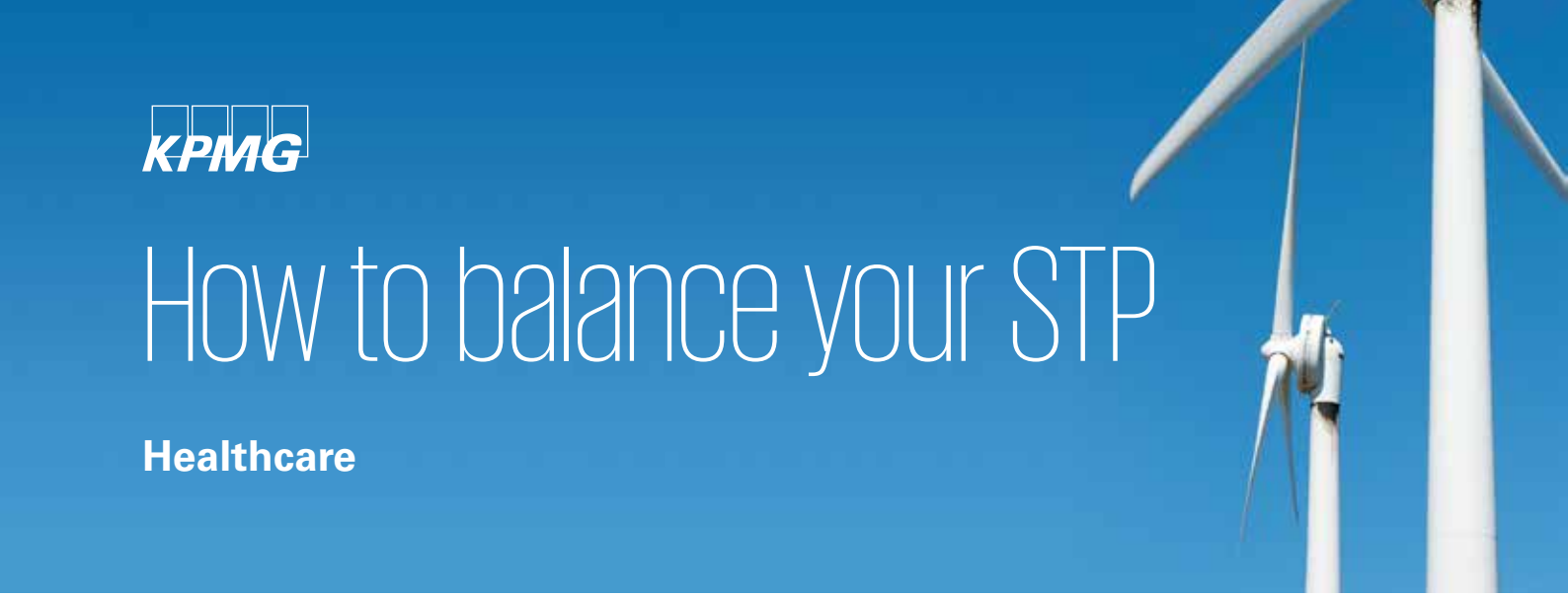

How to balance your STP

Healthcare

The message on Sustainability and Transformation Plans (STP) is clear. They must balance. They also have to meet an ambitious triple aim: to improve the health and well-being of the population; to improve the quality of care; and to create affordable systems which achieve long-term financial sustainability.

Putting these aims in the context of a long list of symptoms such as inequalities in health, increasing prevalence of disease, poor access to health and social care, variation in clinical outcomes, low staff morale, waste and inefficiencies in clinical and business processes and recruitment and retention issues – all in a culture of crisis management and fire-fighting – it's no wonder that many see achievement of their triple aim and in doing so achieving financial balance as a distant dream.

But we believe it is possible. Our hypothesis is that there are just four drivers contributing to the many symptoms that our under-performing health and care system face. By fixing these four drivers, addressing them through four levers or solutions, we believe that organisations can achieve the triple aim, deal with the symptoms, and achieve financial balance.

So what are these four drivers? And, more to the point, what can organisations do about them?

The first is inefficiency in and across organisations. We know that this is often down to the lack of standardisation in clinical and corporate processes, creating waste and variation. Too often organisations operate in isolation, not sharing best practice or thinking about how they could operate collaboratively.

The easy pickings have mostly been done, achieving real transformational improvements in productivity and efficiency requires investment in the right tools, techniques and empowered front line staff that can makes changes. We also believe collaboration is key to addressing previously untapped system inefficiencies.

As organisations work together they can realise significant gains across areas such as agency, back office, procurement and pathology. It's good to see that a number of STPs are starting to think this way. But this trend has to be more widespread.

Second, too much care is delivered in a hospital system. Increased demand from the ageing population currently presents itself at A&E and often ends up as resulting in unplanned hospital admissions. We all too readily see the symptoms from this, longer ambulance waiting times, delays and fire-fighting in A&E, longer lengths of stay as elderly patients become frailer while in hospital and delays in discharge due to shortage of capacity in social care.

The frequently quoted answer to this is that activity needs to "shift left" out of hospital settings and into community settings, out of community settings and back home. Solutions to this area seem overly complicated in many STPs with numerous programmes to fix parts of the provider system, such as GPs and community care, and pathway redesigns to integrate care. We believe STPs need to keep this focused and simple and concentrate on three areas: prevention, primary care at scale, and enhanced and integrated local care. Investment in prevention and wellbeing should be focused on the key population issues rather than an all-encompassing plans which never gets off the ground. For local integration, start small and focused – pick a population of 30,000 to 50,000 people, a single disease, such as diabetes, and use rapid improvement tools to create real change on the ground. Through this process work with local GPs to redesign their role in this process.

Third, there is far too much duplication and variation in clinical services within relatively small geographical areas. Competition and the market conditions in the NHS over the last 10+ years has resulted in providers competing and therefore duplicating many services.

As well as the duplication in costs to provide these services it also often results in clinical variation with different providers operating to different protocols. The effect: inefficiency, variation in clinical outcomes, confusion for patients and higher costs.

We believe there needs to be radical horizontal re-configuration of secondary and tertiary care that centralises or networks care whilst maintaining access. This has to be supported by system-wide clinical strategies that set standards and remove variation.

The NHS has already successfully followed this path with trauma centres and cancer care. We think the next areas that can achieve clear and quick benefits from this centralisation and standardisation are urgent and emergency care, maternity and orthopaedics.

There will of course be difficult political and public conversations around this. But we should not be afraid of explaining why this can lead to higher quality care at a lower cost. Variation is one of the biggest causes of preventable mortality. Standardisation is not cook-book medicine – standards can and should evolve to incorporate innovation and learning once they has been piloted, tested and proved.

Addressing these first three drivers with these three levers is crucial. And we believe that they need to be tackled in order. This way organisations can make their systems as efficient as possible, quantify how much activity can be "shifted left", and then work out how to remove duplication and standardise to improve quality.

Once these three levers have been defined and quantified, the final fourth lever can be applied – this final step in the process is to rationalise buildings and organisations thereby taking out fixed costs. The NHS is saddled with unaffordable infrastructure costs. When budgets were growing, health organisations invested significantly in new buildings, increasing the fixed cost component of their cost base. The number of provider and commissioner organisations grew as well. Today's environment, with its multiple providers and insufficient scrutiny about how the estate is used, bears heavily on bottom lines.

Only once the first three levers – efficiency, demand, and duplication – are addressed can STPs then focus on the fixed cost element of their systems. And we believe that only by applying all three levers rigorously and with ambition, can a health organisation balance its STP and meet its triple aim.

Beccy Fenton

Partner
KPMG in the UK

Share your views and join the debate:

Visit us
kpmg.com/uk/healthcare

Email us
publicsectormarketing@kpmg.co.uk

Engage with us
Follow us on Twitter @
KPMGUK

CRT068831 | December 2016