

Using the NHS reforms to deliver sustained quality improvement

Keith Palmer

May 19 2008

keith.palmer32@btinternet.com

Agenda

- Will the system reforms deliver sustained quality improvement?
- How can we strengthen the drivers to improve quality of care without 'throwing the baby out with the bathwater'?

What are we trying to achieve?

Quality

- High quality care for all patients
- Continuous quality improvement
 - Steady progression of all providers to best practice 'frontier'
 - Push the frontier forward

Right services in the right places in right amounts

- Location – care networks, more out-of-hospital care?
- Spending priorities – prevention/primary-community care/acute-specialist care
- Amount – demand growth, waiting times, intervention rates

Cost effective affordable provision

- Lowest unit cost consistent with desired quality of care

What do we mean by high quality?

Much more than waiting times and HAIs

Provider quality domains

- Clinical quality (clinical outcomes, best practice models of care)
- Patient safety
- Patient satisfaction
- Convenient care (location, opening hours)
- Timely care (early diagnosis/treatment, waiting times)

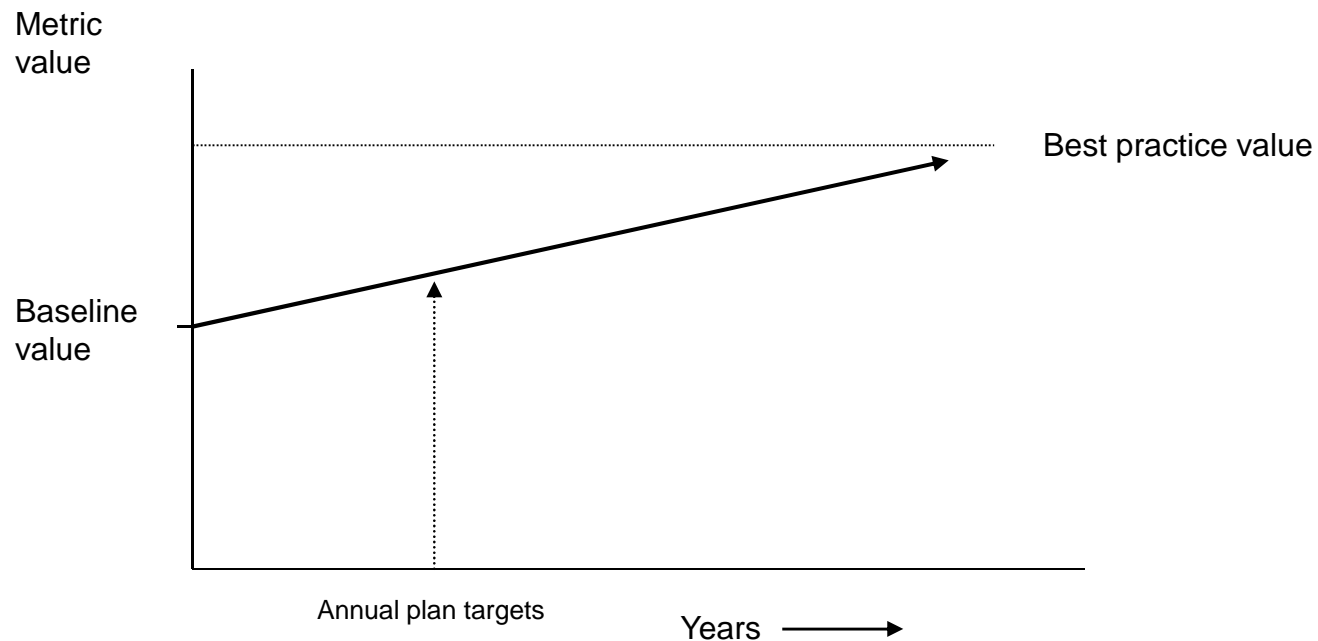
Define quality metrics at **service** level eg cancer, cardiac, stroke, maternity etc

In most services there are evidence-based 'best practice' models of care

For more on quality indicators see Kings Fund website 'Continuous Improvement in the Quality of Care – What is the role of the Board|?' K Palmer 2008.

Setting quality improvement targets

- International and national evidence-based benchmarks – adjusted for local circumstances
- Agree desired medium term values and determine achievable trajectory for improvement



System reforms - where are we today?

- **PbR tariffs/efficiency factor** – sustained downward pressure on average costs
- **Patient choice** - ‘choice and voice’ intended to drive quality improvements
- **PCT commissioning** – aim is ‘world class commissioning’ but significant concerns about PCT capacity/effectiveness
- **Foundation Trusts** - freedoms to drive service improvements
- **Government quality targets** – narrow focus eg waiting times, HAIs

Shift of resources out-of-hospitals is underway

More discretionary funds available to PCTs to drive quality improvement (in and out of hospital)

From 2009 projected ‘surplus’ of some clinicians and hospital estate

The point about incentives is ...

- Positive incentives = beneficial impact on providers if actions are good for the patient
- Perverse incentives = adverse impact on providers if actions are good for the patient
- If strong perverse incentives - desirable service change will happen very slowly – ‘forced’ by PCTs against provider interests
- Perverse incentives result from interaction of funding (PbR), fixed costs and financial regime

Current incentives on hospital providers

- To shorten length of stay and increase day case rates
- To close beds/reduce ward staff and other costs (= maximise bed occupancy rates)
- To reduce time spent by each doctor with each patient
- To maximise capacity utilisation of all fixed capacity
- To maximise number of admissions

Quality improvement incentives

- Few quality improvement targets
- PbR payment is same regardless of quality of care/outcomes
- No extra funding for adoption of best practice models of care (or reduction for not doing so)
- No differential funding to reflect higher per patient cost of clinical innovation

Perverse incentives on hospital providers

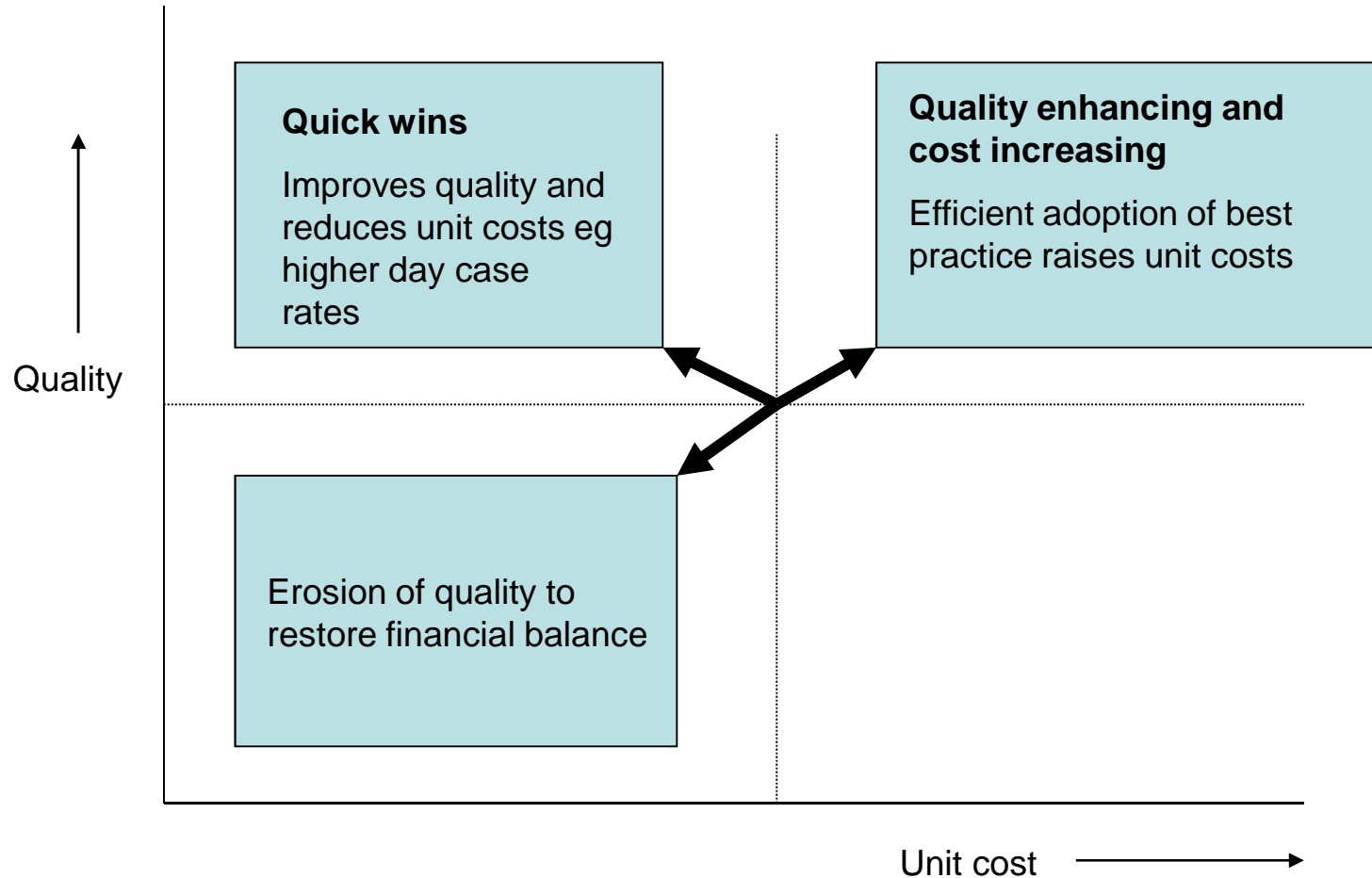
Perverse incentives

- To maximise hospital admissions
- In particular to resist loss of admitted activity
- To focus on growth of activity rather than improving quality
- To under-invest in quality improvement when it is not fully funded in tariffs

Why?

- Marginal income gain is greater than marginal cost so extra activity is profitable
- Marginal income loss is greater than marginal cost savings so loss of activity increases deficit
- Actions to achieve financial balance by eroding quality of care not penalised
- Funding in tariffs insufficient to cover marginal capital costs of investment in quality improvement

The cost of quality improvement



Many quality enhancing programmes are cost neutral or cost reducing for the system but create 'winners' and 'losers' across PCT/provider boundaries

Will the system reforms drive sustained quality improvement?

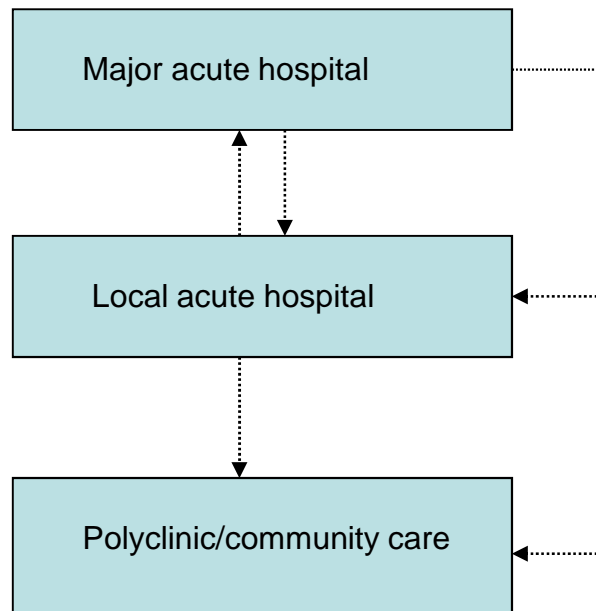
- Waiting times largely sorted by year-end
- Need to strengthen focus on broad quality improvement agenda
- Currently weak drivers for quality improvement especially patients with LTCs, effective networks of care and clinical/service innovation
- There is a significant opportunity to raise the game on quality improvement using the increased discretionary funds now available to PCTs

Improving the quality of care

- Development of effective networks of care
 - Stroke
 - Urgent/emergency care
- Expanding care options closer to/in the home
 - End of life care
 - Polyclinics
- Management of patients with long term conditions (LTCs)
- Supporting clinical/service innovation

Development of effective networks of care

- **Clinical case for change** Darzi stresses the benefits for patients of effective networks of care
- Patient benefits in cancer, cardiac, renal, stroke, paediatrics, obstetrics, urgent care



- Different roles for different hospitals
- Significant redistribution of costs and income across trusts
- Creates 'winners' and 'losers' and increases financial pressures on losers
- Result is resistance to adoption of improved models of care

Networks of care for stroke (I)

Current situation

	Service	Outcomes	Cost	Funding
Major acute	Best practice model of care	Good outcomes Short LOS Early return close to/home	Higher than average	Average system cost
DGH	Non-specialist service	Poor outcomes Long LOS Late return close/home	Average but high share on bed costs of rehab support	Average system cost

Current tariffs create resistance to desirable service redesign

Under-fund providers of best practice model of care/over-fund others

Networks of care for stroke (II)

Desired situation

	Service	Outcomes	Cost	Funding
Major acute	Best practice model of care accessed by all patients	Good outcomes Short LOS Early return close to/home for all patients	Higher than average	Efficient cost of providing best practice model of care
DGH	Specialist stroke rehab service	Strong support to return home Short LOS Stronger support once home	Lower average cost but higher share on rehab support	Efficient cost of providing stroke rehab support

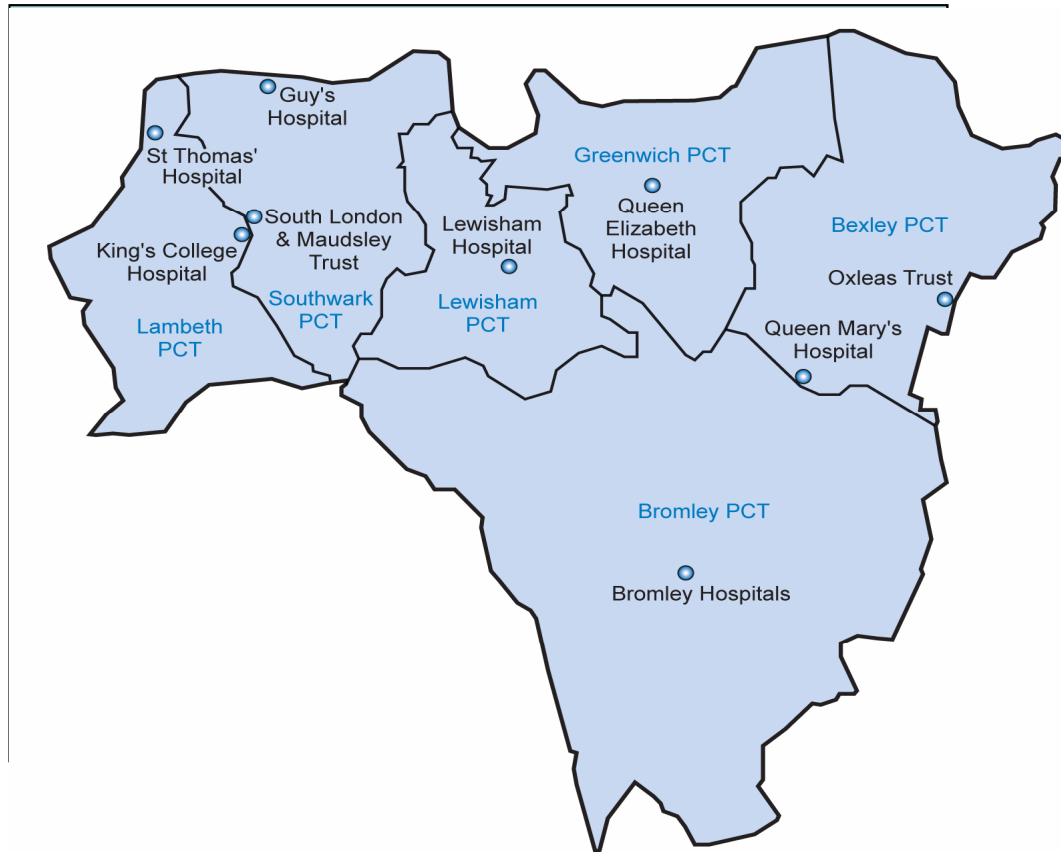
What is needed to make it happen ...

- Strong commissioning by PCTs across a region (in London joint commissioning by more than one PCT)
- Clearly delineated roles in patient pathway for each provider
- Payments linked to cost of providing 'best practice' model of care
- Clear protocols with ambulance service
- Adjustment funding to support transition especially for DGHs
- Monitoring of quality of patient outcomes – reduced payments for poor performance?

Similar perverse incentives operate in other network services

Direction of solutions is the same

Developing networks of care – the case of SE London



- 2 FT teaching hospitals, 4 DGHs, 6 PCTs
- Strong clinical case for change
- Large financial deficit – in 4 'financially challenged' DGHs
- 2 'early whole hospital' PFI schemes
 - + 1 part hospital PFI scheme
- Major changes in pattern of services and income flows
- All hospitals fairly close to patients' homes

- 6 full A&E within 10 sq miles
- Consolidate outer SEL major acute activity at QE and Bromley, QMS = local acute
- Lewisham activity less than planned when PFI scheme approved

SE London reconfiguration

- More activity/income at QE/Bromley eliminates recurrent deficits
- Lewisham PFI costs not fully covered by reduced activity/income
- QMS has stranded costs arising from downsizing to local acute
- Projected annual deficit for 4 DGHs reduced from c £60m pa to c 5-10m pa
- Large legacy debt (£180m) and major asset impairment at QMS

Why agreement on reconfiguration could not be reached

- Boards of 'loser' Trusts could not support because financial problems not solved
- No means of dealing with legacy debt and asset write-downs
- Merger/acquisition solutions not possible unless legacy debt and asset write-downs dealt with and competition policy clarified
- Result was SHA intervention and enforced organisational change – but subject to public consultation

Lessons for other major reconfigurations

- Do not normally expect the 'market' to deliver solutions – nor the SHA unless providers are 'financially challenged'
- Therefore ensure commissioners have the powers to require (subject to consultation) service change where there is clear evidence of unacceptable clinical outcomes
- Clarify competition policy especially the rules for retention of acceptable patient choice (eg for routine acute care minimum 3 providers within 1 hour journey)
- Clarify rules about legacy debt and asset write-downs consequent on major service redesign – to enable acquirers to develop propositions acceptable to eg Monitor
- Create/extend financing facilities to enable providers to fund costs of service reconfiguration

Expanding care options closer to home/in the home

Case for change

- Extending choice options eg end of life care at home, midwife-led birthing centres
- Convenience of patient care eg renal dialysis, chemotherapy, minor elective surgery within easy reach

Incentives to shift care closer to home

- For hospitals it increases marginal costs but no increase in income – so adds to pressures on finance and quality of care
- If average costs of new services are higher than tariff then no incentive for existing or new entrants to supply the service
- Who takes the volume risks of new capital investment?
- Parallel running costs need to be financed by the PCT

End of life care

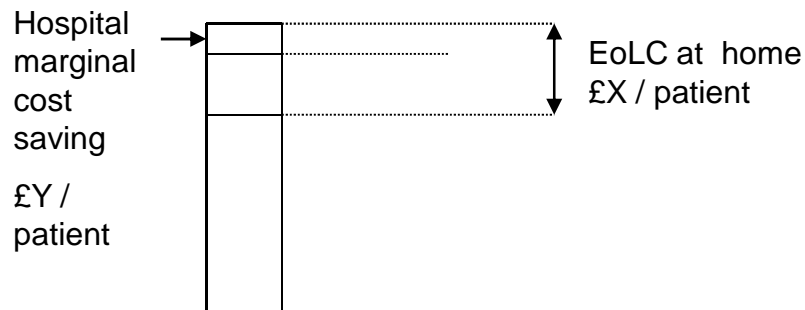
Objective

- Effective choice of where to die – hospital, hospice, home
- Issue is how to make this happen

Current position

- Most patients die in hospital
- Most patients that choose to die at home would be discharged from hospital
- Cost of EoLC at home is average days service provided x cost per day
(= av £X/patient)

The Incentive/Funding Problem



- PCTs fund EoLC in hospital in tariff
- Extra cost of EoLC at home £X/patient
- Marginal cost savings of hospital < £X/patient

Impact of patients exercising choice to die at home

Net increase in cost of EoLC provision/patient = $\text{£}(X-Y)/\text{patient}$

PCT funding of EoLC		Incentive	PCT cost higher
EoLC at home	Payment to hospital		
1. $\text{£}X/\text{patient}$	Full tariff	Strong	Greatest
2. $\text{£}X/\text{patient}$	Reduce $\text{£}X/\text{patient}$	Weak	None
3. $\text{£}X/\text{patient}$	Reduce $\text{£}Y/\text{patient}$	Improved	Medium

Possible solution

Portable EoLC payment set at level sufficient to fund EoLC at home or in hospice

Adjust hospital payments to leave providers cost neutral ($\text{£}Y/\text{patient}$)

Polyclinics

- Annual cost of provision = estate costs + staff costs + equipment costs
- Key determinants of cost are staff mix and estate cost
- Average cost per patient = annual costs/number of patients
- Major volume risk around polyclinics – induced demand and choice

- Existing hospital provision has lowest marginal cost because cost of surplus estate is near zero and high volumes per clinic
- In London surplus hospital estate cheapest location for polyclinic services. Closeness of acute sites to population centres means often convenient
- How much extra will PCTs be willing to pay to transfer services closer to home in dense conurbations like London?

Management of patients with long term conditions

Case for change

- Aim is to manage care in the community and reduce need to be admitted to hospital
- Increasingly recognised that best practice is multi-specialist hospital-based clinicians supporting community clinicians

Current incentives

- Hospitals maximise income/surplus by maximising admissions
- Reluctance of PCTs/community clinicians to involve hospital clinicians in care management for fear of unaffordable/inappropriate hospital referrals

Management of patients with long term conditions

Case for change

- Aim is to manage care in the community and reduce need to be admitted to hospital
- Increasingly recognised that best practice is multi-specialist hospital-based clinicians supporting community clinicians

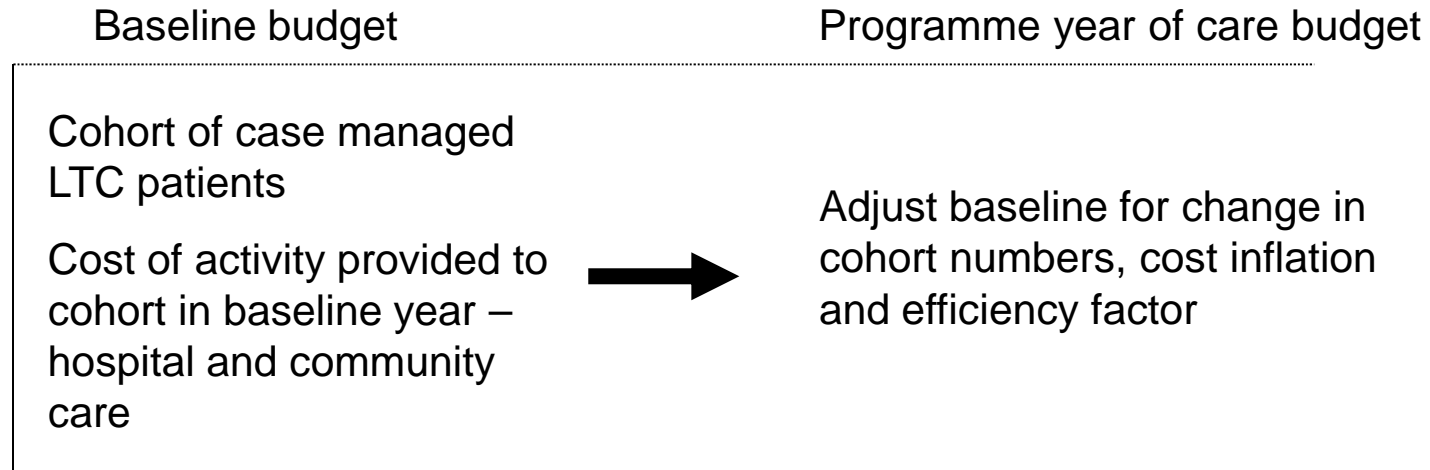
Incentives

- Hospitals maximise income/surplus by maximising admissions
- Reluctance of PCTs/community clinicians to involve hospital clinicians in care management for fear of unaffordable/inappropriate hospital referrals

Direction of solution

- Do not fund LTC services on episodic payment by activity
- Align funding incentives to support integrated working across health economy
- Funding formula based on capitation payment for cohort of patients and protections for PCTs against over-referral by hospital clinicians

Funding a year of care



- Agree Programme Year of Care for cohort specifying contribution of hospital-based clinicians
- Agree hospital share of budget to spend on LTC management in hospital and community
- Cap on hospital admissions paid the full tariff
- Link annual payment to performance against agreed programme year of care
- Unspent budget (if any) to be carried forward to future years

Supporting clinical/service innovation

- Quality improving/cost increasing clinical/service innovation is not fully funded in tariffs – creates disincentive
- A problem for working capital as well as fixed assets investment
- Solution – income supplements for approved clinical/service innovations to fund the gap between efficient marginal costs and average cost tariffs
- Benefitting investments must be signed-off by PCTs as income supplements are a charge against their budgets
- Need mechanism to ensure capital efficiency – in some cases the supplements could be bid competitively
- Need extended access to financing facility to fund approved innovations

Will the system reforms deliver sustained quality improvements?

- Current incentives were designed when hospital activity growth was the objective – this is no longer the case
- Incentives to improve quality across all services are currently weak
- Incentives in some areas are now unhelpful and act as a brake on desirable service improvements
- But do not throw the ‘baby out with the bathwater’strengthen incentives for quality improvement without weakening the positive incentives generated by the reforms

How can we strengthen incentives for sustained quality improvement?

What is needed is a combination of:

- Strong commissioning based on a strong quality improvement agenda – low tolerance of providers with poor quality
- Evolution of funding arrangements to support quality improvement and desirable service change
 - Funding of network services to reflect the efficient cost of provision at each point in the patient pathway
 - Pilot year of care budgeting for LTC patients
 - Accelerated further unbundling of tariffs to enable choice about location of care
 - Income supplements to support clinical/service innovation
- Clarification of policies on legacy and stranded costs, provider competition/M&A and funding of adjustment/parallel costs