

Patient safety in a time of economic crisis

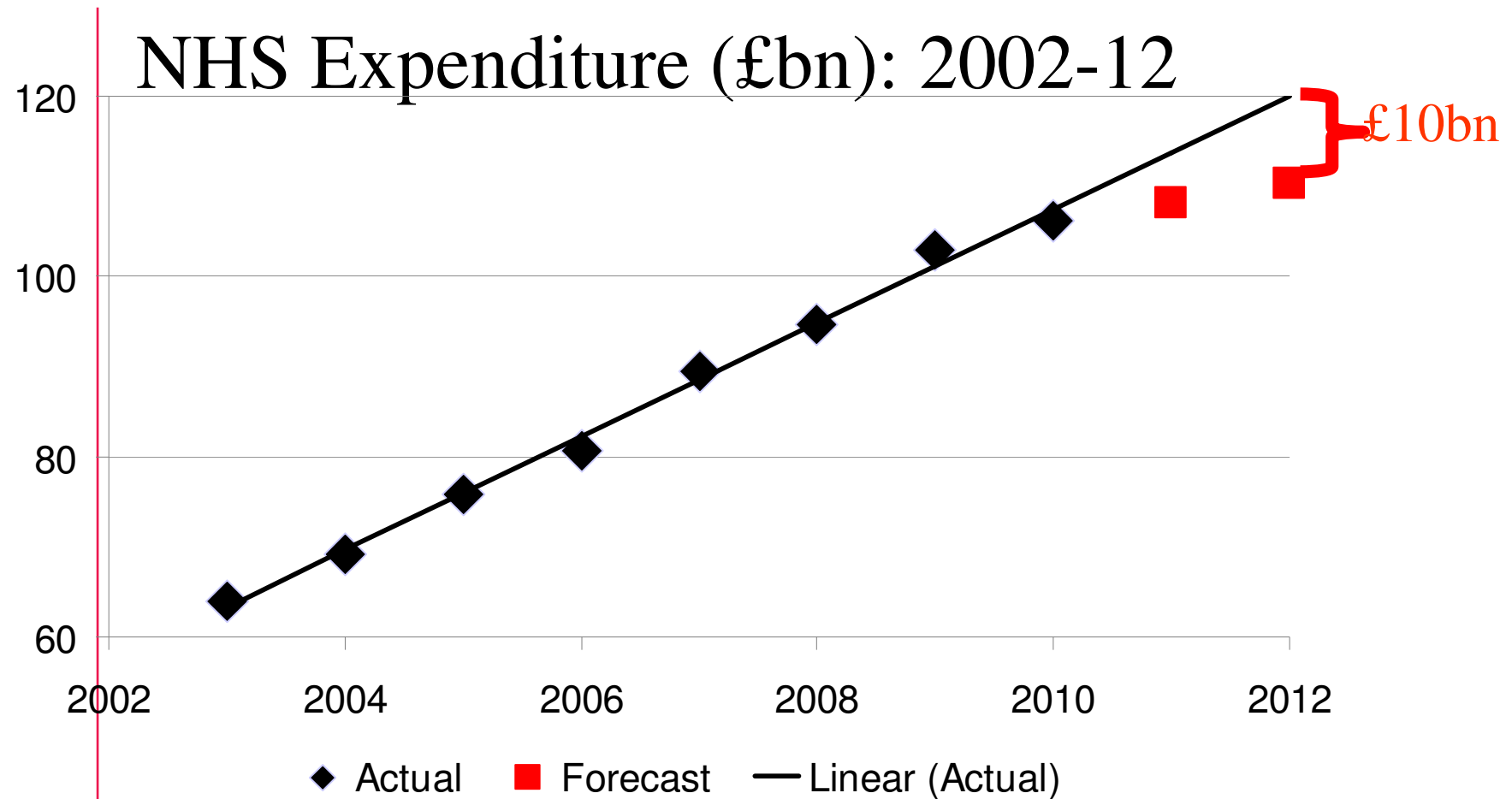
Helen Crisp
26 April 2010

Outline of presentation

- Why the Health Foundation is debating costs, quality and safety
- Findings from research commissioned to see if improving quality saves money
- Outline of our 'Shine Awards' programme
- How we plan to take the work forward

Why is the Health Foundation in this debate?

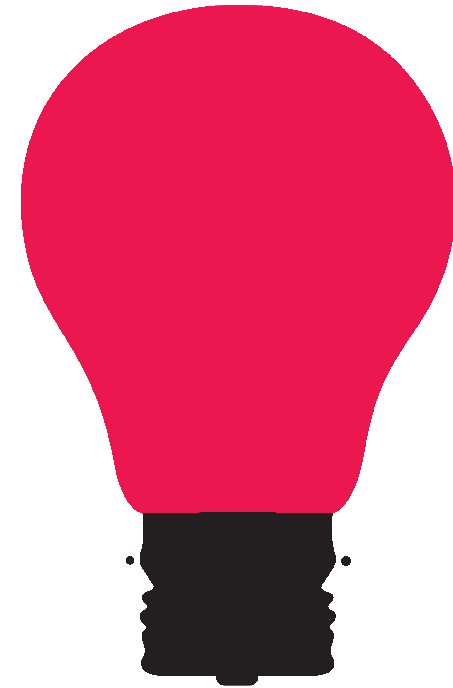
- After 10 years of unprecedented expansion the NHS is facing significant reduction in funding from 2011 – 2016
- The Health Foundation works closely with the NHS and needs to respond to the realities it faces
- We need to be as relevant to NHS in hard times as in easier times
- Quality and safety need to be upheld - not lose improvements made in past 5 years



Source: HM Treasury *PESA 2009 command paper* - Chapter 6 tables. Public Expenditure Statistical Analyses (PESA) 2009, published June 2009

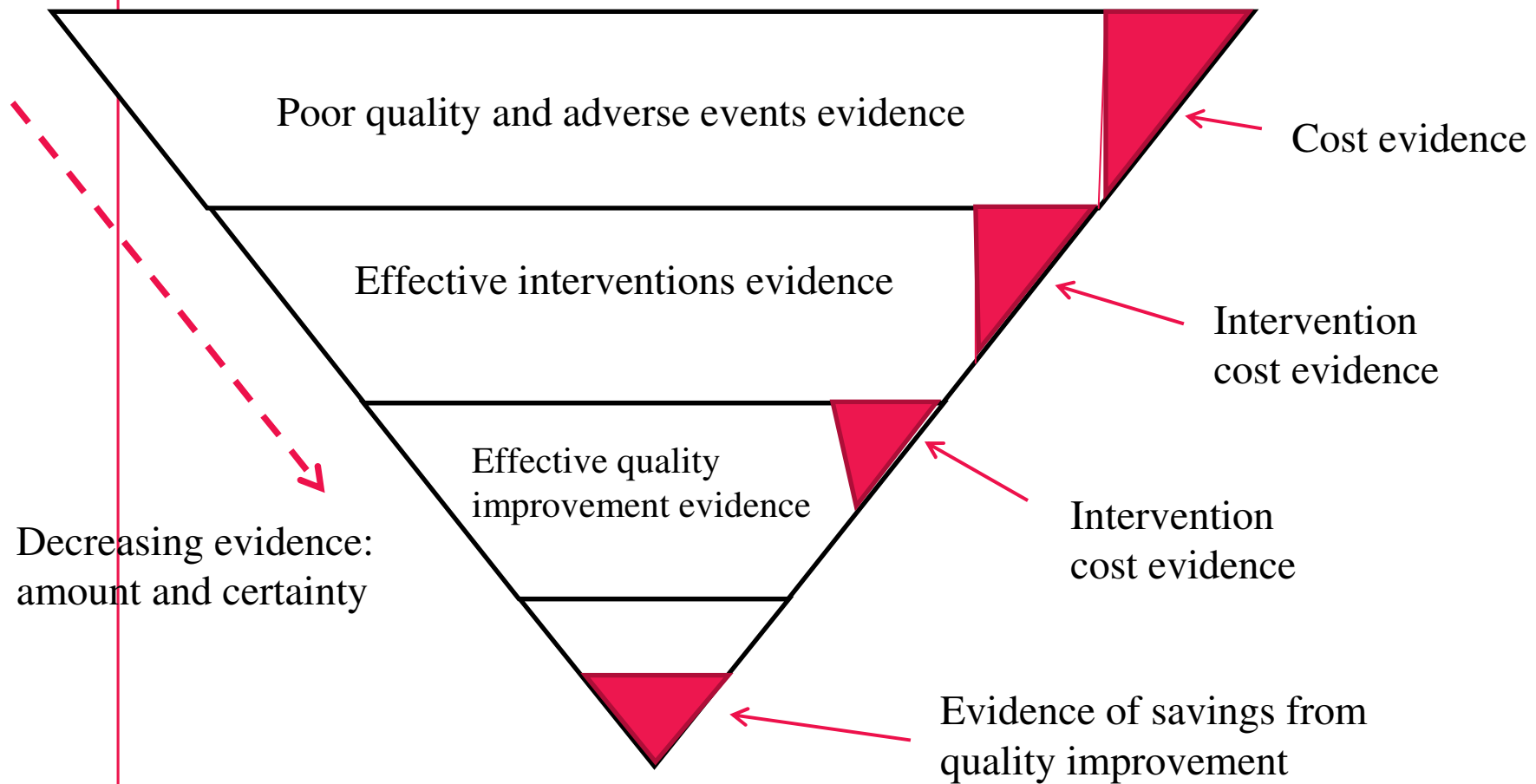
So - does improving quality and safety save money?

Common sense suggests it must
- But where is the evidence?



What do we know?

Map of the literature



Costs of unsafe care

Familiar evidence from the research:

1 in 10 hospital patients suffers an adverse event

Common adverse events:

- healthcare acquired infections
- adverse drug events
- pressure ulcers
- patient falls

**Extra
costs**

- Additional treatment
- Extended length of stay
- Costs of investigation
- Possible litigation and damages

Costs of poor quality

- Growing evidence from research of poor quality not related to adverse events:
 - **duplicated tests**
 - **poor patient experience**
 - **delays in transfer**
 - **poor coordination of services**
- All have associated costs but there is only weak evidence of these being measured

Some estimates of the costs (UK)

25% of radiological procedures unnecessary

Drug errors £0.6bn

Hospital acquired infections estimated at £1.2 bn

Avoidable emergency admissions for chronic conditions

Evidence of savings?

- Few empirical studies
- Some 'savings studies' do not include costs of implementation
- Where implementation costs are included they often appear to be underestimated
- Many studies do not include actual measures for quality
- Rely on anecdotal evidence or experiential surveys of the implementers

How robust is the research?

Economic evaluation is one of
the weakest areas of research
into improving quality:

*“Because we did not calculate
the costs of implementing the
VAP bundle, implementation
costs might partially offset the
savings previously noted.”*



Where are the savings?

Light green dollars: Improvements in the care system that have the *potential* to lower cost

Dark green dollars: Realised cost savings



Where are the savings?

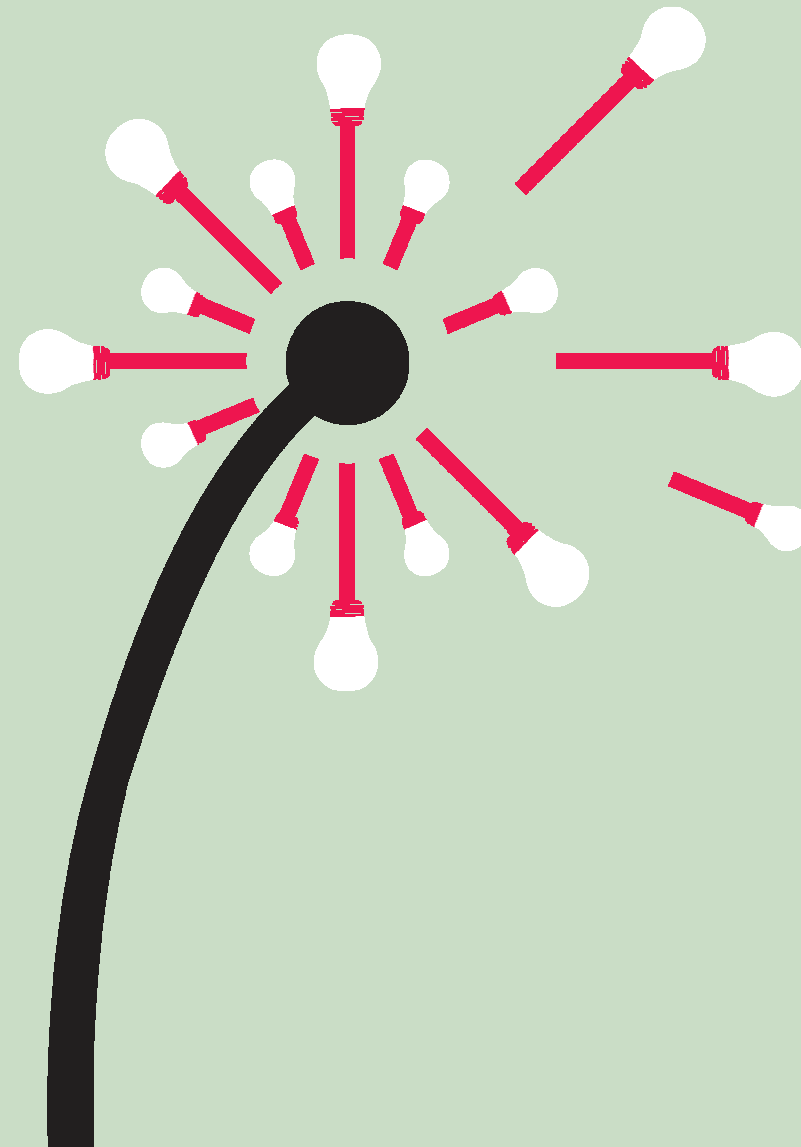
- Savings usually expressed as:
 - saving staff time
 - reducing length of stay
 - reducing use of high cost care; ICU

= Light green dollars

- A few reports of cash savings
 - reduced medication
 - reduced tests
 - reduced consumables

= Dark green dollars

Where does
research
demonstrate
savings?



Multicentre ICU example using central-line bundle to reduce central line infections



The NEW ENGLAND JOURNAL *of* MEDICINE

ESTABLISHED IN 1812

DECEMBER 28, 2006

VOL. 355 NO. 26

An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU

Peter Pronovost, M.D., Ph.D., Dale Needham, M.D., Ph.D., Sean Berenholtz, M.D., David Sinopoli, M.P.H., M.B.A., Haitao Chu, M.D., Ph.D., Sara Cosgrove, M.D., Bryan Sexton, Ph.D., Robert Hyzy, M.D., Robert Welsh, M.D., Gary Roth, M.D., Joseph Bander, M.D., John Kepros, M.D., and Christine Goeschel, R.N., M.P.A.

103 ICUs Working on Central Line Infections:

- 82% Reduction in Mean Rate
- 1,578 Lives Saved
- 81,020 Hospital Days Saved
- “Over \$165million in costs averted”

Other examples

Reducing usage and improving patient safety in ICUs

- Collaboratives aim to reduce patient LOS in ICU
- Multi-professional team approach to care of ventilated patients
- Care bundle to reduce ventilator acquired pneumonia

Routine surgery

- Reducing variation in type of prosthesis used, choose one type on monitoring evidence of robustness and low complication rates (use NJR)
- Reduce operation cancellations through rational appointment and flow systems (e.g. book ICU bed first)
- Routine VTE Prophylaxis

Treat improvement reports with caution

Savings depend on whether the improvement is implemented effectively

Where in the system will the change save money?

Publication bias suggests improvement and savings are more certain than they are

Some improvement projects show results not worth the time and effort

Shine Awards

A Health Foundation award scheme to support innovative ideas that can save money while improving quality

18 awards to clinical teams of £75,000 per award

Areas of focus

- Improving efficiency/ reducing waste
- Right care right time right place
- Pre-emptive action



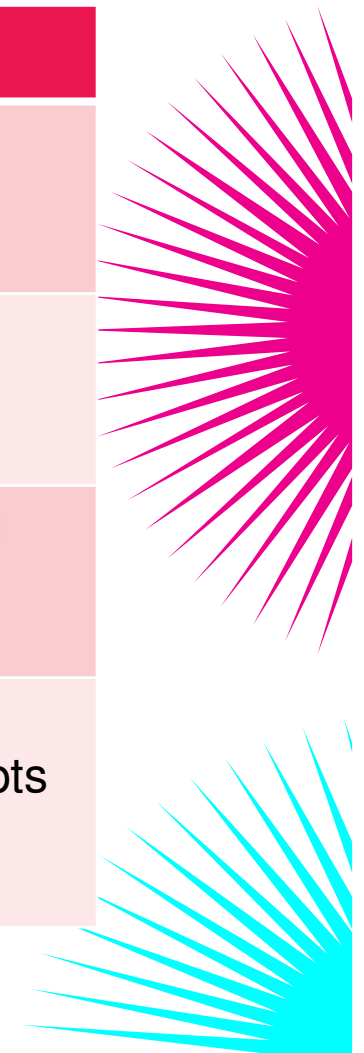
Improving efficiency/ Reducing waste

Project	Estimated Saving
On-line pre-operative assessment to save nurse admin time and reduce cancellations	= £54, 000 per year
Moving hysteroscopy from day surgery theatre to outpatients	£100 per procedure = £120,000 per year
Physiotherapy intervention for staff with back problems	Reduced sick pay = £71,000 Reduced fees for agency cover
Rational use of pathology tests 10% reduction in requests Switch to cheaper tests	One PCT over one year = £146,000



Right care, right time, right place

Project	Saving
Virtual cardiology clinic to reduce inappropriate referrals to hospital	686 fewer face to face consultations per year = £135,000 per year
Support to nursing home care staff to prevent unscheduled hospital admissions for elderly	Fewer admissions to hospital save 144 bed days = £60,000 per year
Expert advice to GPs on COLD/COPD	160 fewer admissions at avg cost £2,200 = £352,000 per year
Rational use of ante-natal services for complex pregnancies - reduce 5 appointment to 4	2% reduction in C-section 20% reduction in hospital appts = £196,000 per year



Pre-emptive action

Project	Saving
Optimise Hb levels prior to surgery to reduce need for transfusions and improve patient experience	Reduce avg. LOS = £120,000 per year
Pre-operative rehabilitation for lung cancer surgery patients	Reduce complications rate and avg. LOS = £22,000 per year
Training for Early warning Scores for patient deterioration	Reduce ICU bed days =66,000 per year



Implications for the Health Foundation

Build the evidence base	Commission research to investigate efficacy of solutions
Evaluation challenge	Build in economic evaluation from the start
Programme design	Describe cost implications at every stage, Set a target for added value
Work with participating teams	Design tools to aid in the collection of cost data Make data collection a contract condition of award
Communications	Share what we are learning Feed into others' programmes

All our reports on research and demonstration programmes are available free to download from our web site:

www.health.org.uk

Thank you!

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