Is it really possible to improve quality and reduce cost in the NHS?

Dr Steven Allder
s.allder@nhs.net
My background

- **Clinical**
  - Junior Doctor, MRCP, Research
  - Consultant Neurologist

- **Improvement/Management/Leadership development**
  - RCP/III, OSPREY, Safer Clinical Systems
  - NHS Executive Fast Track Scheme

- **Roles**
  - Service lead, CD Neuroscience and Ophthalmology, Head of Service Improvement
  - AMD, Board member Glos CCG
Iterative learning journey

2001-2015

Too much demand

Not enough hope

Very depressing

Technical Evidence - CSI

Behavioural Evidence - EI
The NHS Challenge!

Figure 4 The English NHS productivity challenge: QIPP (first and second phases)

Financial reality

Figure 7: Looking ahead, how confident are you that your organisation will achieve financial balance in 2015/16?

- 2 Very confident
- 12 Fairly confident
- 3 Uncertain
- 12 Fairly concerned
- 44 Very concerned
My answer to the question?

Yes, definitely...however...two buts

A small but, and

A very big BUT
Yes, Definitely 1:

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Yes, Definitely 2:

How It Played Out

Neurology Non-elective over 7 days Bed Occupancy

Figure 1
Yes, Definitely 3:

1. Understand the work different Service Lines do: A value stream analysis at Trust level

2. Align quality and financial standards developed by programmes to flows

3. Prioritise

Key Areas

- Longer stay unscheduled care patients
  40% of beds are occupied by patients who have stayed more than 7 days – this equates to approximately 300 beds

- Significant capacity and demand problem across each step of the scheduled care pathway
  Capacity and demand mismatch
<table>
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<tr>
<th>Programme Budgeting category</th>
<th>Preventive &amp; Health Promotion</th>
<th>Primary care</th>
<th>Secondary care</th>
<th>Urgent / emergency care</th>
<th>Community Care</th>
<th>Health &amp; social care provided in other setting</th>
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Making sense of ‘the buts’: The Complete Coherence Leadership Model

**Operational performance today**
- Finance
- ED Performance
- Waiting times
- Safety

**Operation Performance tomorrow**
- Clarify vision
- Set ambition
- Uncover purpose
- Identify strategic building blocks
- Develop full growth portfolio
- Decide on customer battlegrounds
- Establish effective governance

**Personal Performance**
- Step change quality of thinking
- Develop boundless energy
- Uncover personal purpose

**People Leadership**
- Identify organisational “Way” & evolve organisational culture
- Develop executive fellowships & high performing teams
- Clarify personal leadership qualities
This involves change, really involves *creation* which is hard

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**Need to create...**
**Why, How, What..**
First part of How: What to do I need to do differently?

Need to create...

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Two interrelated HOW challenges...
Small but..

Need to create...

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**How 1: Systems approach**
A very big but...  

Need to change...  

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How 2: Socio-cultural
The small but: How to find opportunity to improve care and reduce cost

Technical Analysis

Principles

Operational thinking – 3rd generation systems thinking
This is consistent with emerging reviews of NHS policy.

Reforming the NHS from within
Beyond hierarchy, inspection and markets

The experience of high-performing health care organisations shows the value of leadership continuity, organisational stability, a clear vision and goals for improvement, and the use of an explicit improvement methodology.

A Compelling How?
Systems Approach: *Vanguard method* building on best of health care improvement science
In health care – there are lots of potential symptoms

One department’s data from Trust Databook
Current approach = tackle as issues arise in isolation

Proposed approach = ‘systems – value’ approach to issues
YOU CAN START ANYWHERE!

1. How to find opportunity in theory
2. How to deliver results locally
3. How to deliver results more broadly

Starting point is **ALWAYS** multiple symptoms

Need a **value framework** to orientate you
Putting it all together: Stroke example

Technical Analysis
2008 - Worst Performer in Region

In 2008/2009, PHT death rate was 18.3% higher than the national average.

- £2,000 Loss per Patient
- 1.5 patients per day average
- £1.1 million annual loss

Poor Patient & Relative Experience

Stroke in-hospital deaths by NHS hospital
Standardised mortality rate (percent of national average)
Step 1 – Move from cost control to value creation

Choose demand stream to start with
Value framework (1)

This is very different and very challenging
Step 2 - Define Sub System

Key provide pathways involved
Model of Healthcare System

Regulators

System Architect (commissioners)

Purpose
Add value
Condition
Level

PATIENTS

1
Primary Prevention
Primary Care
Secondary USC
Secondary SC
Community Care

2
MH
Te
SC
Tr
EG
R

3
Direct value creation
Frontline Individuals
Frontline Teams
Frontline Management
Middle Management
Senior Management

Indirect value creation
Step 3: Define ‘entry’ patient demand stream

Population segmentation exercise
Programme Budgeting
Model of Healthcare System: Demand streams

1. Primary Prevention
2. Primary Care
3. Secondary USC
4. Secondary SC
5. Community Care

MH  Te
SC  Tr
EG  R
Mean has been 1.5 admissions per day over the past two years.
Step 4: Define key consumption stream

Understand authentic cause of variation in performance:

1. Demand sub-type
2. Stage of care
3. Step of care
Identify Hot Spots of resource consumption (Ideally, quality then cost)

- **ALOS Days**
  - Low (<3)
  - Med (3-7)
  - High (8+)

- **Number of bed days (percent)**
  - Low (<3): 18 (3)
  - Med (3-7): 83 (14)
  - High (8+): 499 (84)

- **Length of stay for patients with ALOS ≥8 days**

- **Quality:** Interaction of streams

**2009**

**ALOS Days**

- LOS
- Mean

**Consecutive patients**

0 10 20 30 40 50 60 70 80
Model of Healthcare System: Consumption streams
Step 5: Dissect consumption stream

Understand authentic cause of variation in performance:

1. Homogeneous demand sub-type
2. Stage of care driving variation
3. Step of care driving variation
Quality Grid guided case note review: Emergent element of process

**Figure 1: Value Grid**

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<tr>
<th>MRN</th>
<th>Physical state</th>
<th>Mental health issues</th>
<th>SC</th>
<th>Dx</th>
<th>Rx</th>
<th>MC</th>
<th>FS</th>
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<th>Admission</th>
<th>Discharge</th>
<th>Age</th>
<th>Date</th>
<th>Where</th>
<th>Notes</th>
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Presenting complaint/Diagnostic sub-division
5a. Which Demand sub type(s):

Six types of patients were defined based on patient status pre-stroke and the size of the stroke.

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<tr>
<th>Clinical stroke size</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<td>Frail** (53%)</td>
<td>RSU* or convalescence (17%)</td>
<td>RSU or convalescence (20%)</td>
<td>Pathway redesign required (16%)</td>
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<tr>
<td>Well (47%)</td>
<td>Home (23%)</td>
<td>RSU (13%)</td>
<td>RSU (11%)</td>
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Preferred place of discharge for 6 subgroups of patients\(^3\) (percent of total)

* Rehabilitation Stroke Unit
** Frail patients were defined as having medical complexity index of 3, 4, or 5 on a 1-5 scale. 0=No systemic disease other than primary diagnosis, 1=Premorbid, inactive, and or irrelevant systemic disease, 2=Active, relevant systemic disease not limiting function, 3=Active, systemic disease limiting function, 4=Active, systemic disease severely limiting function, 5=Moribund / terminal intermediate.
## Step 5b: Which Stage of care

### Clinical stroke size

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### Target Group 1
- Redesign Pathway: Discharge

### Target Group 2
- Improve Operational Rigour: Rehab
Step 5c: Which Step of care

Target Group 1 – Redesign Pathway: Whole process

Target Group 2 – Improve Operational Rigour: ASU-RSU

<table>
<thead>
<tr>
<th>Patient status pre-stroke</th>
<th>Clinical stroke size</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frail (53%)</td>
<td>RSU or convalescence (17%)</td>
<td>RSU or convalescence (20%)</td>
<td>Pathway redesign required (16%)</td>
<td></td>
</tr>
<tr>
<td>Well (47%)</td>
<td>Home (23%)</td>
<td>RSU (13%)</td>
<td>RSU (11%)</td>
<td></td>
</tr>
</tbody>
</table>

Patient status pre-stroke:
- Frail (53%)
- Well (47%)
Step 6: Redesign steps

The pathway was then redesigned for the key segment (frail patients with severe stroke), and operational improvements were initiated in the RSU for four other patient segments.
Structuring thinking about designing the specific step care:

1. Frail Elderly RIP
2. Morning handover
3. Very intimate
4. Expectant pathway
5. Protocol
6. LCP Hospice
7. Team
8. Costs far less

Source: http://www.lcp.com
Severe Stroke in Frail Patients

- Highest resource consumption
  - 75% of beds were used by the frail patients pre-stroke

- Highest variability in bed occupancy & long length of stay
  - Driven by a lack of systematic care planning

- Care not well-matched to patients
  - Variable treatment and feeding processes, not aligned with patient and relative preferences
RSU Operational Rigour (1)

- No frail patients with severe strokes are sent to RSU
- Active decision for frail patients with moderate stroke
  - Based on clear triage rules and input from acute care providers, relatives and patients
- Previously well patients with moderate or severe strokes go to the RSU
  - Rigorous monitoring is used to determine when patients can be sent home with enhanced community resources (early supportive discharge) or to long-term placement (e.g., nursing home)
RSU Operational Rigour (2)

- Rigorous daily review
  - Status of all patients is reviewed daily (discharge round)

- Staffing adjustment to reduce ALOS
  - A dedicated social worker was added to the RSU to help reduce ALOS

- Consider ongoing re-design
  - PHT is currently redesigning its RSU pathway, assessing its options for community services, and reassessing its pathway for frail patients with mild strokes
In under a year, access to and use of the Acute Stroke Unit has become more efficient\(^3\)

* This is one of the major indicators in the UK National Stroke Audit; if patients are not spending time in the stroke unit, they are either in the A&E or the medical assessment unit, likely not getting the most appropriate care
Lots of Beds Saved...Permanently

Acute beds at Derriford Hospital

<table>
<thead>
<tr>
<th></th>
<th>April 2009</th>
<th>June 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds</td>
<td>33</td>
<td>20</td>
</tr>
</tbody>
</table>

Net acute benefits

Rehab beds at Mount Gould

<table>
<thead>
<tr>
<th></th>
<th>April 2009</th>
<th>May 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds</td>
<td>23</td>
<td>19</td>
</tr>
</tbody>
</table>

Reimbursement level: £4k per patient

New cost of care: £3k per patient, Savings: £1k

17 beds released, implying net savings of 11% across system
An offer of hope

**Figure 5: What do you regard as the most valuable incentives for change? (Select the top three factors)**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Incentive</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Opportunity to attract investment</td>
<td>26.2%</td>
<td>28</td>
</tr>
<tr>
<td>2</td>
<td>Opportunity to improve care for patients</td>
<td>89.7%</td>
<td>96</td>
</tr>
<tr>
<td>3</td>
<td>Opportunity to collaborate with colleagues</td>
<td>24.3%</td>
<td>26</td>
</tr>
<tr>
<td>4</td>
<td>National recognition</td>
<td>7.5%</td>
<td>8</td>
</tr>
<tr>
<td>5</td>
<td>Opportunity to change staff terms and conditions</td>
<td>7.5%</td>
<td>8</td>
</tr>
<tr>
<td>6</td>
<td>Opportunity to reduce costs</td>
<td>33.6%</td>
<td>36</td>
</tr>
<tr>
<td>7</td>
<td>Guaranteed personal or organisational income</td>
<td>12.2%</td>
<td>13</td>
</tr>
<tr>
<td>8</td>
<td>More support from regulators/national bodies</td>
<td>20.6%</td>
<td>22</td>
</tr>
<tr>
<td>9</td>
<td>Enhancing professional views</td>
<td>12.2%</td>
<td>13</td>
</tr>
<tr>
<td>10</td>
<td>Opportunity to future-proof services</td>
<td>12.0%</td>
<td>16</td>
</tr>
<tr>
<td>11</td>
<td>Other</td>
<td>5.6%</td>
<td>6</td>
</tr>
</tbody>
</table>

Total responses: 321