Doctors must lead efforts to reduce wasteful practice

For the NHS to survive it must take its cue from well performing US healthcare organisations that are led by doctors with a commitment to high quality care, says the King's Fund chief, **Chris Ham**

The King's Fund's latest survey of NHS performance in England paints a picture of a service struggling to cope with increasing demands at a time of unprecedented resource constraint.[1 2] The pressures on the NHS are greatest at the front doors of hospitals, with waiting times in emergency departments the longest they have been in a decade. The prime minister's pledge to maintain the commitment to treat 95% of patients within four hours in emergency departments was broken in the first quarter of 2013, a clear and worrying signal of what lies ahead.

With public spending under renewed scrutiny as the chancellor concludes the spending review for 2015-6, there is little prospect that more money can be found to deal with these pressures. Indeed, with press reports suggesting that some of the supposedly ringfenced NHS budget may be taken to support hard pressed social care services, health service leaders will have to redouble their efforts to squeeze more out of existing budgets.[3] The challenge they face is how to do so when about two thirds of these budgets go on staff, and when recruiting and retaining sufficient nurses and other frontline staff are critical to the delivery of high quality and safe patient care.

This challenge will not be met by salami slicing budgets and cutting management costs and back-office functions. Instead, the focus should be on the myriad decisions taken every day by doctors, nurses, and other clinicians on how to treat patients. These decisions—such as on which drugs to prescribe, what tests to order, and whether to admit patients to hospital—determine how most of the resources of the NHS are used. Reducing wide and unwarranted variations in decisions between general practices and hospitals could help cut waste and release resources to deal with rising demands on the service.[4]

The autonomy of doctors helps explain why variations in medical practice persist

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The autonomy of doctors helps explain why variations in medical practice persist and why politicians and managers can't reduce them without the full and enthusiastic involvement of medical staff. Putting general practitioners in charge of commissioning care for patients is an attempt to do this, but it is too early to assess how effective clinical commissioning groups will be. Equally important is to engage doctors providing care in hospitals and other services to see prudent stewardship of scarce public resources as a key part of their role. Recently published research shows that the NHS still has a long way to go in supporting doctors to take responsibility for budgets and services, at a time when this has never been more vital.[5]

The importance of doctors leading the quest for improvements in the NHS was brought home to me on a recent visit to several high performing healthcare organisations in the United States. Without exception, these organisations are led by experienced doctors who combine credibility with their peers with a deep understanding of what needs to be done to deliver high quality care within available resources. Medical leaders in Kaiser Permanente in California, for example, explained that in their experience improvements are best achieved by doctors being committed to high quality care rather than having to comply with externally imposed targets and standards. It is this culture of commitment and not compliance that is important to Kaiser Permanente's high standards of care, as seen in independent national rankings of health plans.[6]

Intermountain Healthcare in Utah goes further, to argue that in some cases high quality care costs less. This is because of the waste involved when patients do not receive the right treatment first time and have to remain in hospital longer than necessary or in some cases to be readmitted for errors to be corrected. A core strategy in this organisation, widely admired and studied for the excellence of its care,[7] is to standardise how care is delivered by medical leaders working with their colleagues to agree on best practice guidelines, thereby reducing variations in care. Intermountain Healthcare enables its staff to make improvements by a long term investment in training in quality improvement techniques.

The same applies in the Virginia Mason Medical Centre in Seattle, which for many years has led the adoption of Toyota's lean production system in healthcare. Like the other organisations visited, Virginia Mason understands the key role of doctors in leading change and their intrinsic motivation to provide the best possible care. It supports them and their colleagues to do so by honing their skills in reviewing how services can be improved by reducing delays and eliminating activities that are not worth doing.

The good news is that all three of these organisations show what can be achieved when medical leaders focus on tackling variations in clinical practice and reducing waste. The more sobering news is that each has been on a long term journey of quality improvement that has taken years to deliver results and has no defined end. All the more important, therefore, that the NHS takes heed of these lessons as it seeks to deliver more value for patients and taxpayers within a tightly constrained budget. Without effective medical leadership and support to enable frontline staff to improve care, the prospect is of ever declining performance and fundamental questioning of whether the NHS model can be sustained.

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- News: MPs reject plan to spend £1.2bn of NHS surplus on social care to ease pressure on emergency departments (*BMJ* 2013;346:f3709)
- King's Fund blogs are at blogs.bmj.com/bmj/category/kings-fund

FROM THE FRONTLINE **Des Spence**

Consultants' contracts: could do better

Doctors complain about the inconvenience when their children's schools close for teacher training. The logic runs like this: why can't training be done during their long holiday, and anyway how much does teaching change year to year?

The frustration may be down to teachers' contracts. And now doctors also have new contracts. General practitioners gave up responsibility for out of hours care and got a pay rise. Today GPs are criticised by the public (and by hospital colleagues) for working part time, not doing weekends, and being overpaid.

The quality component of the GP contract represents activity for activity's sake, with doctors endlessly, meaninglessly filling out forms. The appointment system is clogged with futile reviews, meaning normal patients can wait weeks to be seen.

There's little point in being defensive because these criticisms are legitimate, especially around access—the single greatest quality issue for patients. Things need to change.

Consultants' terms seem excessively generous, inefficient, unnecessary, and frankly unjustifiable

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So what of the new consultant contract? It has increased pay by as much as 28%,[1] with a 50% increase in the number of consultants over a decade.[2] The goal is a consultant led service and better access. But little has changed; weekends still see more deaths,[3] and junior medical staff still deliver out of hours care. Outpatient waiting times are measured in months, clinics are often cancelled, and private practice still thrives on queue jumping. It remains difficult to contact consultant colleagues and nearly impossible for patients to do so. NHS hospitals are dysfunctional, with poor productivity, poor communication, and poor accountability. Little has improved but at great cost.

What I am going to say next will cause irritation, defensiveness, and anger. In a standard consultant contract of a 40 hour week, a quarter of the time is reserved for non-clinical activity known as supporting professional activities (SPAs) such as audit, appraisal, and education.[4] In addition, consultants have two weeks' paid study leave. This time out is deemed essential to deliver quality of care.[4] But these terms seem excessively generous, inefficient, unnecessary, and frankly unjustifiable for the highest paid and the most essential decision makers in an organisation.

Converting SPA time to clinical time would greatly improve access, productivity, continuity, and care throughout the NHS. This obvious fact is increasingly recognised by hospitals, and new consultants are employed on much less generous terms.[5] This inequality between consultants is causing friction. All NHS doctors' contracts need to be rewritten. Just ask a teacher.

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THE BIGGER PICTURE **Mary E Black**

Life assurance

Fragmentation in the English health system means that it is often now not clear who is in charge. We have many new partners, and the old codes of organisational behaviour seem dated but the new ones untested. On 1 April 2013 I emerged from the familiar enfolding recesses of the NHS into the welcoming arms of local government. For public health there are senses of both liberation and loss.

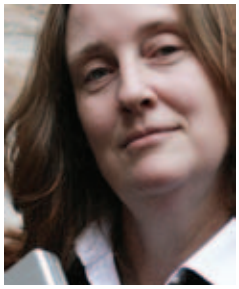
As a director of public health I am exhorted to inspire, lead, and generally be rather amazing and make sure lots of important things for the health of the public get done. But I can't command that they be done. Rather I am expected to collaborate across sectors, work towards "system alignment," and provide much assurance, which means convening, nagging, and cajoling people to do things and telling other people that they don't need to fret.

The "old" NHS operated in command and control mode. Edicts were dispatched from on high, and managers would jump to get things done. We know what this approach can lead to: a drive to hit meaningless targets while missing the important ones (patients).

The NHS is like the Himalayas. Climb one forbidding peak, and at the top you gaze out on a neverending mountainous vista. Local authorities are more like the Galapagos, smallish islands with distinctly different flora and fauna. Try to command or control the next island and you will get a shower of arrows in your face.

Seen from within the NHS, command and control behaviour is familiar, inevitable, and somewhat irritating. Seen from the world of local authorities, the same behaviour by the NHS appears positively niche and odd. Without prior consent or a degree of coercion, command and control does not work.

Our shiny new management toy is "assurance." After a vigorous session of assurance I definitely enter a public health pleasure zone (this happened recently for me when London's various new health bodies finally worked out who was responsible for what in relation to measles). When all the stakeholder plates are spinning in unison a crescendo of excitement builds as I realise that—yes! Yes! YES!—another confirmatory letter or spreadsheet can be filed.



The NHS is like the Himalayas. Climb one forbidding peak, and at the top you gaze out on a neverending mountainous vista

But what if I cannot be fully assured? Managing by assurance provides a sensible reality check but is nebulous and messy. Command and control gave the illusion that things were under control.

The next shiny new management toy, at least in theory, should be accountability. Let's see.

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