

The Transformation of England's National Health Service

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Alliance of Community Health Plans

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Who we are

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Why might this be useful?

- This isn't "how to do it" "the best way to do it" or "we are perfect"
- Understanding some factors and levers that help or hinder transformational change of a large health system
- Unintended consequences and failures (and there are plenty) as well as successes
- Levers that implement strategy at system level and the necessary capacity shifts of the frontline reality
- Case study of "discontinuous innovation"



PROBABLY THE BEST PUB QUIZ...EVER!

A bonus question.....

There are only two employers in the world that are bigger than the NHS. One is the Chinese Red Army

What or who is the other one?

How is the NHS performing?

- 98% patients can get a routine appointment with their primary care physician/General Practitioner (GP) within 48 hours or with another primary care professional within 24 hours
- 97% people with cancer start treatment within 32 days of referral by their GP
- 92% patients get surgery in <18 weeks of GP referral
- 98% patients get through the emergency room in <4 hours (either treated/discharged or admitted to a bed)
- Cancer mortality rates fallen by 19.3% since 95-7
- Biggest reductions in recorded hospital infection rates in the world
- (Currently) highest recorded improvements in public satisfaction with NHS since surveys started

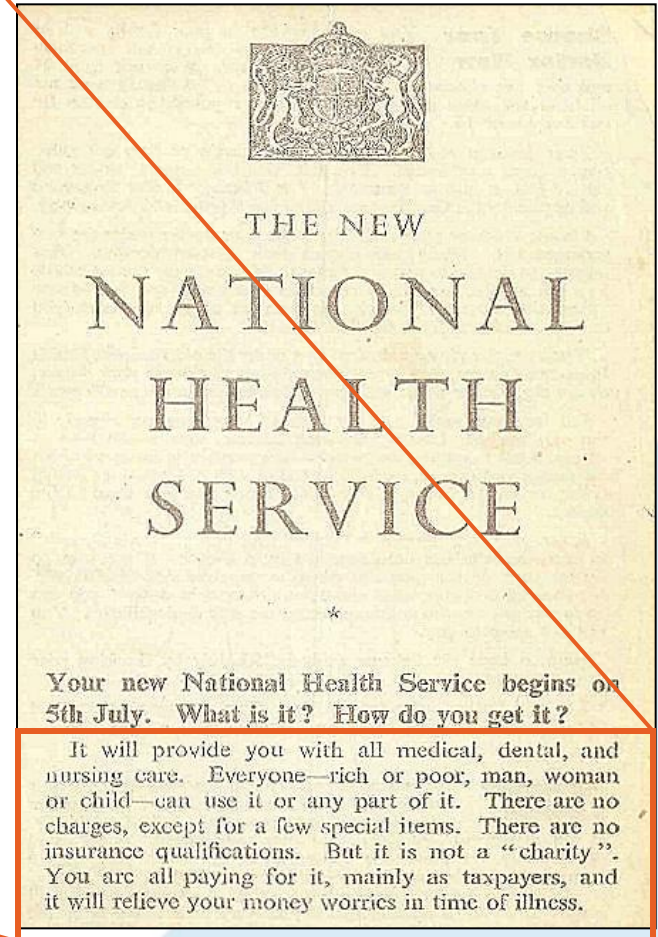
Everyone (54 million) gets this. No-one pays!

Why was the NHS established in 1948?

- **Cataclysmic effects of the war** made it possible to have a massive change of system, rather than incremental modification.
- **The combination of the state and the people** had won the war. Together they could do anything
- The population had rights **healthcare is a right**, not something bestowed erratically by charity
- Bipartisan agreement that the **existing services in a mess** and had to be sorted out
- **Financial difficulties** for the voluntary hospitals
- Creation of an **emergency medical service** as part of the war effort
- Increasing view among **younger members of the medical profession** that there was a better way of doing things

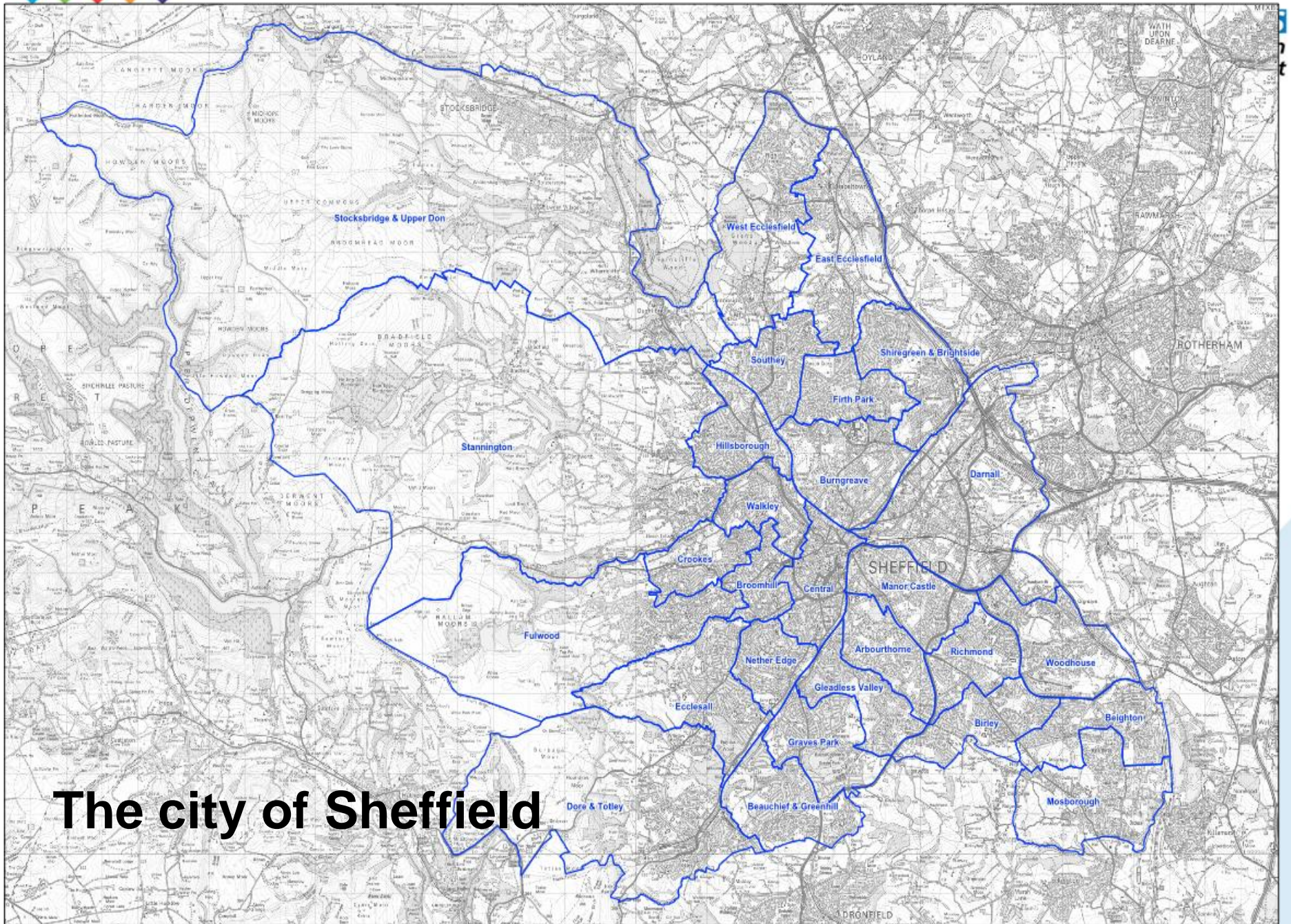
Launch of the NHS, July 1948

“It will provide you with all medical, dental and nursing care. Everyone - rich or poor, man, woman or child – can use it. There are no charges... There are no insurance qualifications. But it is not a “charity”. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.”



Universal coverage is not a panacea to the health of a nation

- It helps, but.....
- After 61 years, significant health inequalities exist
- “Inverse care law”



The city of Sheffield



What event happened in 1997
that was seminal to the NHS?

How was the NHS viewed by the
people at this point?

The architecture of the new NHS from 1997

- The main change in the architecture was to separate purchasers from providers *within* the NHS system
- Geographically based commissioners are the purchasers (Primary Care Trusts) Their duty is to:
 - buy the best health and health care for their geographical population whoever lives in that locality
 - think about their populations' health care as well as individuals health care
 - make the best bargains
- Hospitals and primary care are separate providers; their duty is to develop efficient and quality health care organisations that the commissioners want to buy
- Prices are set at a national level which are the transaction between demand and supply. Nationally NICE (National Institute for Clinical Excellence) decides the drugs and treatments that are cost effective for the NHS

All prices are set nationally

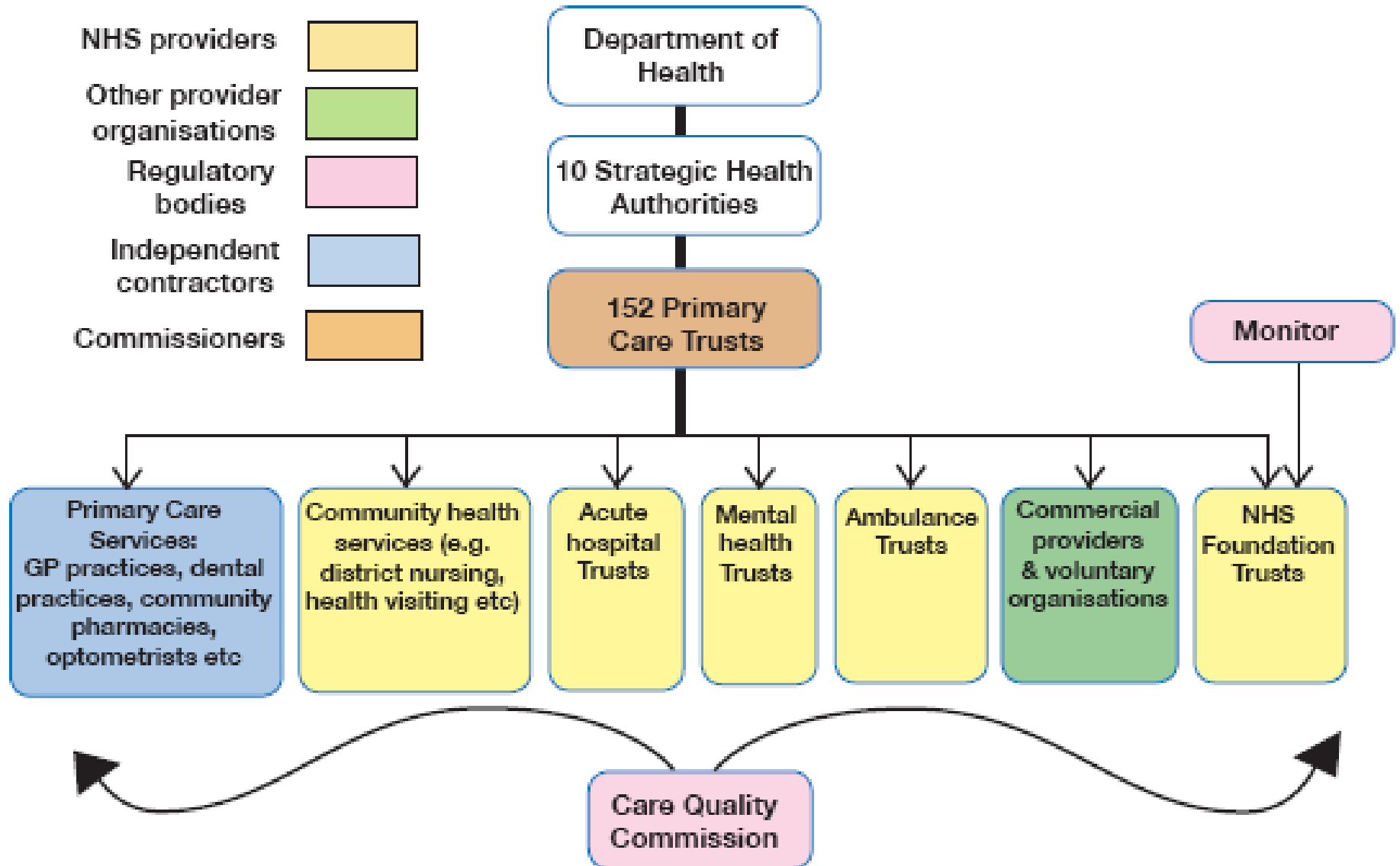
Examples

- COPD with length of stay one day or less £462
- Minor mouth procedure (adult) £1,221
- Rigid bronchoscopy £774
- CABG (first time) £7,851
- Minor hip procedure (trauma) £1,642
- Abdominal hernia procedure with complications £2,838
- Kidney major endoscopic procedure £568

NHS Plan (2000) was the biggest change since 1948

- 20,000 more nurses; 2,000 more GPs, 7,500 more hospital specialists; 6,500 more therapists; 100 more staff childcare facilities
- challenging national targets for patient waiting times, backed by clear accountability and performance management regimes
- Expansion in services for cancer, heart disease and mental health
- “earned autonomy” for local hospitals that perform well (“Foundation Trusts”)
- New contracts for hospital doctors and GPs
- 85% of NHS budget given to Primary Care Trusts to determine where it should be spent rather than giving money straight to hospitals
- In real terms, 50% extra in funding over five years

Structure of the NHS



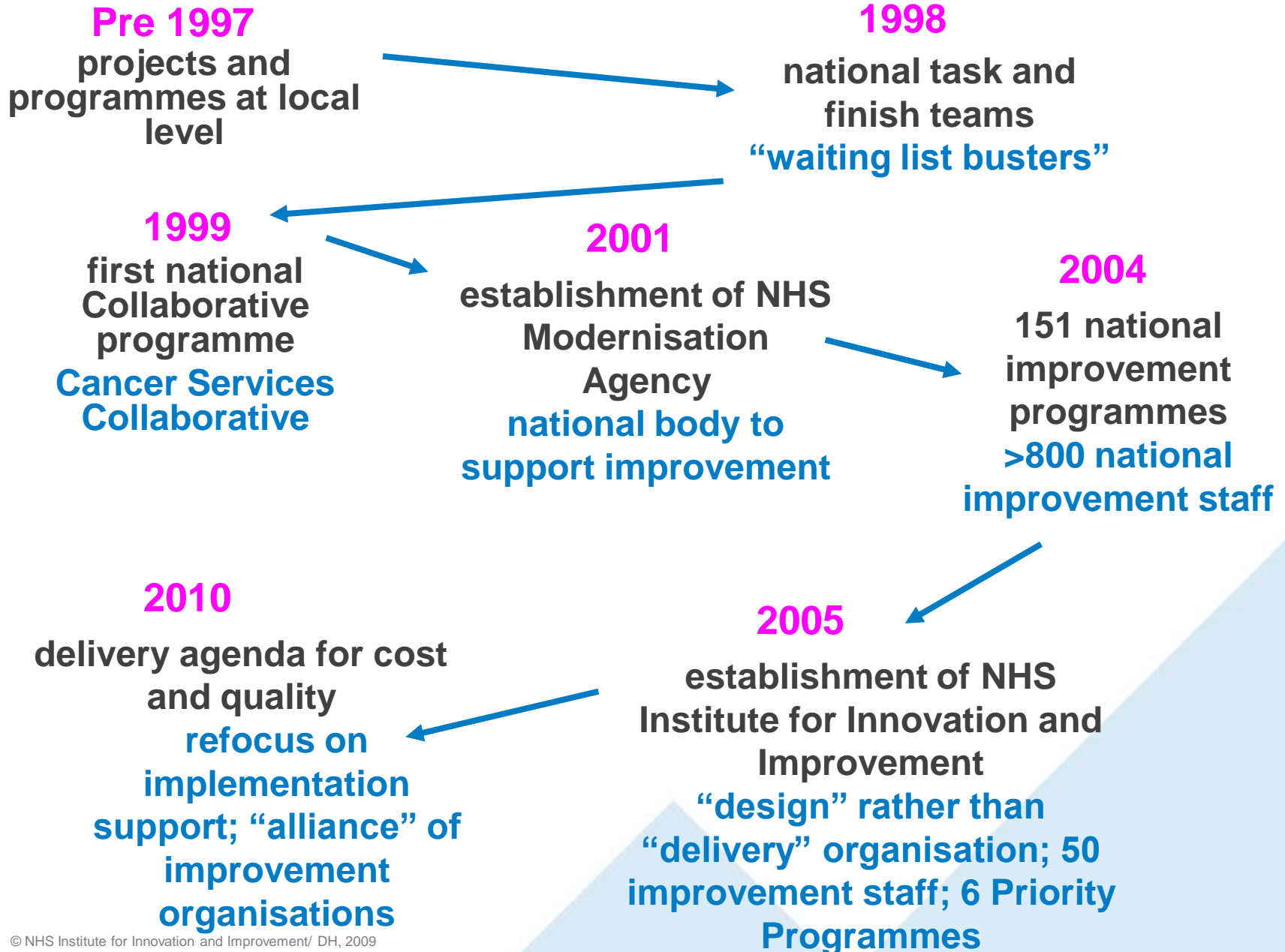
A considerable increase in resources flows through the reform levers

- Over 10 years, commissioners learn how to construct a market in care
- Providers learn how to provide to that commissioning and be responsible for their own organisations
- The national system learns to construct contracts and pricing relationships
- We learn to use national contracts to change staff behaviour.



Where is “improvement” in all this?

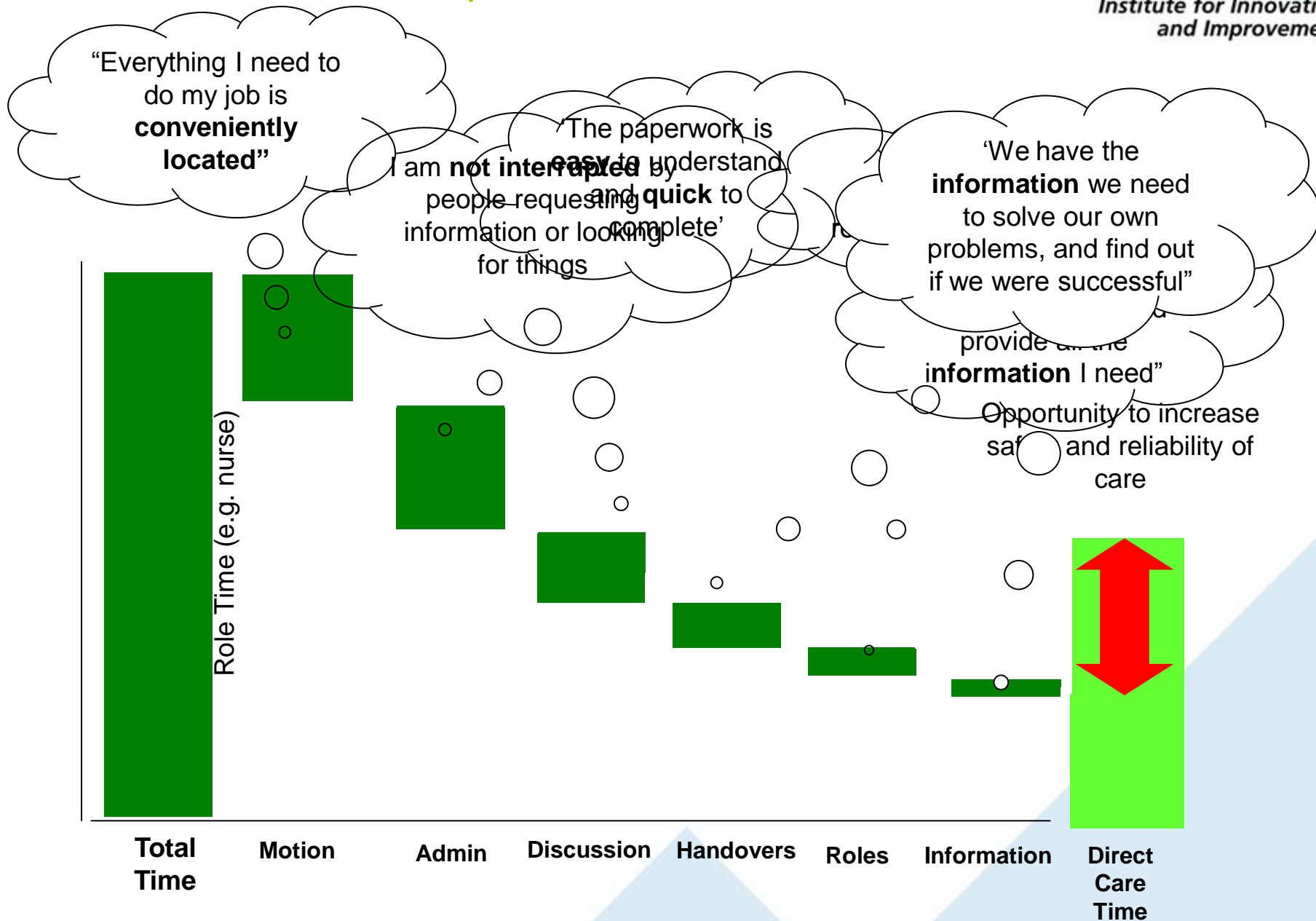
A short history of NHS improvement



The Productive Ward: *Releasing Time to Care*

How much energy can be unleashed by encouraging front line teams to question how they work and providing simple tools and skills to do this

The focus is on direct patient care



Modular Structure: Module Box Set



Sheffield Teaching Hospitals

- A five hospital system
- 100 wards/units
- Went “live” January 2008
- Last group started this month

Successes

- Direct care time increased by 32% (4.5 hours per nurse per shift)
- Time spent walking / looking for equipment reduced from 130 minutes (over 2 hours) to 25 minutes
- Time spent on nursing documentation reduced from 127 minutes to 82 minutes
- Tenfold reduction in short term sickness absence sustained
- Handover reduced by 30 minutes per nurse per shift – 3 hours per day
- Ward round reduced from 60 – 90 minutes to 20 – 40 minutes



Successes

- No more looking for keys – digital locks for drug cupboard keys
- Short term sickness reduced from 10% to 1% and sustained
- Reduction in falls
- Handover reduced by 30 minutes per nurse per shift – 3 hours per day
- Ward round reduced from 60 – 90 minutes to 20 – 40 minutes

- *Releasing Time to Care* has been a significant catalyst for change
- It has resulted in measurable, positive impacts.
 - 13 percentage points increase in median Direct Care Time
 - 7 percentage points increase in median Patient Satisfaction Scores
 - 23 percentage points increase in median Patient Observations

Source: NHS London 2009

Productive Wards hailed for transforming care

Scheme helps nurses spend an extra 500,000 hours with patients in one year, research shows



This equates to having an extra 255 full-time nurses....while an equivalent level of service improvement without the programme would cost an estimated £7.5 million a year



Challenges for the future of the NHS

The “QIPP” challenge for the English NHS

- Realise a savings gap of \$25 billion between 2011 and 2114, whilst improving quality
- Achieve these outcomes at a scale and pace never seen before in any industry
- A completely unsustainable environment!

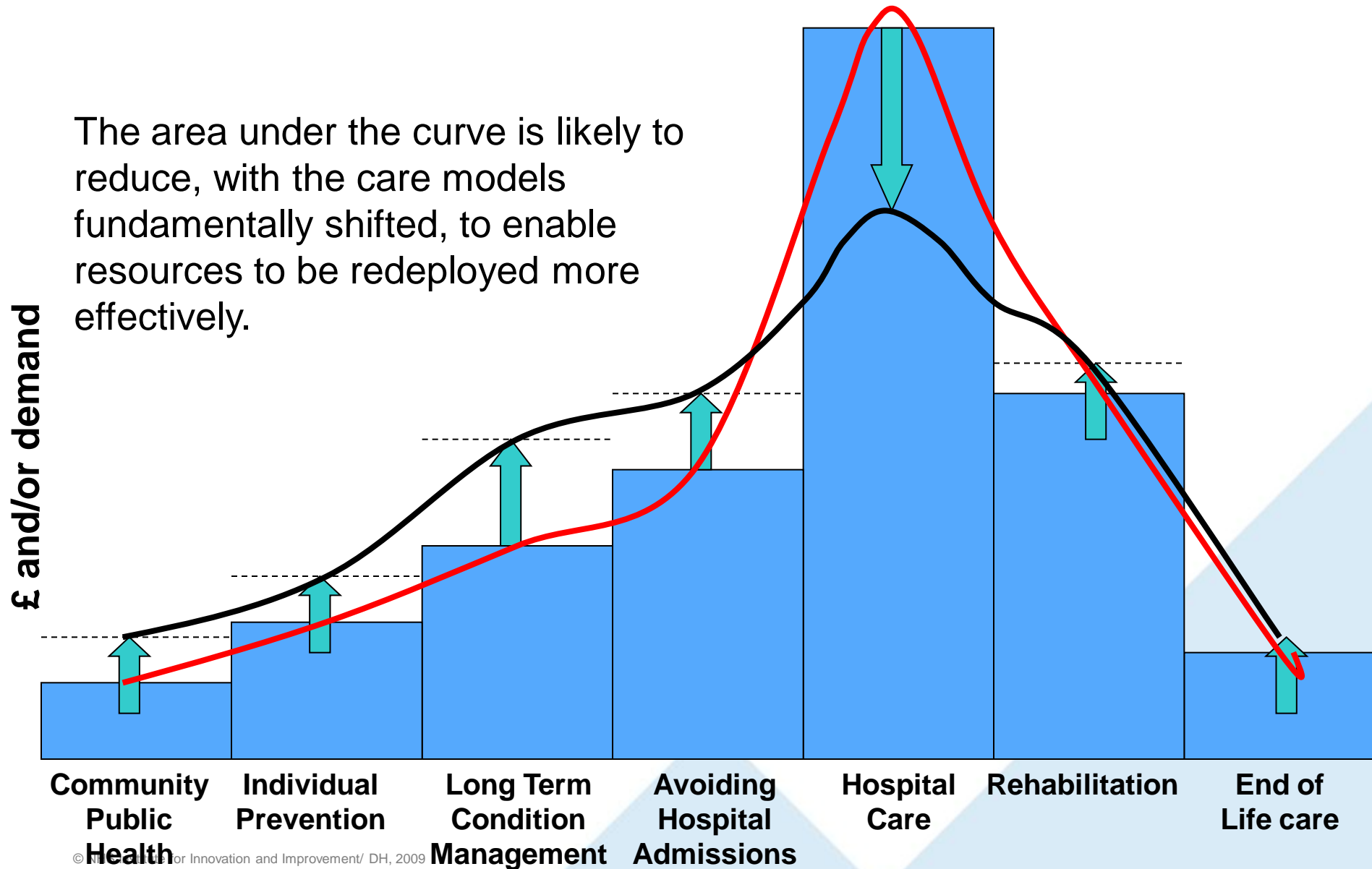
Quality, innovation, productivity and prevention

What should our response be?

- Since in the past financial resource has risen with demand, if that does not happen now, how do we realise (bring into reality) other sources of value?
- Other industries use new technology to wipe out old technology. Health services are bad at doing that as the old technology makes sense in the hands of very powerful professionals
- How do we transform by finding new value relationships and stopping old value relationships?

A transformational response

The area under the curve is likely to reduce, with the care models fundamentally shifted, to enable resources to be redeployed more effectively.



A different future:

1. commissioning a new pathway

- Currently we typically commission episodes rather than pathways of care.
- A year in diabetic care pathway would provide better joined up care
- But the care commissioned also needs to contain the buying of much more support for self management and primary care.
- And buying less secondary care

A different future

2. providing a new pathway

- The pathway needs to have very proactive primary care with the family practitioner finding the diabetic much earlier
- The practitioner then directs the patient to nurse supported patient groups
- The emergency care beds need to be decommissioned as a part of this process

A different future

3. building will and capability

- Creating a common narrative based on core purpose and future direction; not just “improve quality and save cost”
 - “reconnect with the fundamental mission of the NHS in a modern way for a modern world”
- A mobilising call to action at every level of the system
- Accelerating skill building for NHS commissioners
- Redesigning new, more flexible job roles
- Co-create with service users and citizens

A different future

4. realising new value

- In the current model, healthcare only provides value when a patient comes into contact with staff or kit
- The patient is a sponge of value not a co producer. Other industries have been revolutionised by the customer co producing value alongside the provider
- Patients with long term conditions have the possibility of adding considerable value to their health care if the provider will allow them to do it.
- A new business model, new mindsets and new providers?