proportion are drawn from other professions, Non Executive Directors and the Independent Sector. Its aim is to support and promote high quality financial management in UK healthcare, helping to improve the quality and cost-effectiveness of frontline services.

www.hfma.org.uk/