

## State of the Nation



Tuesday 20<sup>th</sup> January 2009

“We are in the midst of a crisis..... our healthcare costs are too high.....We will restore science to its rightful place, and wield technology’s wonders to raise healthcare’s quality and lower its cost”

“All this we can do. And all this we will do”

Barack Obama, Inaugural speech, 2009



Tuesday 20<sup>th</sup> January 2009

“The NHS belongs to the people. It is there to improve our health, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.”

The NHS Constitution

- The NHS is owned by and needs to serve our society
- Society is changing
  - Older
  - More diabetes & obesity
- Medical science and technology
- Information technology
  - iPod, Web 2.0, Interactive television
- Changing attitudes and expectations
  - Waiting lists have gone
  - Personal and responsive service
- Safety and quality
- Economics & Politics
- Change is a professional and moral imperative
  - Not because the Government has told us to change

## How has the NHS responded?

- Change in philosophy
  - Focus on quality of care
- Assess funding
- Change the system
  - More responsive to patients
  - Introduce incentives to improve quality

## The last decade: Changing philosophy



A First Class Service  
(1998)

### Setting standards

National Institute for Clinical Excellence (NICE)  
National Service Frameworks (NSFs)

Coronary Heart Disease  
Cancer

### Implementing standards

Local clinical governance

### Monitoring standards

Independent regulator  
National Patient and User Surveys

### The last decade: Building capacity

- 2000/1: £43.9 billion
  - 2003/4: £72.1 billion (40% increase)
  - 2005/6: £79.3 billion
  - 2007/8: £95.9 billion
  - 2008/9: £105.6 billion
- ↓  
120% increase  
Since 2000
- 2010/11: £110 billion
    - 70% are staff costs (vacancies, EWTD)
    - Medical equipment becoming more expensive
    - Two thirds spent on people over sixty

### The last decade: Building capacity




**93 new hospitals**

**Reduced the proportion of pre NHS hospitals**  
From >50 to 20%

**Primary care**  
**one building every week**  
**in 2008**



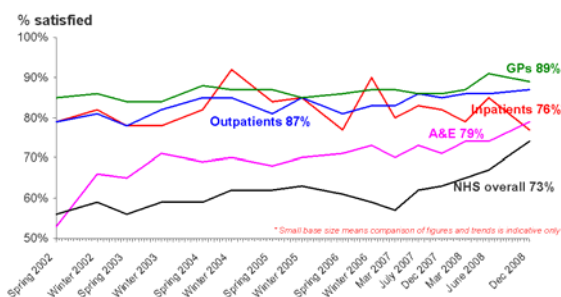

### The last decade: Making the system more responsive

- **Transactional reforms**
  - Money following the patients
  - Financial incentives for quality
- **Demand-side reforms**
  - Information for choice
- **Supply-side reforms**
  - Competition
  - More diverse providers
- **System management reforms**
  - More effective organisation management
  - Tougher regulation

### UK appears to be doing well against other systems

	Australia	Canada	Germany	New Zealand	UK	USA
Overall ranking	3.5	5	2	3.5	1	6
Quality care	4	6	2.5	2.5	1	5
Right care	5	6	3	4	2	1
Safe care	4	5	1	3	2	6
Co-ordinated	3	6	4	2	1	5
Patient centered	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Long, healthy lives	1	3	2	4.5	4.5	6
Per capita cost 2004	\$2,676	\$3,165	\$3,005	\$2,083	\$2,546	\$6,102

### Satisfaction with the NHS is increasing



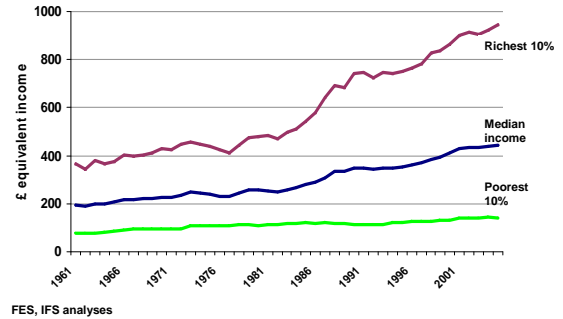
### An inconsistent triad in healthcare



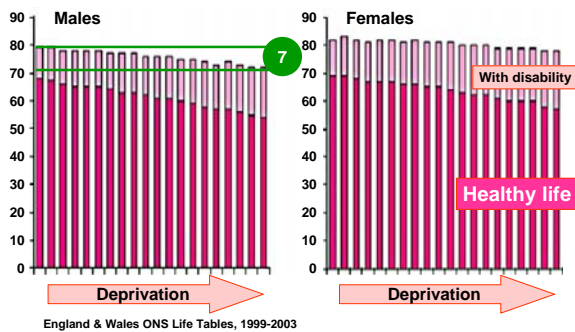
## Good healthcare

- **Public health**
  - Resolving social inequalities that underpin many diseases
- Providing high quality acute care when illness strikes
- The link is effective, responsive, personal and accessible primary care

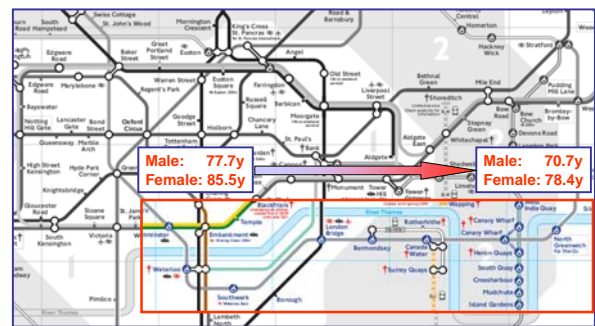
## The income gap between the richest and the poorest is growing not shrinking



## Poorer people live shorter lives with 5 more years of disability



## Travelling east from Westminster, each tube stop represents nearly one year of life expectancy lost



## Proximity to services is not the problem

People living in poorer communities are closer to medical facilities

To GP (miles)	GPs within 1 mile	To acute trust (miles)	To cancer centre (miles)
0.8	2	6	11
0.9	3	6	11
0.6	5	5	10
0.4	8	4	8

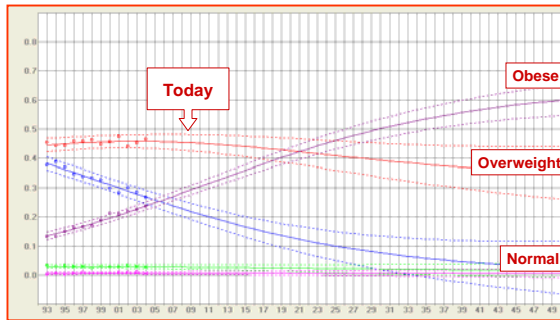
Similar to rest of Western Europe



## The problem is broader than healthcare

- Education
- Opportunity
- Lifestyle
  - Smoking
  - Obesity
  - Exercise

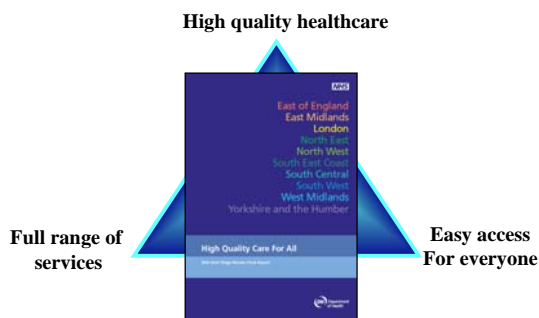
## An obesity epidemic



## Obesity is associated with:

- **Vascular disease**
  - Diabetes
  - Coronary disease
  - Peripheral vascular disease
  - Renal failure
  - Stroke
- **Cancer**
- **Liver disease**

## An inconsistent triad in healthcare



## Making quality the organising principle of the NHS



## Emerging “Quality Framework”

1. **Bring clarity to quality**
  - Changing the way quality standards are developed and identified
  - Sea of standards

## What is “Quality”



All equally important

## Bring Clarity to Quality

“Sea of Standards”

**Google:**  
 “Diabetes”?:  
 103 million  
 “Diabetes clinical standard”  
 374,000  
**National bodies**  
 50

- NICE to create Quality Standards – either through its own work or by selecting the best available standards
- NHS Evidence – a new, single portal to access clinical and non-clinical evidence and best practice

## High Performing Clinical Teams

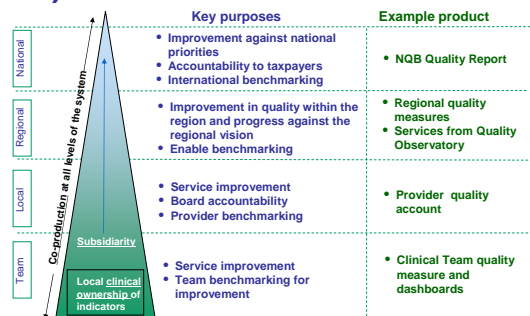
- Excellent clinical leadership
- Management goals expressed as clinical benefits
- Clearly understood common culture
- Clinical ownership of service performance
- Strong emphasis on measurement
- Eagerness to compare with other services
- Continuity of senior staff
- Quality improvement integral to work
- Patient and family involvement strong
- Jobs and individuals developed

## Emerging “Quality Framework”

### 2. Measure quality

- Quality Metrics, developed in phases and working with clinicians to eventually cover clinical teams across the entire range of NHS services
- Clinical dashboards for teams

## Measuring for Quality Improvement (MQI)



Sources of evidence-based indicators include Royal Colleges, specialist societies, NHS Information Centre, universities, commercial sector

## SHA updates for end January

SHAs engaging locally with providers, commissioners and at the level of clinical teams.

- Local measures identified for use in Quality Accounts
- Proposed regional measures
- Recommendations for national indicators and benchmarking measures
- Recommendations for national support to develop quality improvement skills and capacity
- Gaps in the metrics framework

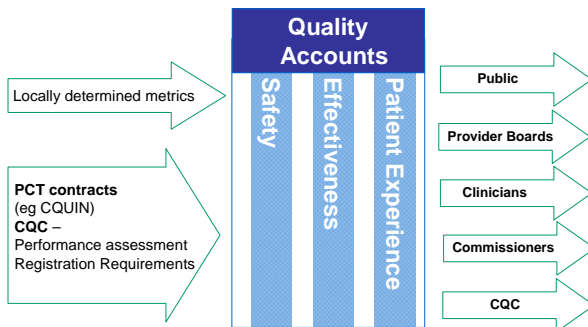
## Emerging “Quality Framework”

### 3. Publish quality performance

A climate of transparency

- All providers of NHS services will publish ‘Quality Accounts’ from April 2010
- Comparative information on [www.nhs.uk](http://www.nhs.uk)
- CQC Annual Report
- NQB Annual Report

## Quality Accounts



## Emerging “Quality Framework”

4. **Recognise and reward quality**
  - **New Commissioning for Quality and Innovation scheme (CQUIN)**
  - **Local contract within national framework based on**
    - **Safety**
    - **Clinical outcomes & PROMs**
    - **Patients experience**
  - **Small proportion of a provider’s contract value conditional on local quality improvement and innovation goals**

## CQUIN Payment Framework

- **Quality improvement and innovation will be integral to what PCTs pay for**
- **from 2009/10 to embed the quality in commissioning**
- **PCTs should agree local schemes with all providers on national contracts, though for non-acute services in 2009/10**
- **In the 1st year, schemes can incentivise measurement for quality improvement**
- **Thereafter, goals on improving quality and innovation**
- **Local CQUIN schemes should be published**

## Emerging “Quality Framework”

5. **Raise standards**
  - **Clinical leadership**
  - **Stronger clinical engagement in commissioning**
  - **Medical Director and Clinical Advisory Group at every SHA**
  - **Quality Observatory in every region**
  - **National Quality Board**

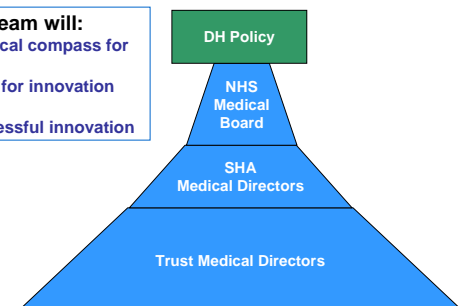
## Clinical leaders

- **Essential for success of change programme**
- **Clear vision**
- **System wide view**
  - **Inter professional collaboration and challenge**
- **Understand the principles of change**
- **Prepared to take risks**
  - **Freedom with the art and delivery of medicine**
  - **No freedom with the science**
  - **Seek evidence based innovation**
- **Support research**

## National Clinical Leadership

**A coherent team will:**

- **Provide a clinical compass for policy**
- **Provide cover for innovation and risk**
- **Spreads successful innovation**



## National Quality Board

- Prioritising development of Quality Standards
- Overseeing the development of metrics
- Publishing a report to the Secretary of State for Health accounting for Quality in the NHS, including international comparisons

### Membership:

- Chaired by CE of the NHS
- NHS-MD, CMO, CNO, DG Social Care
- NICE, CQC, Monitor
- 4 experts & 4 lay members

## Emerging “Quality Framework”

### 6. Safeguard quality

- Strong role for regulation by the Care Quality Commission
- Registration – from 2010 providing assurance that all providers meet essential levels of safety and quality
  - These requirements will not be ‘quality’ standards but will define the entry level
- Regulation extended to primary care for first time

## Emerging “Quality Framework”

### 7. Stay ahead

- Best Practice Tariffs programme from 2010/11
- SHAs to promote innovation
- Health Innovation & Education Clusters
- Academic Health Science Centres

## Effect of the economic downturn

Drivers	Economic effects	Dept of Health issues
<b>Credit Crunch</b> Reduced risk appetite Reduced Credit Higher cost of borrowing	<b>Falling Asset Prices</b> House prices fall Hit to pension funds and other investments	<b>Health and Wellbeing</b> Changes in consumption of food, tobacco & alcohol Unemployment Fuel poverty
<b>High Inflation</b> Price hikes in: • Energy • Food • Commodities	<b>Economic Contraction</b> Lower tax receipts Job losses Pressure on earnings	<b>NHS</b> Future funding Increased demand Higher costs Building (PFI & LIFT) Independent providers
	<b>Depressed Incomes</b>	<b>Social Care</b> Sector investment Provider stability Ability to pay Third sector
	<b>Rising Unemployment</b> Manufacturing Retail and service	

## Professional, social and moral duty to innovate

- Tendency to risk aversion in difficult times
- Open our minds to new ideas and ways of working
- Must innovate
  - Reduce waste
  - Promote efficiency, effectiveness, economy
  - Failure is another patient’s opportunity cost
- Innovation requires leadership and risk
  - mitigate, manage or transfer risk

## Engaging the next generation

- Love our jobs despite the system
- Many young professionals feel alienated
  - Give them some corporate ownership
  - Trainee doctors and nurses as change agents for quality and safety

## **EWTD**

- **Tension between training and service delivery**
  - O&G, paediatrics, surgery, acute medicine and anaesthetics
  - Smaller hospitals
- **This must be solved**
  - Law
  - Feminisation of workforce
  - Generational attitudes

**We are borrowing the future of the NHS from the next generation**

- **Workforce**
  - Education and Training
- **Research & innovation**

## **Clinicians are cynical**

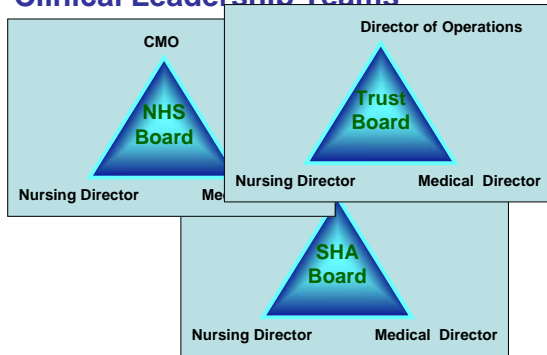
- **DH history**
  - New ideas
  - Not evidence based
  - Not piloted
- **Change will only happen if:**
  - Those affected believe it is worthwhile
  - Good leadership close to the change
- **MUST be a new working relationship with policy makers**

## **My vision:**

- **High Quality Care for all means a safe effective experience for patients**
- **Provided by clinical teams with time to focus on individual patients and to improve their service in an NHS that works to prevent illness, diagnose problems early and treat them safely and effectively.**

**Thank you**

## Clinical Leadership Teams



## Developing our approach to leading change

### Lessons and challenges:

**•Role of the system** – we need to get people thinking in terms of the whole system rather than within traditional organisational boundaries; this applies particularly to improving quality

**•Role of leadership** – we need to change the nature of leadership its focus on targets to prioritising quality, taking risks, and looking out not up

**•Pace of change** – we cannot expect consistent pace of change across the system, so we must encourage innovators and not hold back the "leading edge"

**•Change not churn** – we must avoid change for change's sake e.g. further structural reform ("messaging about masquerading as action")

### Resulting principles for change:

**•Co-production** – need to work jointly with NHS / stakeholders, examples of NSR; World-Class Commissioning; quality metrics; Op Framework

**•Subsidiarity** – devolving power / decision-making as close to patients as possible e.g. Practice-based Commissioning, clinical dashboards

**•Clinical leadership** – aligning managerial and clinical priorities and leadership e.g. SHA Medical Directors, Service Line Reporting

**•System alignment** – making sure all parts of the system work together and pull in the same direction, example of National Quality Board