

Better Care at Lower Cost – the Challenge for the Next 5 Years

Introduction

The tolerance of variation in our NHS is the biggest challenge preventing us from assuring reliable service standards and improved productivity. Over the next five years NHS providers must be more adept at standardisation and reliable implementation of best practice. 240 (the number of Trusts) separate approaches are not providing the public with high standards of care, nor the taxpayer with value for money – change must happen and it must be organised to happen at scale. Horizontal integration across organisations enables scale to be achieved and it must be pursued in addition to local vertical integration between primary and secondary care.

The *Five Year Forward View* highlights the NHS' challenges and signposts what must be done, rightly giving emphasis to integrated solutions and collaborative working. Because its focus is more on the 'what' than on the 'how', NHS providers need rapidly to find new ways of assuring reliable, high standards of care every day of the week - and do so at lower cost. We should no longer accept the wide variation of service standards in this country and we should not tolerate those who say they are protecting patients' interests from change when what they really mean is that they are protecting their own organisational or personal interests. Not only do we need new models of care and new governance models to deliver them, but as important we also need new mindsets and behaviours to deliver the improvements in standards, productivity and performance which currently elude us. We need new governed systems to deploy these standardised solutions and improvements at scale.

On Improvement: Trust Our People and Leaders To Improve Care and Productivity

I wholeheartedly support the key messages of the Health Foundation's *Constructive Comfort* and believe that if the 'Centre' and Regulators could improve the system by strong 'command and control', then they would have done so by now! Highly engaged staff provide higher standards of care: front line staff are best placed to understand the impediments which prevent them from providing the best care they are capable of. Creating a true learning culture is crucial: where staff are supported to challenge the status quo by using methodology to test, replicate and spread ideas for improvement across the whole organisation, and where there results are publicly reported. Leaders must be comfortable with transferring 'power, for change' deep into their organisations, with staff clear that such autonomy must be exchanged for accountability This approach, when perfected within one organisation, is capable of being deployed across others within an enlarged, single system of governance.

On Improvement: The Contribution of Staff Must Be Aligned to the Priorities of Their Employer

Boards must govern through a values-based and goals-orientated approach, where each person and team understands their own contribution to the priorities, goals and values of the organisation. It is almost beyond belief that most NHS organisations do not have effective processes which can measure the contribution of staff in terms of 'what' they have done and most importantly, 'how' they have done it. It's easy to speak about the importance of culture, teamwork, behaviour and attitude – but harder to describe the processes by which Board's systematically measure behaviour and give feedback to teams and individuals on it. Most Boards preside over a disconnected hierarchy where they are unable to influence the core ingredients of behaviours and attitudes within their organisations. Michael West and others cite the importance of effective team behaviours to delivering high standards of care and outcomes. I agree. Moreover we must align our remuneration and incentives to positively reinforce the contribution (what and how) that people provide. All pay progression, whether cost-of-living, increments or awards should be tied to the assessed contribution that people make to the goals and values of their employer.

On Improvement: Improving Productivity to Deliver Services at Lower Cost

The NHS is a comparatively efficient system – but it is not yet anything like as productive as it needs to be. People are rightly concerned about the financial outlook for the NHS and one thing is for certain – the NHS is perfectly designed today to deliver a £20+ billion deficit in 5 years' time. Lord Carter's review will make a significant contribution to improving our productivity and

efficiency – but, if all we do is do better what we do now, then we will not be in the place that we need to be. That is why I believe new approaches are required, to sit alongside the existing models of organisational delivery.

On Standardisation - Care Pathways Assure Better Care at Lower Cost

Care pathways should be standardised to the evidence (with permitted variance) to know whether patients are receiving care and treatment to best practice standards. This will reduce overall variation of clinical practice that exists in each Provider. It is indulgent to allow practitioners and trainees to determine their own diagnostic testing and management plans based on personal experience and preference. By exploiting the potential of our electronic healthcare records we can provide better care to our patients by supporting clinicians, particularly those in training, to make the right clinical decisions. The beauty of this approach is that it will also provide better care at lower cost. Having standard 'order sets' for patients for each diagnostic condition will allow us to get greater control over operational processes, procurement of standardised product lines and deployment of our workforce.

On Standardisation - Deploying Staff to Meet Needs of Patients at Lower Cost

Staff should be deployed to meet the needs of patients. Improvements are being made, but annual leave planning remains erratic; sickness absence is stubbornly above other sectors; activity and acuity is highest on a Monday and Tuesday, whilst patient needs in the community are highest at the end of the week – yet our daily staffing profiles remain generally flat throughout the week; and our weekend staffing levels are a step lower than our weekdays (resulting in lower patient outcomes). Getting the basics of staff rostering right is vital but is the comparatively easy part. Electronic Patient Records provide a new opportunity for staff deployment. Standardised care pathways allow us to arithmetically determine the quantum and skill mix of staff required to meet the assessed care/treatment needs of patients. Of course, professional judgement will always be required, but using this approach to accurately predict the staff required, 6 weeks' in advance, to meet the needs of elective patients, or in real-time for emergency patients, provides operational managers with a whole new way of managing staff deployment at optimal cost. In 5 years' time this should become our usual way of working. Doing this at scale opens up a range of possibilities.

On Standardisation: Sharing Back Office and Clinical Support Services

It is bordering on the ridiculous that we have over 200 purchasing offices, over 200 offices paying invoices, over 200 recruitment offices and over 200 IT offices etc, each undoubtedly working hard but each adding a level of management overhead which is not sustainable. Our 240 organisations must learn to share back-office functions by specifying the standards they require and organising delivery so they can benefit from economies of scale. The same is true for our diagnostic and clinical support services.

On Standardisation: Standardised Care Can Still Be Personalised Care

Leaders should do more than just say they put the interests of patients first, they should be able to demonstrate how they involve them in all aspects of their care and treatment. For example, asking at the beginning of a consultation "what matters most to you", or giving a patient or relative the means to write everyday on a whiteboard next to their bed "what matters most to me" allows for a different conversation: one that transfers the power to the person and is focussed on satisfying individual needs, one that provides options and supports a patient to make the treatment or care choice which is right for them. We must ensure that this sensitive and considerate approach occurs consistently, not just in the best organisations, but in every one.

On Scale: Enabling Assurance of Key Standards for Patients – Saving Lives

It is a sad reality that no acute hospital is able to meet the Royal College of Surgeons standards for emergency surgery. As a consequence, our country experiences thousands of avoidable surgical deaths and it is likely that the majority of these occur due to untimely access to surgery, and poor identification and management of sepsis. Meeting the RCS standards is not going to be possible for separate hospitals, requiring 24/7 availability of resident surgeons. The cost cannot

be afforded and even if it could, the surgeons are not available to recruit. New solutions are required which mean that hospitals should integrate horizontally and create 'single shared services' to serve population sizes of c.1 million. In so doing, staff of say 3 hospitals can pool their labour and work across the sites, with probably one site being designated for high acuity surgery. The service could be jointly managed by the 3 Trusts, each sharing risks and benefits through a joint venture Board, rather than the stand-offs currently experienced when Boards calculate whether their organisations will win or lose from proposed integrated arrangements. An alternative to a joint venture would be a Group organisation. There will be many reasons why people say this change is inappropriate, but whilst they struggle for an alternative which protects the independence of their own organisation, patients will get a sub-standard service and some will lose their lives.

On Scale: Delivering Standardised Care through a Group of Organisations.

A Group allows the benefits of standardisation to be achieved at scale. Standardisation *and* Scale – are the key elements. A Group arrangement is NOT a traditional merger or acquisition (M&A): the NHS has a limited experience of successful M&A. It is a new approach which can assure a number of operating entities (let's say up to 6 current Trusts within a geographic cluster) deliver clinical services, consistent with the new care models, which are evidenced based. A Group Board can identify the best evidenced-based practices for our patients and provide decision support systems for our clinicians to assure that their decisions and the deployment of staff are more reliable. This will provide not only better outcomes but repeating the same processes across a group of providers will bring us better care at lower cost. Organisations with a strong track record of high performance, able to support their staff to assist in local improvement and with the capability to develop standardised operating procedures, have the best opportunity to deploy solutions into organisations without these capabilities. NHS Provider organisations working within a Group arrangement, by consent or transaction, should be supported to assure better, more reliable care at lower cost. Groups will not provide the solution in all areas – but their contribution to providing benefits of standardisation delivered at scale should be tested as soon as possible.

On Scale: Consolidating Accountable Organisations whilst Retaining Operational Excellence

The current number of c.240 organisations is no longer a sensible and affordable way of organising the delivery of reliable NHS care at lower cost. Organising delivery via a Group, or through pooled sovereignty, reduces the number of accountable organisations, providing benefits of a reduction in management overheads. Either of these arrangements allows for the creation of standardised operational processes and a consolidated leadership able to pursue the benefits of strategic partnerships. We need strong, effective Operational Executives to manage local services, systems and processes to meet access standards and financial plans and also to understand local needs of both patients and staff. But the skills to manage the operations of a complex healthcare organisation are different (not better/lesser) from those that are needed to design strategic programmes of change, manage complex external stakeholder relationships and deliver productivity improvement at scale. High level strategic leadership skills are in short supply, but they are needed to organise the standardisation, codification and deployment of successful assets (technologies, systems, methodologies and culture) at scale.

On Scale: Creating a New Relationship with Industry Partners

It is unrealistic to believe that the NHS will invent every solution to every problem. Indeed it is said that "the problem is moving faster than the solution". The NHS has a poor record of adopting and implementing evidence of best practice, new technologies and products - and yet if we did so at scale, we would have the real potential to make improvements to standards and productivity. Developing strategic partnerships with industry is crucial to the success of the NHS. Companies are investing £millions in product development to solve our problems and yet we do not know how to engage effectively with them. Most Trusts are too small to make partnerships effective and so the arrival of AHSNs is to be welcomed. A Group delivery system, to include a founding organisation with a successful track record of standardising and deploying technologies, is most likely to offer accelerated benefits.

On Rewarding Success

Like most things you can measure, the NHS has normal distribution, with some organisations having a track record of success and others in persistent difficulty - and a lot in between. Our 240 provider organisations are not homogenous and those which are successful will be so due to many factors. A real 'system of consequence' should be created where it matters if you are successful rather than just having a sense of pride in a job well done. We need to create a system which rewards success and enables Providers to spread their success to other parts of the country who are currently unable to receive assured high standards of care. Most successful Trusts are better placed than any central body to know how to manage change and improvement. I would prefer to see NHS organisations being commissioned to undertake 'turnaround' and project management work that we currently ask management consultancies to organise. This would provide a real opportunity to reward NHS organisations so that they can 'earn' additional income through their success, at a lower cost to the NHS. On the flip side, those organisations in persistent difficulty should only be provided access to finance with conditions: failure to improve would trigger an intervention, which could include a transaction to move the Provider under the management of another, for all or part of their services.

On a New Strategic Focus: Replacing Hospital Beds for Care at Home

Each time Salford Royal has undertaken a 'points prevalence study' of its patient population on any one day it has shown that about 20% of patients do not need to be in hospital. Most of these patients have care needs, some complex, but these could be provided at home or near to home. Liberating 200 beds from Salford Royal or c.2000 beds, if directly extrapolated across Greater Manchester, is worthy of consideration. We urgently need to find the care co-ordination and assistive technology solutions, including adapting the 'built environment' to radically improve care for people out of hospital. This would undoubtedly be better for patients and for their families, especially for those people living with dementia. But there is a key economic driver too. Nearly all hospital estate has some elements which need renewal or refurbishment and most Trusts will be planning to access or generate capital for this. What if, a new strategic direction was pursued: that all hospitals, in aggregate, should reduce their bed stock by 20% and replace this with a community substitute? All hospitals would remain open, but their size would reduce and as a consequence, the need for their capital renewal/refurbishment programme would be correspondingly reduced to enable the funding of the at home/community provision. The need for less capital would bring significant financial benefits by reducing the need for internally generated cash and loans to be serviced and also lowering the value of assets to be depreciated. Evidence also suggests that care out of hospital is less costly in revenue than hospital care, couple this with savings to capital programmes by eliminating the need to replace the element of hospital estate in poorest condition, then Trusts have the potential to effect a real strategic financial saving. The ability to do this in a single organisation is limited – but linking this across a Group of providers would be a game-changer.

On a New Strategic Focus: Improving Care in Our Neighbourhoods

Our primary care system is the envy of the world and yet it has within it high levels of variation of standards of care. NHS England rightly is pursuing an integrated care and service strategy to improve the health and wellbeing of the population. In each locality in England we have major opportunities to create mutually beneficial relationships, between primary and secondary care, at a neighbourhood level. Designing collaborative arrangements, utilising multi-disciplinary teams and blending the contribution of all practitioners provides the best means of focusing on better designed care pathways used by patients. There are a range of options being pursued but each requires strong and effective governance arrangements. These arrangements must ensure that the focus of GPs and hospital staff places the health of the people and population first, and in so doing that the organisational needs of the practice and the hospital are subjugated. Using new technologies, new systems and management capabilities will provide the means by which demand for care and treatment can be better managed. New contracts and job plans will need to be agreed which describe new responsibilities for neighbourhood networks, federations and pathways to deliver more reliable standards of care 24/7, 7-days a week, and in a more productive way. Providers (acute and primary care) should act now to radically improve primary and neighbourhood care.

Conclusion

The NHS can prosper, but it will need to adapt. New approaches are needed and these will include: a commitment to reduce variation in services and outcomes; standardisation of clinical pathways and operating procedures - and the delivery of these at scale; supporting improvement deep inside our organisations; rewarding our people and organisations for the contribution that they make; and shifting our strategic focus to support people in our neighbourhoods at or close to home. The NHS can provide better care at lower cost. We have the ideas – we now must find the will to pursue them.

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