A culture of stewardship

The responsibility of health leaders in Northern Ireland to deliver better value healthcare

Professor Sir Muir Gray

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If you want more information about this briefing, please contact Paul Healy, Head of Analysis, NHS Confederation on paul.healy@nhsconfed.org
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The wake of the Titanic was perfect until it was too late to do anything about it. All the dials and the controls were working perfectly, and then they hit the iceberg. One of the principal reasons was that, to save money, the lookouts didn’t have binoculars.

The future is like the Manchester Ship Canal – it is something we have to imagine, design, plan and build.

The next big thing

We’ve had two revolutions in healthcare and they’ve been astonishing. The first was the public health revolution. What John Snow did with the Broad Street pump wasn’t scientific; it was empirical. Snow knew nothing about bacteria because it wasn’t discovered until 30 years later. Just like the Industrial Revolution, where James Watt knew little about the physics of steam, Snow just worked out there was some force that could be controlled. The second revolution in healthcare has been the high-tech revolution and it’s been fantastic. What’s happened in the last 40 years has had an impact on the health of individuals and populations as great as the first revolution. It’s been an astonishing period of time.

Yet, at the end of this revolution every country and society faces huge problems, even after money, technology, and bad outcomes. Let me take each of these in turn.

The future is value

Traditionally, we’ve looked at institutions and assessed their quality. Even though this continues to be essential, when we look ahead we need to look at population-based measures that relate to value. Quality and value are different. The length of time to get an appropriate test is about quality, and the variation in ultrasound activity is about value. We don’t always know what the right level is, but we can demonstrate continuing patterns of variation.

This means more of the same is not the answer, not even better, cheaper, greener, safer versions of the same. What we need is a new paradigm – a paradigm on value.

There are in fact three definitions of value, which I like to call triple value. The first is allocative value, which asks whether we have allocated resources to different groups equitably and in a way that maximises value for the whole population. Then there is technical value, in which improving quality and safety of healthcare increases the value derived from resources allocated to a particular service. Finally, there is personalised value and this relates to ensuring decisions are based on conditions and values of individuals, including the value they place on good and bad outcomes. Let me take each of these in turn.

So, we need a new approach.

Allocative value

A lot of time is spent debating how much money should be spent on healthcare. When you spend more than 10 per cent of the economy on health, it looks like you start to bite into other public services pretty hard. More importantly, though is how much money should be allocated to different patient groups, such as people with cancer or people at the end of their life. Most people on the front line have no idea at all how much we spend by patient group.

Once you’re clear on how much to spend on each patient group, we then need to look at value within each programme budget. For example, what’s the right balance in a respiratory budget between how much we spend on COPD compared to asthma?

I want to run a campaign then to change the Hippocratic oath – “first do no harm”. The only way to do no harm is to do nothing – all healthcare does harm. Safety and quality changes the shape of the curve, but all healthcare does harm. The more ways you do, the more drugs you give, the more operations. Eventually there comes a point when increased resources do not equate to added benefits, which is called “the point of optimality.”

The broken leg service works very well. If you’ve got a broken leg, you get to the right place, but most of healthcare is more complex than broken legs.
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Donabedian curve for the individual

### Personal value

Perhaps the most important point is whether we are sure that every individual patient is getting what is right for him or her. The above is the Donabedian curve redrawn for the individual. When you start off with treatments like hip replacement or statins, for example, you only offer it to a small proportion of people in the greatest need, so the benefit is high and the harm is low – we call that necessary or high value.

As you do more, the benefits get less. You are not transforming people’s lives in the way that you did, but the harm is still the same, both the probability and magnitude. There may come a point where the lines cross and this would be called negative value or futile care. This is demonstrated by big operations in people with really no prospect of life when there are other ways in which we can help them cope with their remaining years. As the rate of intervention in the population increases, the balance of benefit and harm changes for the individual patient as well as for the population.

### A good steward

We need to focus on population health, not just referred patients, and the triple value agenda. We need to personalise care in the way I’ve outlined and to create a new culture, a culture of stewardship. Most management theorists thinking about the effectiveness of an organisation will give 10 per cent to structure, 40 per cent to systems and the rest to culture. Culture is the set of beliefs and assumptions that permeate an organisation.

Stewardship is holding something in trust for another generation. A good steward leaves the farm in a better condition than they found it. If we screw up the NHS, there won’t be one. This is the message from the Bengoa report and I think it is something we, as health leaders, have to accept.

For more information about this briefing or the Decisions of Value project, please contact Paul Healy, Head of Analysis, NHS Confederation on paul.healy@nhsconfed.org