Shaping the health debate

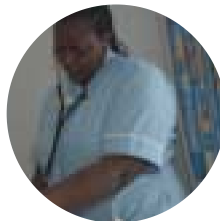
THE **NHS** CONFEDERATION

What is productivity?

The NHS has received unprecedented levels of money since 2002. Since then, there has been growing criticism that the NHS is becoming less productive and is not providing value for money. This briefing examines what productivity actually means and how it relates to how well the NHS is treating patients.

What are the criticisms of the NHS and its productivity?

Assessing productivity in the NHS is widely recognised as being very difficult. The current measure of productivity used by the Office of National Statistics divides outputs (activities the NHS does such as operations or ambulances trips) by inputs (such as people and capital). Using this measure, productivity in the NHS has fallen over the past decade by between 0.6 per cent and 1.3 per cent a year.[1]



[1] *National Statistics, Public Service Productivity:* February 2006

The productivity measure has fallen – why?

Given the increased investment in the NHS we would expect productivity to have improved, yet the levels have fallen. There are two main reasons for this:

First, there is a finite number of patients. This means that extra investment will not necessarily lead to more ambulance trips or more operations as there are only a certain number of people needing care. What we should be looking for instead is an increase in the quality of treatment for our patients. Better drugs, faster treatment, improved technology and increased levels of nursing care are all good for patients and improve the quality of their care, yet all of them decrease productivity under the current measure. Increasing the number of nurses on a ward may not sound very productive but there is good evidence from the USA[2] that this has a direct impact on lengths of stay in hospital and reduces patient mortality. This currently, however, would not be measured as an increase in productivity as quality of care is not factored into the measure.

[2] *J. Needleman, P. I. Buerhaus, M. Stewart et al., Nurse Staffing in Hospitals: Is There a Business Case for Quality?*, Health Affairs, January/February 2006 25(1):204–11

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Second, the baseline data for measuring changes in productivity starts from a period when the NHS was running at an unsustainable level of work, given its funding. This meant that staff were working very hard but the NHS was weak on systems to improve quality of patient care. Staff pay and the recruitment of key staff had fallen behind European levels. Waiting lists were high, A&E departments were overstretched and spending on maintenance, capital improvements and other discretionary services were cut. This inflated the apparent productivity of the service and left a raft of areas that needed to be improved before staff left and patient care suffered. As new money arrived most of it inevitably had to be used to deal with these long-term problems.

Less can be better

If we accepted the views of some of the critics of NHS productivity then the NHS would be at its most successful when the maximum number of people are admitted to hospital. A major objective, however, of the NHS is to prevent people needing to be admitted to hospital and improving care outside of hospital.

Statins are a class of drug used for lowering cholesterol. They are very effective in reducing heart attacks. It is estimated that they save over 9,000 lives per year. Using statins represents a loss in productivity because they reduce admissions to hospital for heart attacks and reduce the need for cardiac surgery. However, clearly they deliver a much better outcome for patients.

More can be worse

More emergency hospital admissions for patients with long-term conditions can mean the NHS is failing to help them control their conditions

If long-term conditions such as diabetes or asthma are well managed then there should be fewer unexpected hospital admissions. Through better information and more support in monitoring their condition, people with long-term conditions are increasingly managing their own conditions and needing less emergency treatment. The number of admissions to hospital represents an increase in productivity, and therefore fewer admissions gives a lower productivity score.

More stays in hospital can mean the NHS isn't working for patients if they could have been at home

Increasingly, more care is being provided in the community and in people's homes. Stays in hospital before and after operations are often excessively long. We should be ensuring that patients are in hospital for the right length of time receiving the right treatment at the right time. Patients often prefer to be cared for at home and being at home means they have a reduced risk of hospital-acquired infections. More and more work is being done to ensure that patients get the kind of care they want – which includes remaining at home when they want to. Again, hospital admissions are counted as extra productivity when clearly reducing these stays can be beneficial to patients.

More stays in hospital can mean the NHS is less productive if patients are just waiting for diagnostics or specialist opinion

Time spent in hospital is often managed around systems rather than patients and their time. Hospitals should be ensuring that patients do not need to be in hospital as long, which would reduce productivity in the current measure.

More stays in hospital can mean the NHS isn't listening to patients needs

Of the 530,000 people who die in England every year, just over half die in hospital yet few of these would have chosen hospital as their preferred place of death. Many are admitted to hospital when they don't want to be. Hospital admissions are included as a measure of productivity yet we need to be ensuring that people are cared for in the environment they choose.

What would be a better measure?

The Government has acknowledged that the current measure misses a lot of what the NHS does. *The Atkinson Review*[3] 2005 looked at output and productivity across Government departments. The review recommended that productivity estimates for health should take account of quality of care which would include things like survival rates and waiting times. These measures, it suggested, needed to be directly attributable to the NHS rather than general health outcomes such as more people giving up smoking. Following the recommendations of the Atkinson Review, the

[3] *Atkinson Review:* Measurement of Government Output and Productivity for the National Accounts: 2005

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Office of National Statistics (ONS) introduced a new measure in 2006 alongside its existing output/input measure that assessed a number of quality measures such as waiting times and patient satisfaction. Taking account of these changes the ONS estimates that NHS productivity has risen by up to 1.6 per cent per year.

Yet measures such as patient satisfaction probably still don't truly measure what patients want and value from their care. Satisfaction levels with clinicians in particular are usually high. We tend to trust clinicians and rate the care as good. Patient satisfaction is important but a better measure may be to assess what patients report the outcome to be rather than satisfaction. This would give us a better idea about how well patients feel the treatment has worked.

The Department of Health is developing new metrics for productivity which will start to address the need for other indicators of productivity beyond the traditional outputs used. It is crucial that they build in measurement of patient outcomes and how patients view the quality of their care.

What do patients value?

Productivity should start with the quality of patient care, what patients value and what represents improvement in the health of the population. This means that measures that do not incorporate quality of outcomes, the quality of the patients' experiences, the idea of prevention and well-being are missing a very important part of the story.

Our current measures focus on outputs rather than outcomes. For example, hip replacements are currently measured by the number so that the more hip replacements we do the more productive the NHS is rated. Yet for the patient, measures such as how mobile the patient becomes after the operation, how much the pain has reduced, whether they have had any additional infections or how much longer the replacement has improved their life as a result of the procedure are much better indicators of success.

A useful tool for assessing how well the NHS is performing might be to look at what patients think of the health service and what they value in their care. The Healthcare Commission patient surveys[4] consistently find that patient safety, cleanliness,

[4] *Healthcare Commission Inpatient Survey 2005*

ease of access, how caring the staff have been and being treated with dignity are some of the most important things to patients.

Our current levers for making things happen in the NHS don't encourage improvements in the quality of care. Current targets are outcome-based and Payment by Results measures activity not results. Payment by Results can only be successful in driving up quality in the NHS if it works together with patient choice. If people base their decisions on which hospital, for example, to choose then this should drive up quality levels between competing hospitals. Yet it also depends on how patients are making the choice. To make a truly informed decision patients need good information on published outcomes. These outcomes should be based on indicators of quality of care that are important to the public and not what the NHS thinks should be the indicators.

A significant advantage of focusing on experience and outcomes is that they are considerably more robust and less likely to be manipulated than when using targets. For example, it is far from clear that an increase in the proportion of patients seen within four hours in A&E will increase the quality of the experience for an individual patient because improving one part of the system does not cause the whole system to improve. Being moved from A&E after 3 hours 55 minutes may not improve patient experience if it is followed by a long wait for action in another, albeit slightly more comfortable, setting. Asking patients about the whole experience will provide a much better measure.

What are the pressures on NHS trusts to become more productive?

Increasing NHS productivity has now become a key policy objective for the Government. The Department of Health has taken a much harder line on the clearance of deficits this year. The rate of increase in NHS spending is expected to slow after 2008. The Gershon review which assessed Government department spending has also set the NHS a demanding target to make savings as part of the overall attempt to increase public service productivity.

The introduction of Payment by Results and tariff changes have also exposed the relative costs of each individual trust to greater scrutiny and these costs now affect income in a very direct way. This creates pressure for each trust to improve its productivity.

'The Lean approach is about redesigning processes to take out steps that don't add value.'

Among other things, the Government has also set the NHS a new target of achieving a maximum waiting time of no more than 18 weeks between referral and hospital treatment by 2008 which will require major improvements in productivity across a range of areas. New pay deals and contracts for NHS staff expect a more productive and efficient workforce as a result of the extra investment too.

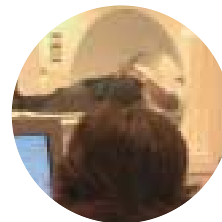
How might the NHS become more productive?

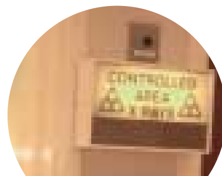
We need to drive up the quality of care in the NHS without the cost increasing. The NHS does need to introduce ways of improving productivity. The Lean management approach was developed by Toyota to improve quality while reducing costs. The Lean approach is about redesigning processes to take out steps that don't add value. This method can be applied to the NHS to improve care for patients.

Bolton Hospitals NHS Trust has redesigned its hip fracture treatment process and as a result has reduced the time from A&E to operation by 38 per cent and reduced the number of deaths from complications by 50 per cent. By applying Lean methods, waste is reduced and the savings are reinvested to improve value for patients[5].

Conclusion

The current measure of productivity is not accurate, and does not enable benchmarking or the identification of areas where the NHS needs to improve. After 2008 the NHS is unlikely to receive the increases in funding that it has over the last few years. The NHS will need to manage its valuable resources wisely. Productivity measures need to encourage the NHS to manage its resources in the best interest of the patient.





[5] *Lean Healthcare in the NHS*, NHS Confederation, 2006

This is the second of five briefings on the most controversial issues facing the NHS. It forms part of the NHS Confederation's work on public confidence in the NHS which aims to create more informed public debate. The series of work highlights examples of where the NHS is working well, to address some of the most controversial issues facing the health service and to support the work of NHS Confederation members. The NHS is a diverse and changing organisation and we aim to highlight the issues surrounding managing NHS trusts and the difficult decisions needed to improve patient care.

For more information about this briefing or the series please contact Anna Scott-Marshall, Stakeholder Relations Manager on 020 7074 3303 or anna.scott-marshall@nhsconfed.org

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The NHS Confederation brings together the full range of organisations that make up the modern NHS in the UK.

We act as an independent and powerful force in the drive for better health and healthcare. We do this by:

- influencing health policy and the wider public debate
- supporting health leaders with information-sharing, networking and tailor-made services
- promoting excellence in employment to improve the working lives of healthcare staff.

Our work is determined by our members. Our aim is to reflect the different perspectives as well as the common views of the many organisations delivering the new NHS.

Our core membership covers all types of statutory NHS organisation. Our members are the organisations themselves and these organisations are represented by individuals from board level – chief executives, chairs, non-executives and directors. We also have an affiliate membership scheme for commercial and not-for-profit organisations providing frontline services on behalf of the NHS.

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