STRASYS

Closing the Performance Gap

A review of NHS Cost Improvement Programmes

We need a new approach to closing the NHS performance gap.

Traditional NHS cost improvement programmes may offer short term benefits but do not work in the longer term, leading to increased costs in the long run. Strasys examines current practice and suggests a better way to achieve long term sustainability, based on empirical research and experience.

It is no secret that the NHS is facing significant financial pressures. The issues and economic arguments are well documented; as is the underlying challenge of 'balancing the books' by 2023, requiring system wide savings of around £27bn.[1] Whatever the future financial settlement, the ageing population, availability of new treatments, higher consumer expectations and increasing clinical complexity means the NHS will have to deliver more; improving care outcomes within ever limited resources.

For many years, a key response to financial short-falls has been to pursue provider cost improvement programmes (CIPs) with the objective of delivering 2% - 6% savings per annum.[2] These plans typically depend on a range of interventions focused on managing cost pressures and overruns, investment decisions and non-recurring savings. CIPs are sometimes referred to as: 'financial improvement programmes', 'productivity initiatives' and 'efficiency plans', but whatever they are called, the fundamentals remain the same.

Delivery of substantial provider CIPs are also assumed in Sustainability and Transformation Partnerships (STPs). Our analysis shows that up to 70% of the savings required by STPs are based on the delivery of 'business as usual' cost improvement activities. Savings from system wide strategic initiatives (service reconfiguration, de-commissioning, disruptive innovation, new service/operating models) make up a much smaller element of the proposed cost reduction plans (Figure 1)[3].

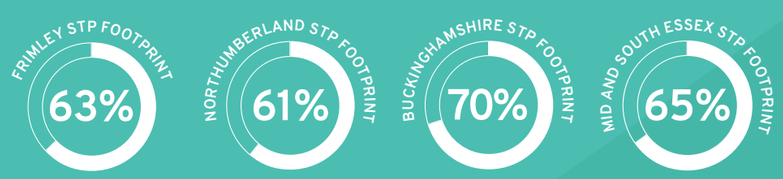


FIGURE 1:
Proportion of STP savings based on CIPs for sample STPs

Source: LSBU (2017) – 'Sustainability and Transformation Plans: How serious are the proposals? A Critical Review'

For some years, CIPs have been the main mechanism utilised by NHS providers to deliver improved organisational finances in the short term. Historically, providers have struggled to deliver the target savings with most realising less than 50% of the CIP target in real cash savings. In addition, even where higher levels are achieved, they are often contingent on non-recurring measures.[3]

Through our research, we discovered that traditional cost improvement programmes are ineffective at improving long term costs. In practice, they often lead to reduced productivity and increase the cumulative deficit and cash burden whilst doing nothing for long-term sustainability. Although CIPs may lead to short term gains and meet regulatory 'demands', we find they result in a burden that is shifted over time or between organisations, ultimately increasing system costs in the long run.

Arguably, CIPs are doing more harm than good. They are not delivering a sustainable financial position and there has been a material impact on quality of care, access and outcomes for patients. At a national level there has been a downward shift in performance against key national targets; for example, over 2015/16 and 2016/17 there has been an[3]:

11% Increase in the number of patients waiting more than 4 hours in A&E.

9% Increase in the number of patients waiting longer than 18 weeks for planned treatments.

8% Increase in the number of patients waiting more than 62 days for their cancer treatment to start.

24% Increase in the number of lost bed days due to delayed discharges.

Strasys analysis of the cumulative quality and operational performance of individual Trusts demonstrates a direct link between deteriorating financial performance and a downward trend in quality and performance against key targets (Figure 2).

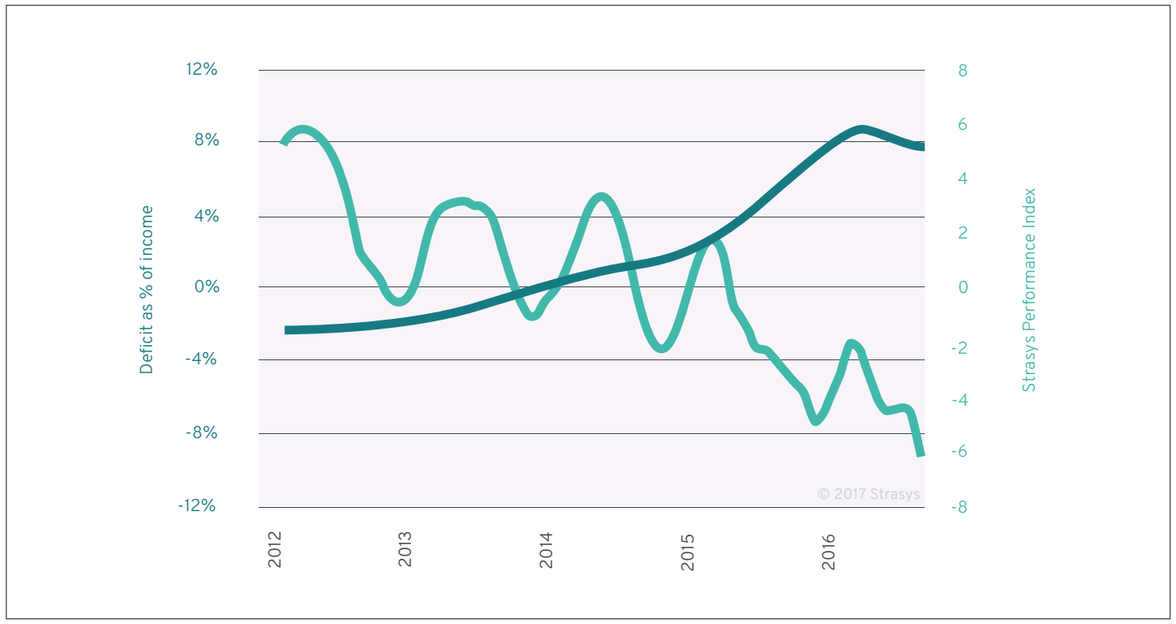


FIGURE 2:
Declining quality performance and increasing deficit of a sample of NHS acute providers with backdrop of CIP

Source: Strasys Analysis, Trust board reports, NHS Digital, NHS Improvement. Strasys performance index based on sample of provider trust performance

Given the impact CIPs to date have had on financial, quality and operational performance we must now consider whether it is realistic to continue to place a significant reliance on the traditional CIP approach to deliver NHS sustainability.

So why are CIPs failing to deliver and what can be gained by taking a different path to sustainability?

The traditional approach to CIPs

CIPs identify efficiency savings from current operations - in lay terms, the opportunities the organisation has to 'do more with less'. Regulatory parameters, expectations and service, efficiency and financial requirements are set out in planning guidance issued in advance of each planning round.[4]

FIGURE 3:
The current CIP process

Source: Delivering sustainable cost improvement programmes, Monitor 2012

At an organisational level the CIP process is often driven by the Director of Finance but is in principle, owned by the whole organisation with the Board overseeing its implementation and divisions and clinical units held accountable for delivering their targets.[5]

Fundamentally, the CIP is based on traditional budgeting principles. A top down process identifies the organisation's financial gap based on a transactional view of activity, income, cost and demand. Benchmarking information (such as Carter, Right-Care, Reference Costing), regulatory directives, previous financial performance, service line financial information and experience of senior managers inform the identification of cost saving opportunities. Organisations may focus on business areas that did not deliver in previous years but more commonly the requirement for savings is proportioned across all services and functions; corporate departments are expected to take a fair share of the burden, and increasingly a greater share.

At a clinical specialty or divisional level, planning priority is often given to addressing existing operational, staff and quality cost pressures. Proposals may include service growth to meet increasing demands and generate additional income. Commissioning plans may inform the CIP process at this stage, however these are often not seen as credible by front line clinicians and managers.

Also, in some systems where there is limited joined up working, or extreme performance challenges, there can be conflict between the provider and commissioner demand management plans and strategies.

Engagement in the CIP process is impacted by day to day organisational and operational pressures, especially delivery of the access targets in the winter months. It is not unusual for the typical planning process which kicks off in October, to be derailed by December due to winter pressures and the complete distraction by the operations team as the Trust moves into 'black' or OPEL 4 (Operation Pressure Escalation Levels).

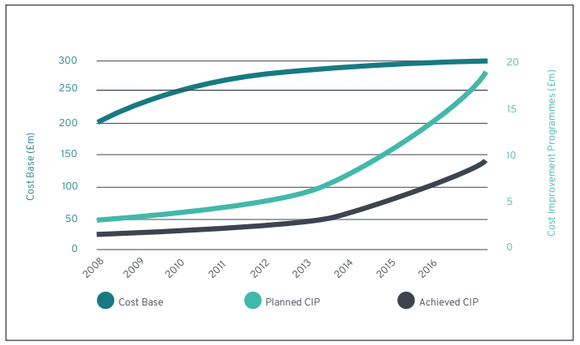
Once developed, a short list of CIP proposals is filtered through a quality assurance process and an iterative process of challenge and counter challenge between senior management and clinical teams. Plans are subject to internal and external assessment of their robustness and delivery risks; this is influenced by the risk appetite of the Trust Board and regulators.

For many Trusts, concerns about delivery capacity and capability lead to the recruitment of external support and 'encouragement' to sign up to regulatory financial improvement measures, bringing external advisors with their traditional approach to cost reduction.

When agreed, plans are turned into a programme of work that moves to the implementation by the end of April each year. Delivery is a battle against time; Q1 of the new year is spent rebalancing the savings target as a result of higher than planned exit run rates, non-recurring delivery of the previous year's plan and the last minute imposition of control totals or commissioning requirements. A programme management approach is taken to delivery with regular reporting and performance management. Further planning and action is taken in year as delivery fails to meet targets and new risks emerge; by their very nature in-year actions are top-down, restrictive and focused on short term non-recurrent savings. Every year this cycle repeats itself, with the savings burden increasing. Figure 4 illustrates a typical journey of a provider trust and the ever-increasing CIP pressure.

FIGURE 4:
An illustration of planned versus achieved CIP and increasing cost burden of a typical NHS Provider

Source: Strasys analysis



CIPs – the outcome

Based on our analysis, interviews and observations, external support and delivery programme management often fails to result in the necessary level of recurring savings. Indeed, over time it can be shown to lead to additional costs, erosion of internal capability and poorer performance in the longer run. Figure 5 shows the financial performance trajectory of a NHS acute trust which had a series of external interventions to drive productivity but failed to stem its declining performance.

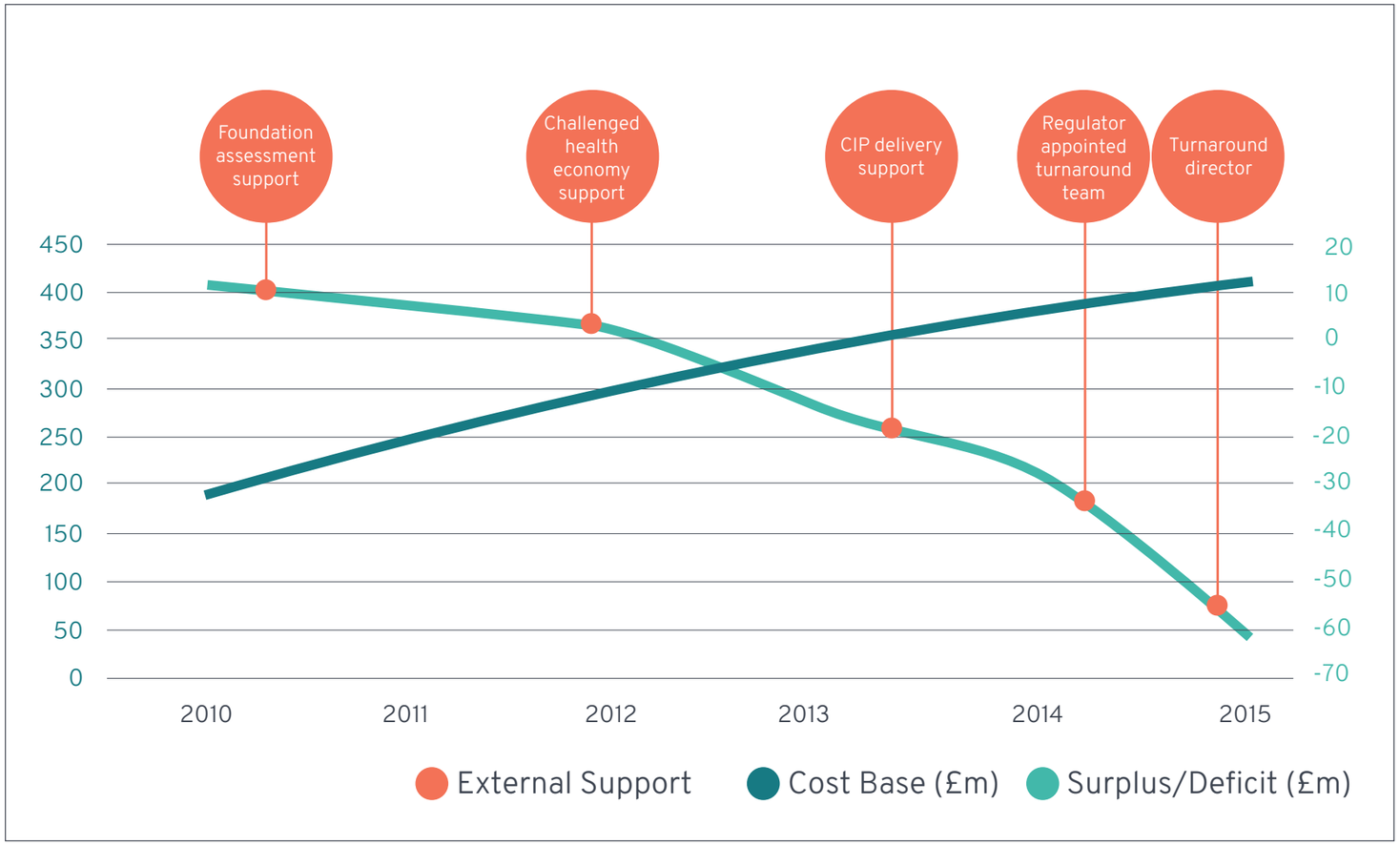
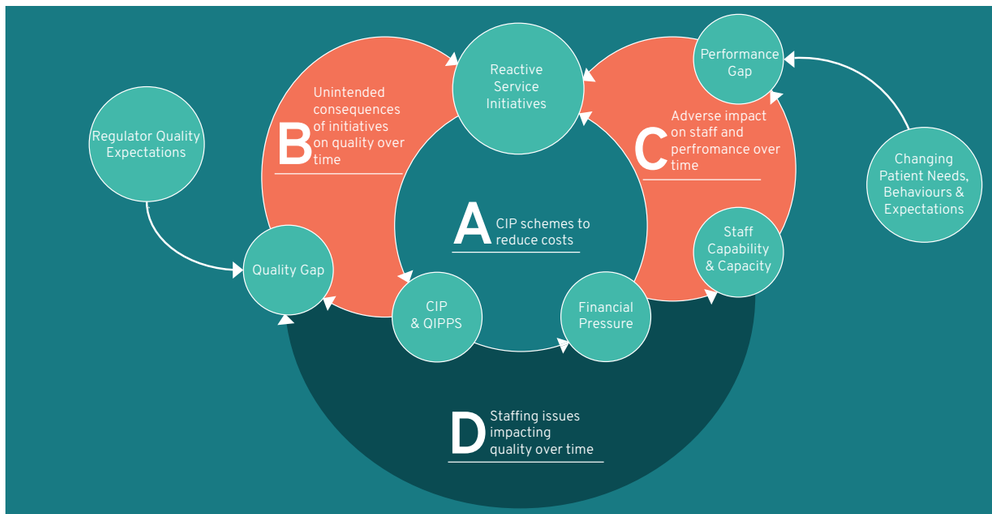


FIGURE 5:
Impact of external support to pursue traditional CIPs for a NHS Provider Trust

Source: Strasys analysis

FIGURE 6:
Dynamics of the vicious cycle of CIP planning and the unintended consequences

Source: Strasys analysis, observations and interviews



CIPs become large and complex programmes of work with potentially more than 100 initiatives and multiple interdependencies. The delivery process becomes highly bureaucratic and time consuming, diverting significant management and staff time from transforming patient services.

Poor planning and risk management can lead to adverse impacts on quality of service and performace requiring corrective actions that ultimately lead to increased costs. The Trust becomes 'locked' in a cycle of continuously shifting focus from quality to costs, costs to operational performance, and so on - the vicious circle of financial challenge continues (Figure 6).

Taking multi-year view, Strasys research identified a series of unintended consequences and behaviours resulting from the current CIP process:

- **Disengaged staff** - with increasing pressure on financial delivery, staff become demoralised and disengaged with the process. It can become the Finance Director's issue – as one senior manager pointed out "finance manages to sort it out anyway so don't worry about it. Even when they don't and the Trust makes a deficit, life goes on and everybody still gets paid".

- **Reactive behaviour** - the need to deliver results leads to 'kneejerk' responses without real understanding of the long-term impact. A culture of 'heroism' is encouraged and celebrated but not necessarily rewarded in future years.

- **Lack of accountability** – leaders, particularly clinicians, are frightened to own the cost reduction plans because of a perceived conflict with quality and performance. It is becoming acceptable to be in deficit and people feel powerless to make a long-lasting impact– as one Finance Director puts it "£30m deficit is the new break-even…if you are achieving your access and quality targets".

- **Transactional currency** - with increasing complexity, CIP have become more reliant on transactional logic (activities, income, costs, contracts) and non-recurring plans. The common language becomes finance which gives lie to the mantra of patient focus and does little to engage frontline staff.

- **More politics** – a focus on historic performance records and central imperatives results in constrained stakeholder relationships, sometimes leading to further counterintuitive interventions from the centre.

- **Herd mentality** – with less time to understand the root causes of their unique performance issues, Trusts tend to resort to 'off the shelf' solutions or adopting ideas from other Trusts without due consideration for applicability and relevance.

- **Increased risk to patient care** – most CIP initiatives are undertaken in silos. There is very little analysis done to understand how these discrete service changes impact on the overall sustainability and the patient journey and outcomes over time. When they materialise these impacts require corrective action resulting in additional costs (Figure 7).

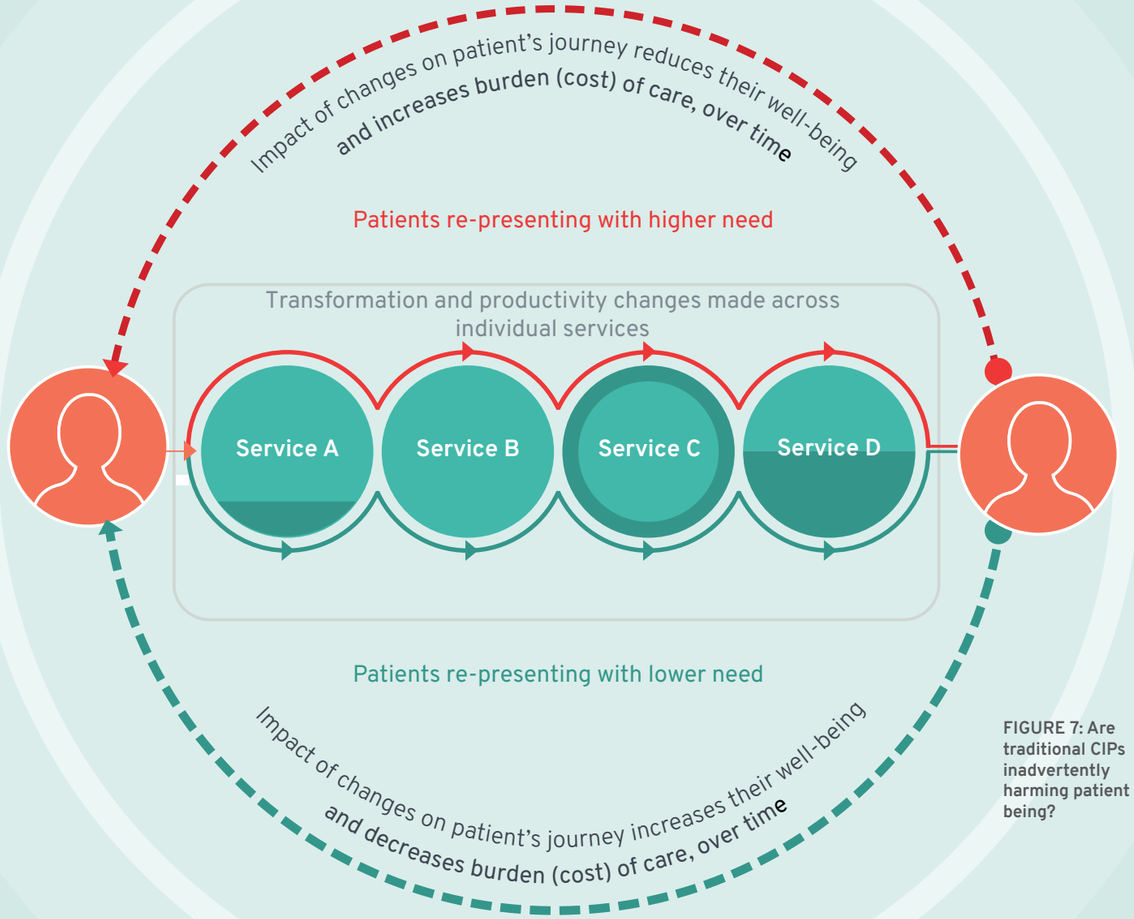


FIGURE 7: Are traditional CIPs inadvertently harming patient well-being?

Why do we need an alternate approach?

We believe that the design of CIPs and the initiatives they are based on are flawed because:

- **The consumer is an afterthought.** We have not yet seen any plans that look at consumer behaviours, motivations and needs at a detailed enough level to allow meaningful and disruptive changes to be identified at the scale required. A recent review of STPs concluded that there is very little reference to consumers beyond basic demographics and public health statistics.

- **There is an unhealthy overreliance on external benchmarking and top down initiatives.** Benchmarks may reflect variances in predetermined metrics but they do not reflect the reality of the unique ecosystem in which the Trust operates such as local service configuration, resources, capabilities, demand, stakeholders and socio-economic drivers. Top down initiatives also fail to reflect local context and their value is often lost by not allowing sufficient time for planning their local application to deliver local value.

> "At best benchmarking compares how two or more organisations perform with a similar set of inputs; they don't tell you what is really possible with the resources available."
>
> Finance Director, NHS Trust

- **There is a real lack of intelligence despite high volumes of information.** For example, it becomes very difficult for a directorate to determine the impact of CIPs when they do not have a basic view of the income and costs of their services. Data without context and interpretation is not intelligence.
The focus continues to be on the actions of individual organisations. Opportunities for service transformation and reconfiguration are constrained by existing provision and service models. Opportunities for collaboration are lost or benefits are not delivered because the 'whole-system' impact has not been understood or managed.

- **The leadership is too detached and does not lead from the front.** We are constantly surprised by the lack of understanding at the Board level of the basic 'mechanics' of the organisation's business or indeed the basic make-up of their consumers beyond the activity headlines. Decision-making is significantly impacted without a clear understanding of how costs are distributed across the organisation and the outcomes per unit cost.

- **CIPs are developed in a silo.** There is often minimal linkage between the CIP and the Trust's strategic, quality, corporate and service transformation agenda which leads to increased complexity and wastage.

- **Despite experience, the reality of delivery is underestimated.** The implementation and opportunity costs of efficiency plans are not fully recognised and understood and there is always a time lag before benefits are fully realised. These basic facts are often ignored.

[Reference: Jules Goddard paper]

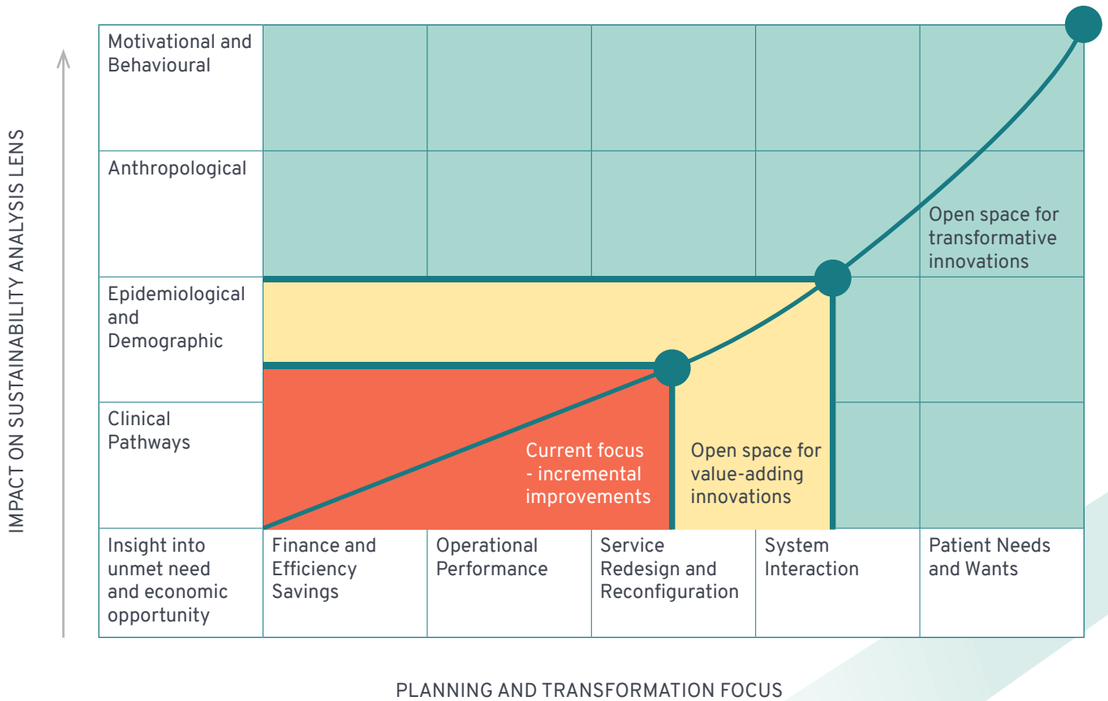
Low risk appetite, high levels of regulatory attention and a pressure to comply with traditional CIP development practice drives the planning process, with Trust after Trust shying away from actions that will transform the system; losing their focus on patients/ customers and their humanity in the process.

Sticking with the traditional approach and variations on it is demonstrably not working. We believe that the only real way to transform the system and close the performance gap is to learn from other sectors and truly place the consumer at the centre of disruptive innovation.

The future – a patient focused alternative

The patient at the centre or a patient centric approach to strategy and system re-design is not a new concept to the NHS. It is an approach that makes a lot of sense for a service whose business is responding to specific individual needs and behaviours, and we know that the public sector lives or dies by its ability to focus on its consumers.

However, to truly adopt this approach and reap the benefits requires a major shift in mental models and operational approaches. We need to escape the current vicious circle of finance centric planning – and think differently. This requires courage, commitment and the time to understand the real issues. Organisations must be confident that refocusing the organisation's agenda on the needs and behaviours of patients will concurrently drive quality, efficiency and operational performance.



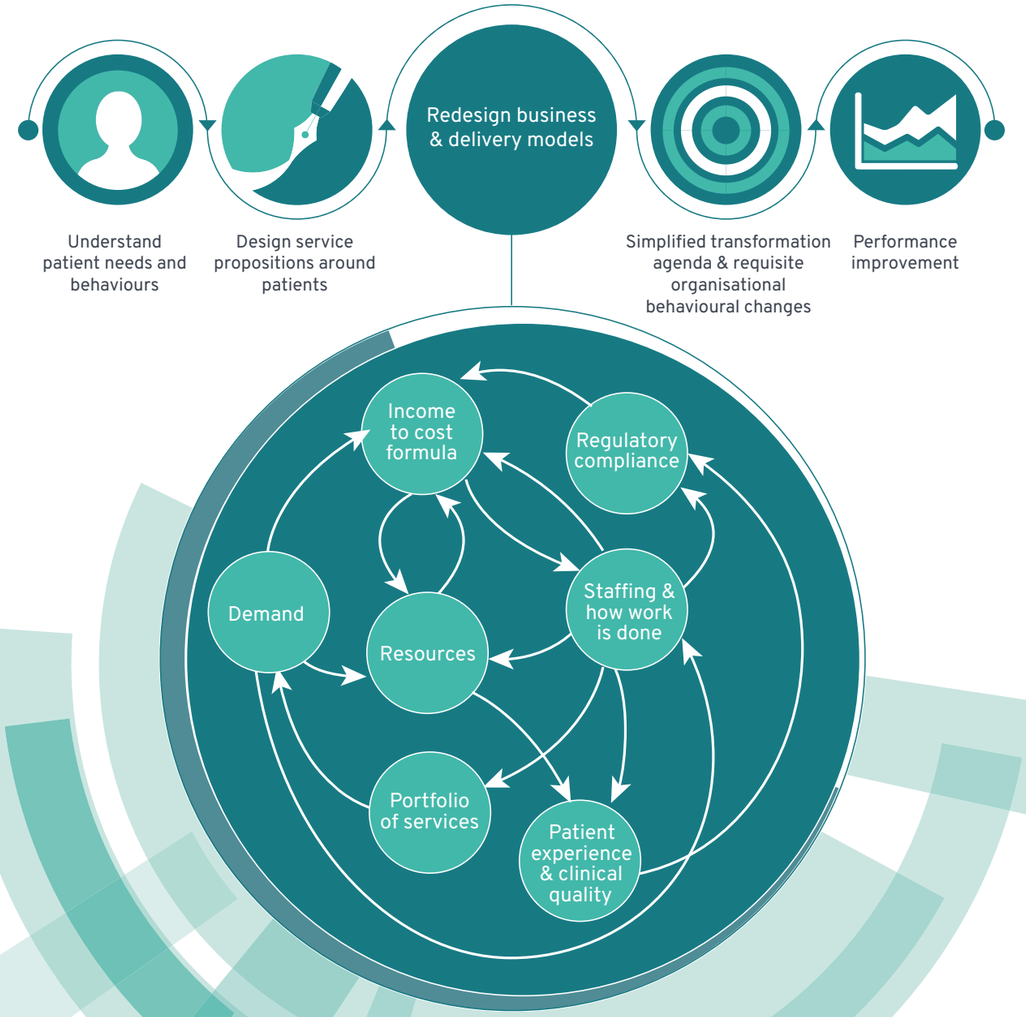


FIGURE 8:
An alternate approach to sustainability

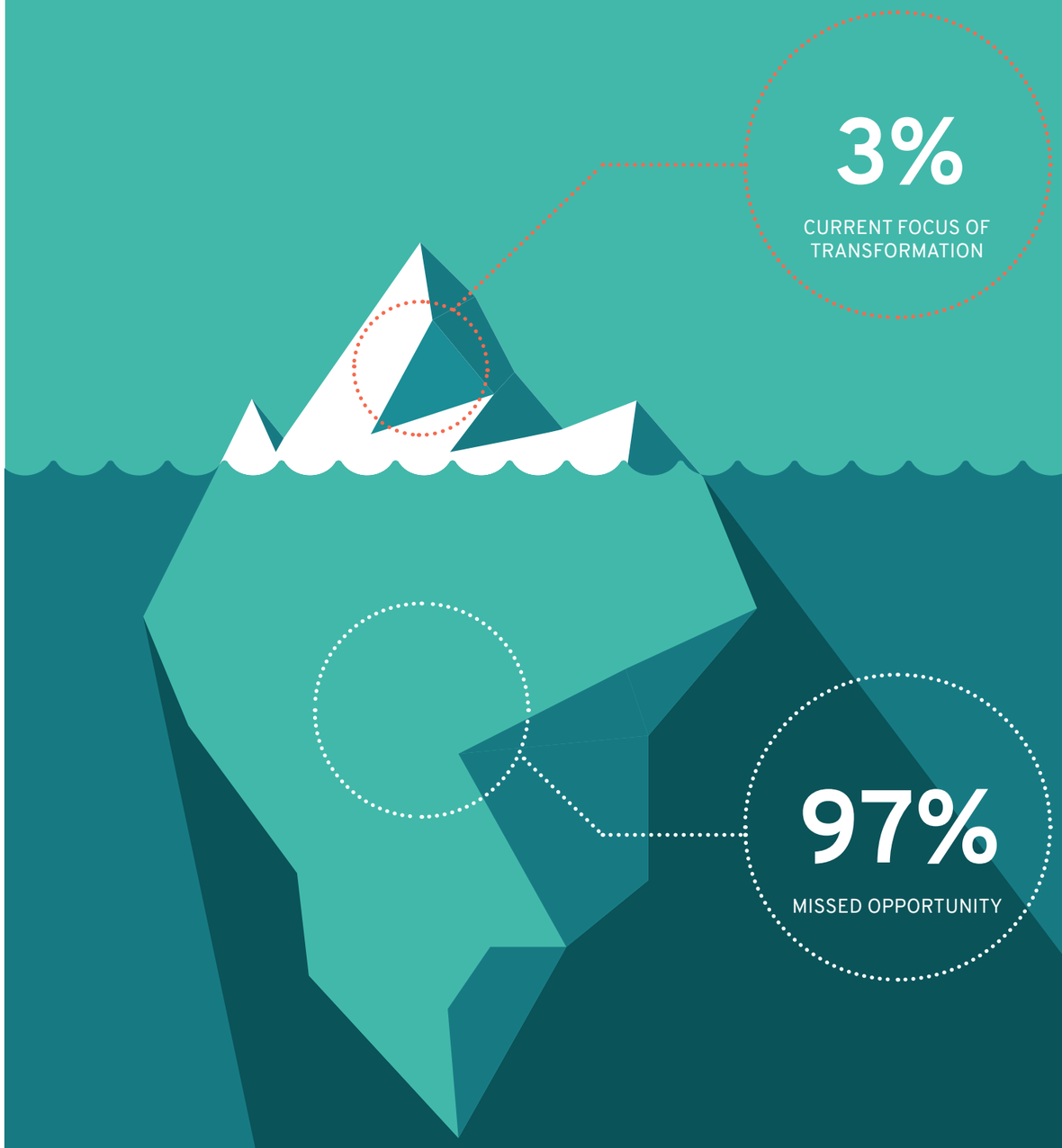


FIGURE 9:
Moving to a holistic view of transformation

We suggest an approach that starts with truly understanding the needs, behaviours and motivations of the consumer and how they interact with service providers. We also need to understand the motivations and drivers of the organisations involved in providing services. This 'human' insight can then be used to determine how the service, organisation, and system model needs to change to provide the healthcare interventions required, whilst demonstrating impact on cost to serve and performance (Figure 8).

This goes beyond the realm of demographic forecasting and public health data, taking a whole person view enabling needs and behaviours to be better understood and responded to. With greater objectivity and focus on the human aspects of service use and need, systems find it easier to cut through the politics, identify common goals and beneficial service transformations, and commit to and collaborate on change.

By adopting this approach, we can begin to refocus a Trust's transformation and efficiency programme on all consumers and the resources available to deliver innovative services (Figure 9).

What will be different?

Moving the focus from a transactional view to a more human insight approach will enable organisations to refocus on patients and the realities of current needs and behaviour and cut through preconceptions about how efficiencies are best delivered.

A better understanding of local needs and the current capability of the organisation to meet them provides a better basis for planning transformation than traditional transactional analysis. True innovation and transformation opportunities can be identified along with their associated benefits – changing perceptions about what is possible and achievable and delivering improved effectiveness and efficiency at the same time. In particular, this approach will see improvements in:

- **Engagement** – a focus on understanding the needs and behaviours that drive service use now and in the future and on making changes that directly benefit patients by meeting these needs is a powerful driver for engagement. Staff are empowered to take ownership of making transformational change in the knowledge that it can both improve outcomes and drive efficiency and performance.
- **Collaboration** – understanding the interdependency between services and the potential long term impacts of change gives a focus for a collaborative approach based around common patient needs.
- **Empowerment and ownership** – leaders, particularly clinical leaders, are empowered to make positive change for patients within defined quality and performance parameters. An approach that seeks to use resources more effectively to meet patient need resonates with clinicians and managers alike enabling them to demonstrate improvements and advocate for change in terms that are meaningful to all stakeholders.
- **Human benefits** – the focus shifts from traditional transactional analysis to how people and services interact to deliver effective services, the common language becomes the needs of patients and how these are best met rather than performance targets and finance.
- **Local adoption** – improving the understanding of the local context enables national and centrally mandated initiatives to be adapted and design to add real value to the local system rather than being adopted wholesale with variable and unpredictable outcomes.

Conclusion

Based on our analysis and observations, we conclude that traditional cost improvement programmes do not work and lead to increased costs in the long run. We believe there is a better way to achieve long term sustainability with a focus on the consumer, the consumers' behaviour as they journey through the health and social systems and the resources used to meet their needs. By transforming that journey and better meeting needs we can drive a far more productive and efficient service that can celebrate at its very core the values that make the NHS great.

Authors

If you would like to learn more about our research or discuss any of the ideas presented, please get in touch:

David Meikle
Director
david@strasys.uk

Naeem Younis
Managing Director
naeem@strasys.uk

References

1. Nuffield Trust (2017), 'NHS funding choices and the 2017 general election'
2. Monitor (2012), 'Delivering sustainable cost improvement programmes'
3. London Southbank University (2017) – 'Sustainability and Transformation Plans: How serious are the proposals?'
4. NHSE (2016), 'Operational Planning Guidance 2016/17-2018/19'
5. Monitor (2012), 'Delivering sustainable cost improvement programmes'
6 NHS Improvement (2017), 'Performance of the NHS Provider Sector year ended 31 March 2017'

About Strasys

Strasys is a London based advisory firm that helps organisations to innovate and solve complex and ambiguous problems through putting people at the heart of their strategy and behaviour. Strasys brings deep customer and strategic foresight to enable organisations to reimagine their products, services and businesses, and establish the organisational behaviours to succeed.

T: +44 (0) 203 150 0213 | www.strasys.uk