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College President

Can improving quality cut costs?

I started the last President's column with a discussion of the warnings of impending 'financial famine' for the NHS. At risk of being repetitive, here's some more. My justification is that this is big, and it will not go away. If any of you currently have your head in the sand or the clouds, kindly remove it now. It's become clear that pathology is not actually predicted to receive 20% funding reductions just because of Lord Carter's report; similar cuts are to be spread across the board. It is being described as 'no increase in funding' but, if you consider the rate of inflation for medical care and the increase in demand due to the ageing population, it doesn't take long for that to equate to a 20% 'efficiency saving'. We will not be excused our share of the misery. The Carter report just added focus, urgency and a potential course of action in the context of pathology.

As I explained last time, for a variety of reasons (possibly including an impending General Election?), the NHS has a space of about 12 months to make preparations before the financial problems really begin to bite. As part of the solution, the Department of Health (DH) has embarked on a programme to persuade everyone that the solution is to improve the quality of healthcare. Improve your quality to cut your costs, we are being told.

My initial reaction to this was somewhat sceptical; that George Orwell's description of "Newspeak" in *1984* had been proved right once again. But my scepticism has been considerably reduced by recent experiences from an unexpected quarter. A few weeks ago I was one of a number of Presidents of Royal Colleges sent on a short study trip to the USA, funded by The Health Foundation (note: no cost to RCPath subscription payers. No holiday for me, either). I was initially unclear as to the purpose, but I found myself meeting many of the individuals whose work underlies this 'improving quality cuts costs' idea.

I was very impressed by their results. They provided numerous examples of system redesign that had improved quality and, by eliminating readmissions, infections, waste, etc. they had indeed cut costs. But this is not simple, there are several complex and challenging messages. Change must come from within; externally imposed ideas (and, emphatically, externally imposed management consultants) don't work because they don't win hearts and minds. You need local enthusiasts to embed a culture change that lasts. Sadly for the NHS, sophisticated IT systems that can simultaneously track activity and expenditure are important. If you don't measure it, you can't claim you've improved it. Openness is crucial; publicising your failures as well as your successes actually helps, even in a market-driven system such as the USA.

I was not completely won over. In describing the biggest savings there was a tendency for different speakers to highlight the same issues – notably reduced intravenous line infections and reduced ventilator-associated pneumonia. So if you apply these principles across a whole healthcare system, how much do you save? Brent James, the CEO of Intermountain Health, proudly stated that his organisation had held costs to the retail price index for several years, rather than the 'usual' rate of medical inflation; and in the same period, all available measures of service quality had gone up. Given the difference between the two inflation rates, that's actually very impressive; but everyone agreed that overall efficiency improvements of 20% could not be achieved this way in a couple of years.

So maybe this is not a complete solution to all the problems donated to us by our bankers. But that's not a reason to put your head back in the sand. Just the opposite. The more we can change in preparation for financial stringency, the less 'slash and burn' we will see; so if improving efficiency is not a complete solution, that makes it all the more important that everyone helps to do as much as we can, that no-one leaves it all to others to worry about. If your department is measuring its performance and is actively taking steps to improve quality and cut costs, it is likely to fare much better in the searching financial reviews that we will all face.

Incidentally, almost all the charismatic managers I met had a medical degree. Americans do not, on the whole, regard running a supermarket as an appropriate training for running a hospital.

So what can we do? The College is its members, so the College can do nothing unless you do something. But if you do something, maybe we can help each other. We can collect examples of good practice as well as bad practice. We can moan about the latter, but the former we can use to develop workshops or other forms of training on system reform.

In the last *Bulletin* I discussed measuring quality in the pre-analytical and post-analytical phases. So how do you establish the authority to refuse to do unnecessary tests? How do you

implement the rational use of a new test, when it costs the pathology department some precious investment money but saves a clinical department much larger sums? How do you ensure that the report needed to save a life (or to discharge a patient) gets to the clinician fast, gets read and gets understood? How do you avoid having expensive machines standing idle for many hours each day? How do you sort out the unreliable transport system that you don't control? And – most of all – how do we persuade everyone to accept the need to unite against the common financial enemy, to forget the local turf wars, to stop insisting that 'service reconfiguration is OK as long as I end up in charge', and to get on with reconfiguration in a way that's agreed by pathologists instead of accountants?

You don't have to be a Clinical Director or Head of Department to get involved; you just need to have a head for change and some energy. It's relevant that the College has a new Assistant Registrar. Rachael Liebmann is also Clinical Director of the Kent and Medway Pathology Network, was awarded a Fellowship of the British Association of Medical Managers (BAMM) in 2008 and is now a member of its Board. Rachael had already expressed an interest in the calls from several quarters for more involvement in 'medical leadership'. She has accepted the challenge of coordinating the College response, to help Fellows to cope with financial challenges, to tackle them head on. You can expect to hear more from her in coming months. You may have found 'management' and 'leadership' a turn-off in the past. Please don't turn off now, or you may find that it's your service that's been turned off. This is for real.

Medical revalidation

Medical revalidation continues to move forward. All the Colleges have now submitted their 'frameworks' on how doctors will demonstrate compliance with the GMC's 'Good Medical Practice'. So far the GMC has not identified any serious problems with these proposals. There are still many uncertainties, especially in smaller and 'unusual' specialties, of which pathology has several. We hope to run small 'revalidation pilots' in some of those areas, assisted by DH funding through the Academy of Medical Royal Colleges. Schemes to pilot the whole revalidation process start in ten sites across England in January, run by the Department of Health Revalidation Support Team; similar pilots are planned in the devolved countries. We must try to use these pilots not to prove that the proposed system works, but to find out how it could work better and – crucially – to measure what it will cost. Full implementation of revalidation is still dependent on agreement from the Treasury, and the country's financial woes surely mean that this will be scrutinised very closely. The College will be undertaking additional work in a sub-set of the identified pilot sites in order to test how the proposals work for pathologists. If you work in one of the locations involved I hope you will assist. Please see www.rcpath.org/index.asp?PageID=221 for further information.

A heavy-handed HTA

More doom and gloom; the Human Tissue Authority (HTA) has issued a Regulatory Alert to Designated Individuals in the post-mortem sector, expressing concern about levels of compliance with its Codes of Practice (which, incidentally, I find now extend to more than 1,000 pages in total). The main trigger is the discovery of five cases where after post-mortem examination the brain was not reunited with the body before disposal. We learned from the 'organ retention scandals' of ten years ago that in the eyes of the public, there just isn't a defence for that sort of mistake.

But there's something strange about these cases. It seems that they occurred in units spread across the country. All of them involved brains that were sent for specialist neuropathological examination, and – remarkably – all were being investigated as potential homicide cases. One might expect the tracking of specimens in forensic cases to be meticulous, or evidence would not be admissible in court. But it seems that in every case the underlying problem was a breakdown in communication between pathologists, coroners and the police, once it had been decided that the criminal justice process no longer had need for retention of the brain. An Officer of the Coroners Society has pointed out that, desirable though it may be, coroners have no duty in law to inform the pathologist when tissue samples are no longer needed. But the Human Tissue Authority has authority over pathologists, not over coroners or the police; and a solution to the problem is being demanded from pathologists. My small personal attempt to insert a change in the new Coroners and Justice Act 2009 that would have imposed a duty on coroners to pass information to pathologists was blocked by the Government, in my opinion without justification.

Even more seriously, in the summer the HTA called in the police to undertake a criminal investigation at a large mortuary. At the time of writing we have as a result a Designated Individual who has spent four months waiting to find whether criminal charges will be pressed; even now a decision still has not been made. I have asked what criminal offences are alleged, but so far I have only been told of breaches of HTA Codes of Practice, not of criminal law. There is little that can be said while such a case is still under investigation. Perhaps there are things of which I am not aware. But as part of this I have seen an internal HTA policy

document on instigating criminal investigations under the Human Tissue Act 2004. I did not find the tone to be at all consistent with the messages of 'criminal prosecution only in the last resort' that we heard when the HTA was first established. The fact that no-one can be forced to be a Designated Individual, nor indeed to undertake post-mortem examinations, does not seem to be a matter of concern.

I fear the HTA has lost all sense of proportion; a loss no doubt exacerbated by the resignation of all three pathologist members of the Authority, reported in my last column and still with no promise of replacement. I suggested to the HTA that it should use peer assessors in its site visits, as does Clinical Pathology Accreditation (UK) Ltd, to help add that sense of proportion. The suggestion was rejected out of hand. Perhaps this is something that happens to all regulators, as they strive to justify their existence. As I write, Ofsted (the Government-imposed regulator of schools) has just been castigated in the press for identifying a headmistress's small, docile and very aged pet dog as a danger to pupils at a school in Devon. In Somerset, children have been told they cannot stick glitter to their Christmas cards because it's a health and safety risk. In such a world, maybe the HTA complaining that 'The height of the post-mortem tables is not readily adjustable' (yes, that is an accurate quotation) is not so surprising. The HTA explains that such comments are within its remit, because the Act charges it with determining whether the premises are 'suitable' for undertaking post-mortem examinations. Are you convinced?

It is interesting to compare the fees charged annually by the HTA to license a single mortuary (£8,000 p.a.) with the fees charged by CPA to inspect a single pathology laboratory (£2,100 plus £360 per additional discipline). Putting aside tabloid newspaper hyperbole, errors in which type of establishment present the greater risk to the public? If the cost of regulation is not proportionate to the size of the risks, then surely either one system is too 'light' or the other is excessive? In the present financial climate it seems clear where the problem lies. It's an ill wind that blows nobody any good.

Is there something to lighten the gloom? Indeed there is; an immensely successful National Pathology Week. I can leave it to the rest of this edition of the *Bulletin* to tell you about that, but I must thank all those whose hard work made it such a success. Some, but far from all, are identified in the following pages.

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Speak up: give your view on College consultations

All members should get involved in College's consultations on the guidance and documents that are relevant to their specialty.

Your opinion is vital in helping us ensure that all the documents we produce are reliable and workable in practice – and what you say, counts. You can also claim up to 2 CPD credits for this work. All college documents are put for consultation on the website, you just need to login and visit www.rcpath.org/index.asp?PageID=90

Here you will find all the documents open for consultation and information on the status of documents in the process of being revised before final publication. When a new document is posted, we send out an email to the relevant members advising them of the open consultation.

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