The King's Fund

Ideas that change health care

SUMMARY

Better value in the NHS

The role of changes in clinical practice

July 2015

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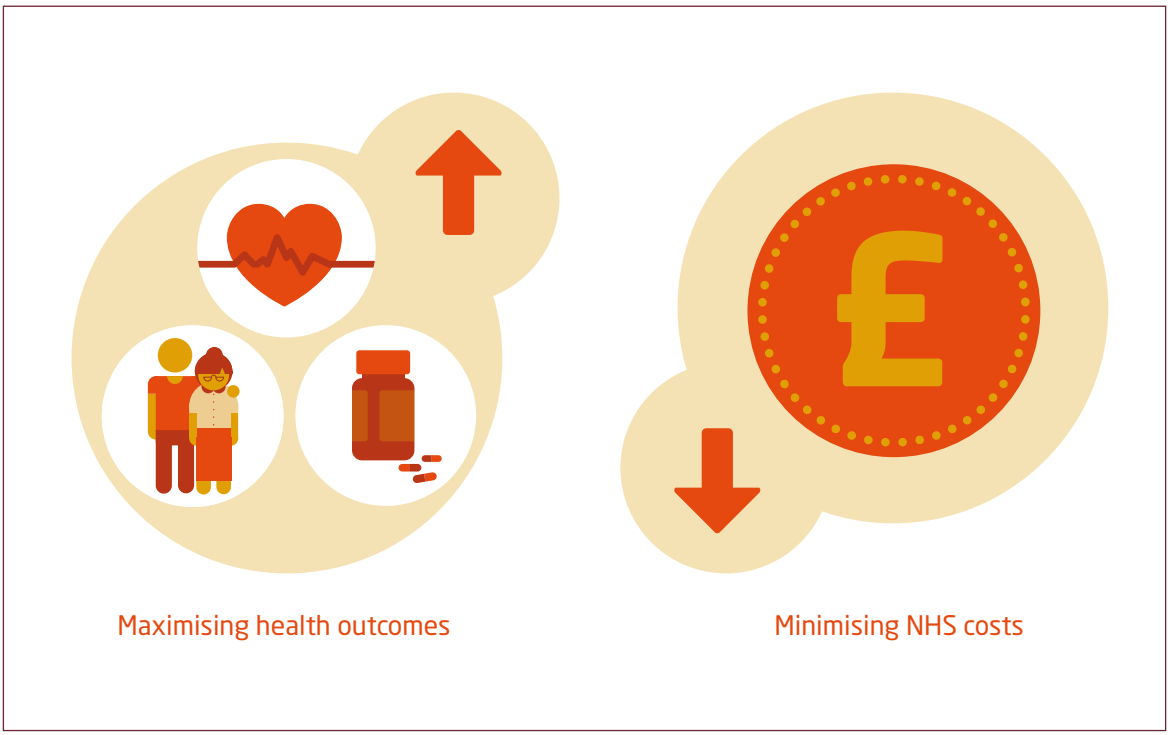
The NHS has always strived to improve quality and reduce costs. That issue is coming into even sharper focus, given the context of unprecedented financial constraint and the calls for efficiency savings of £22 billion from the *NHS five year forward view* (Forward View).

However, focusing on the monetary value of the challenge risks missing the real essence of the task facing the NHS, which is about getting better value from the NHS budget. This means maximising the outcomes produced by the activities the NHS carries out, while minimising their costs. Framing the debate in terms of efficiency and costs also risks losing the opportunity to engage clinical staff in the challenge of changing the way in which care is delivered.

Our review of the evidence suggests that there are significant opportunities to get better value from the NHS budget. In our report *Better value in the NHS: the role of changes in clinical practice,* we look back at past trends in NHS productivity and draw on evidence to illustrate a number of areas where NHS services can be improved in the future.



Productivity in the NHS so far

Examining past trends in NHS productivity can offer a number of lessons for today's financially squeezed health system. It provides a broad idea of what we might expect of the NHS based on past performance and helps us understand how improvements have been made so far to offer a guide for future action.

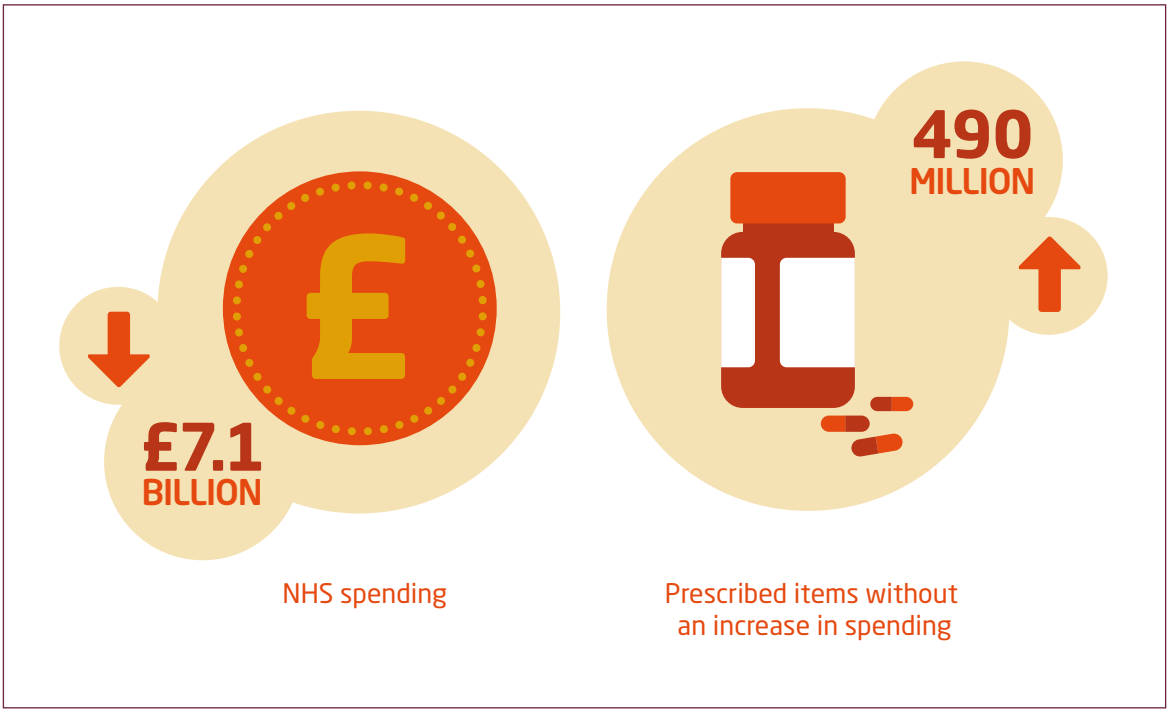
Improvements in overall NHS productivity have been modest over the past 35 years. Estimates of the average annual growth in NHS productivity from the early 1980s to 2012/13 range from around 0.7 per cent to 1.2 per cent, depending on the methods used – less than the 2–3 per cent gains the NHS would have to achieve to deliver the £22 billion in productivity improvements identified by the Forward View.

These aggregate measures of productivity have an obvious appeal – not least their simplicity and ease of reference. Yet reliance on them risks overlooking valuable detail within the overall picture. In particular, these measures fail to tell us anything about *where* improvements have been made in different parts of the NHS. They also fail to offer the level of detail required to analyse how improvements have been achieved.

Analysis of productivity in three areas

Single-aspect measures of productivity can be used to paint a more detailed picture of improvements in different areas of the NHS. We illustrate this with an analysis of three indicators where the NHS has made unambiguous improvements in productivity over a number of years: generic prescribing, length of stay and day-case surgery.

In each of these areas, the NHS has made significant and sustained gains in productivity, allowing more (and better) care to be delivered within the same budget. For example, increased levels of generic prescribing from 1976 to 2013 (from 20 to 84 per cent) has in effect saved the NHS around £7.1 billion and allowed 490 million more items to be prescribed without an increase in spending. Put simply, the NHS is now getting much more value for every pound it spends on prescribing.



Another way of looking at the impact of these gains is by estimating what would have happened if the NHS had failed to make improvements in each of these areas. A particularly striking example is the progress made in switching inpatient activity to day-case admissions. If the proportion of patients treated as day cases had remained unchanged from 1998/9 to 2013/14 (all other things being equal), NHS spending in 2013/14 would have paid for 1.3 million fewer elective patient episodes than it was actually able to do.

Our analysis also suggests that there is still potential to make further improvements in these areas in the future. A good example is average length of stay in hospitals. While lengths of stay in England have fallen from 10.5 days in 1974 to 4 days in 2013/14, comparisons with other countries and data on variations in performance between hospitals in the NHS suggest that there are still gains to be made. If further reductions of, say, 15 per cent were made by 2023/4, the NHS would be able to treat around 18 per cent more patients than it did in 2013/14, within the same overall budget.

Drivers of improvement

These examples reveal a positive, if often hidden, picture about improvements made in the NHS where patients received better value care. So what can be learnt in terms of the drivers of improvement? Two lessons seem especially important for the NHS today.

First, in each case, the drivers of change have been multiple and overlapping. They include a combination of technological, clinical, cultural, policy and economic changes that have worked together to (directly or indirectly) stimulate and support changes at the front line of the NHS. Future approaches to improvement must recognise these complementary factors in order to make sustained change happen.

Second, improvement takes time. Progress is typically made over a number of years through a series of small steps rather than giant leaps forward. Whether the NHS can move from steps to leaps to make the gains needed over the coming years remains to be seen – but history certainly tells us that would be the exception rather than the norm. It is more likely that the NHS will need to depart from tried-and-tested approaches to improvement if it is going to have any chance of supporting staff to meet the challenge laid down by NHS England Chief Executive Simon Stevens in the Forward View.

Opportunities for the future

Evidence suggests that there are a range of opportunities for the NHS to get better value from its £116 billion budget through changes in clinical practice. This is because the NHS, like all other health systems across the world, sometimes fails to deliver high-quality care, leading to poor outcomes for patients and wasted resources.

Inappropriate care

One way of illustrating these opportunities is through evidence of inappropriate care, which happens when:

- care is delivered even though the potential for harm outweighs the benefits (overuse)
- effective care is not delivered but should be to provide a better outcome (underuse)
- care is poorly delivered (or not at all) leading to preventable complications or harm (misuse).

We draw on evidence to show that overuse, underuse and misuse are common and costly across the NHS.

Examples of overuse include overdiagnosis of a range of conditions leading to unnecessary tests and treatment, overprescribing of relatively ineffective drugs like antibiotics for coughs and colds, and overusing low-value procedures in acute hospitals. Reducing overuse would free up resources for the NHS to use for more effective care.

Examples of underuse include the underdiagnosis of people's conditions leading to missed opportunities to prevent them from getting worse, failures to deliver effective treatments and the underuse of effective drugs. In many cases, tackling problems of underuse could save the NHS money (particularly over the longer term) while in other cases it might increase costs (particularly in the short term). In both cases, tackling these problems will improve quality of care and outcomes for patients.

Examples of preventable harm can be found across the NHS, but most of the available evidence about these incidents comes from hospitals. They include preventable falls, venous thromboembolism, medication errors and adverse drug reactions. Like both overuse and underuse, the financial cost of preventable harm can often be significant, offering the NHS significant opportunities to get better value through delivering safer care.

As well as making sure that services are delivered in line with best practice guidelines, tackling inappropriate care will require NHS staff to work together with patients to understand their preferences and the outcomes that really matter to them.

Variations in care

The scale of these quality problems in the NHS is powerfully illustrated by data on the variations in clinical practice. These variations are widespread both within and across different parts of the country – so wide that they are not explained by differences in people's health needs and patients' preferences. In other words, these variations are unnecessary and avoidable.

Why is there a more than 1,000-fold variation in the rate that GPs refer patients for some diagnostic tests? Why do rates of elective tonsillectomy in children range from 145 to 424 per 100,000 young people? Put more simply, why do some people in the NHS receive much better care than others? Answering these questions and tackling the resulting variations in care is one of the most significant ways for the NHS to improve quality and value.

Of course, not all variation is bad variation, as patients may receive different services because of their health needs or personal preferences. The challenge lies in retaining this good variation by involving patients in decisions about their treatment, while identifying and removing the unwarranted variation arising from inappropriate care.

Service areas

Another way of looking at the opportunities for the NHS to increase value from its budget is by highlighting major service areas where improvements in care can be made. We examine three areas where evidence suggests that service quality can be poor and where better (and often cost-effective) ways of delivering care and support are known:

- services for people with long-term conditions
- services for older people living with frailty and complex needs
- services for people at the end of their lives.

For people with long-term conditions, the NHS could diagnose their conditions earlier and prevent them from getting worse, support people to manage their own health and involve them in treatment decisions, and co-ordinate services more effectively between different parts of the health and care system.

For people living with frailty and complex needs, the NHS could support transitions between people's homes, hospitals and back again more effectively. This includes preventing inappropriate hospital admissions, improving patient flow as patients move through hospital and other care settings, and improving discharge and re-ablement as people move out of hospital.

For those needing care at the end of their lives, the NHS has opportunities to reduce the time that people spend in hospital, to co-ordinate services more effectively and to provide better training to staff to deliver high-quality care.

Across each of these three areas, the cost of poor-quality care to patients and the NHS is often high, while the cost of effective interventions to improve quality of care is often low. In some cases, evidence suggests that better quality care will save the NHS money.

Teams delivering better value care

We also illustrate the opportunities to increase value in the NHS by drawing on examples of teams across the NHS who are already doing just that. These examples show that the opportunities identified through our research are not simply hypothetical – they are grounded in the real-life experiences of teams and organisations who are seizing opportunities to deliver better value in the services they provide.

Plymouth Hospitals NHS Trust

In the redesign of stroke services in Plymouth Hospitals NHS Trust, staff walked in the shoes of patients to understand how they moved through services, the quality of care delivered at each stage of the process and how services could be changed to improve the lives of patients and their families.

Particular attention was paid to the small number of frail people in the acute stroke unit who had had new severe strokes. This sub-group consumed the most resources on the unit, had the highest variability in bed occupancy and stay duration, and the greatest mismatch between care delivered and patient needs.

Frontline teams mapped out and redesigned the care pathway for this key group of patients. A locally tailored dashboard of metrics was developed and reviewed weekly to help understand how the service was performing, and to allow issues to be identified for more detailed examination.

Within a year of redesigning the service, transfers to the stroke unit were 12 per cent faster, the average length of stay had fallen by 6 per cent, and 13 acute and 4 rehabilitation beds were permanently closed. Better care had also saved the hospital money, an average of around £1,000 for every stroke patient.

A critical factor in the success of the programme was the fact that individual staff with an aptitude for championing change were supported and encouraged to make those changes.

Examples such as these can be found across the country and need to be shared and replicated to support others to make the same kind of improvements.

Importantly, these initiatives are built on the knowledge of those working within a service about where the opportunities to improve value lie, as well as the experiences of patients and their families about the services that they receive and how they could be improved.

It is clear that there is a body of evidence that illustrates where the NHS should focus its attention to improve quality and outcomes – and by doing so increase value from its limited resources. While the evidence that we highlight is in no way exhaustive, it offers an indication of what can be achieved through changes in clinical practice led from the front line of the NHS.

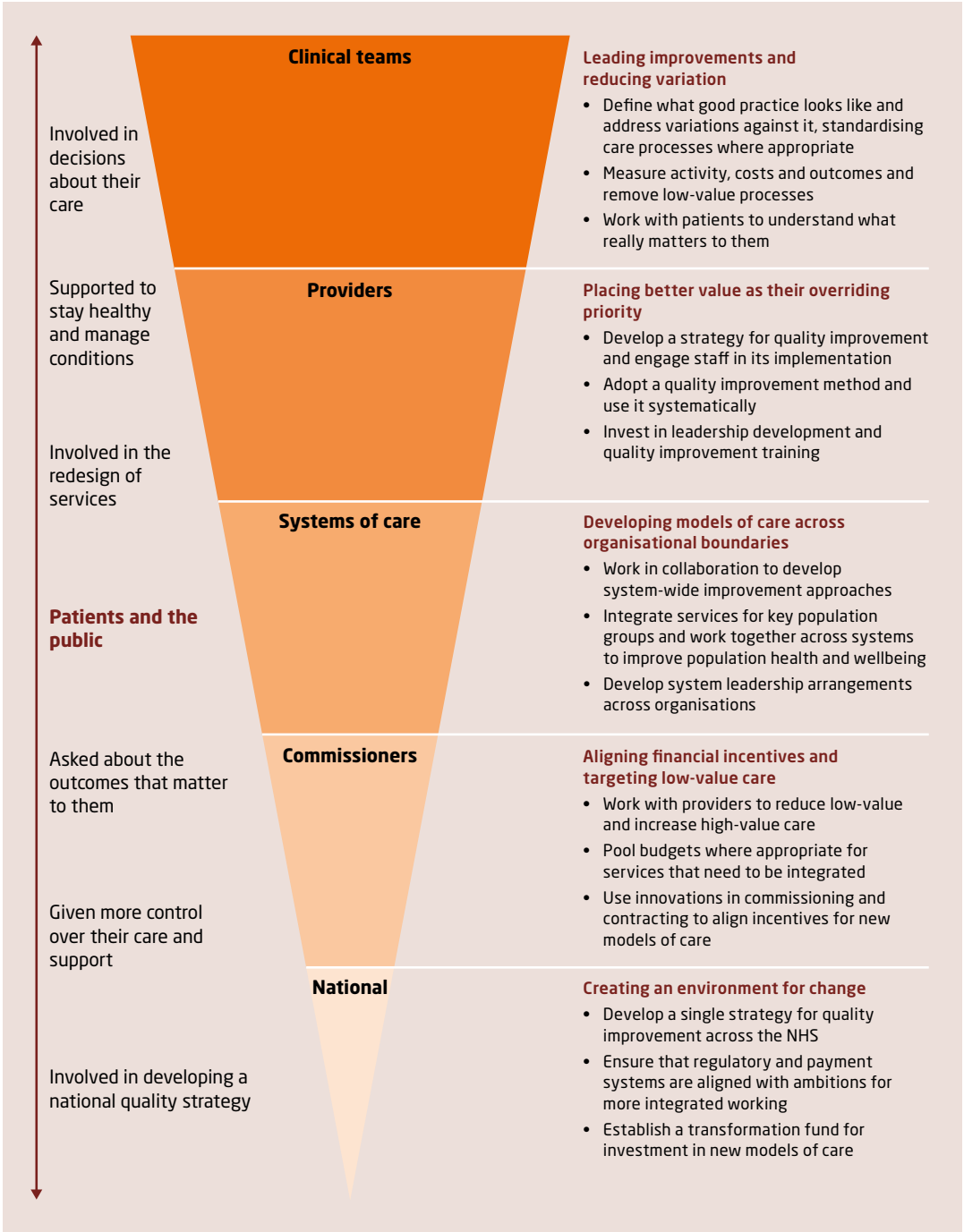
Creating an environment for change

Recent slow-downs in funding growth have highlighted the need to improve productivity, but getting the greatest value for patients from every pound spent on health care has always been a primary focus for the NHS. In 2010, the NHS faced the task of making productivity improvements valued at around £20 billion by 2014/15. The main approaches used to meet that challenge were national controls of pay and prices within the NHS and cuts in management costs. These central policy levers are now coming to the end of their effective life. Further improvements in productivity to meet the new challenge to close the £22 billion funding gap must therefore come from elsewhere.

The evidence brought together here points to many opportunities to improve outcomes and deliver better value. All these opportunities require changes in clinical practice to provide care more appropriately and in more co-ordinated ways, and to build on the work of medical leaders. Most importantly, they all have the potential to improve the lives of patients – sometimes significantly – as well as those of staff working in the NHS.

While understanding where the opportunities lie is important, the real challenge facing the NHS is being able to turn these opportunities into tangible improvements in care. This is highlighted by the fact that although few of the opportunities described in this report are particularly new, they remain largely unrealised.

An agenda for action



Where next?

Making change happen will require a fundamental shift in approach by government and NHS leaders – away from using external pressures to improve performance towards a sustained commitment to supporting reform from within.

These changes will require action and alignment at all levels of the system, aimed at supporting clinical teams to make improvements to the way they deliver services in collaboration with their patients.

The challenge facing the NHS over the coming years is fundamentally about improving value rather than reducing costs. Framing the debate in these terms emphasises the role of quality and outcomes in meeting the challenges facing the health system, as well as providing the right language to engage clinicians and frontline staff in making change happen.

To read the full report, *Better value in the NHS: the role of changes in clinical practice,* go to: www.kingsfund.org.uk/bettervalue

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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