DON’T MENTION THE ‘E’ WORD

Experts debating how to turn plans for huge NHS savings into action raised everything from the managerial skills deficit, to working across boundaries – to the reaction you get from too many staff when you say the word ‘efficiency’. By Daloni Carlisle

Understanding and accepting the scale of the financial challenge in the NHS has been tough. Drawing up the strategies to deliver savings has been painful. Now comes the hardest part of all: turning strategy into action.

This was the topic of a roundtable debate convened by HSJ and supported by Newton Europe Ltd. Around the table were chief executives and finance directors as well as policy leaders.

Alastair McLellan, HSJ editor, set the scene. “In theory, the emphasis now is on the service to make change such as moving care to the community,” he said. “But there also has to be an expectation that provider organisations are able to do more for less.”

“Sounds simple,” he said. “In reality it is a lot more complex than that description provides. We can all point to ideal scenarios that may or may not come about but there is a very real challenge in the NHS for the next two years. What has to be done and how should it be done?”

Mike Farrar, chief executive of the NHS Confederation, picked up the challenge first. He described four levels where there can be done in your organisation; what can be done locally to change pathways; what can be done collectively by acute providers; and what can be done nationally.

“My assessment is that most people have worked very hard at the first level and are running out of road about what they can do in their own organisations. The savings nationally on pay have happened.

“We have not, however, made much ground at levels two and three with care pathway redesign, moving care into the community and the pattern of acute provision.”

And this is because the system is not geared to make that step change, he added. “The tariff does not support it, the incentives are not geared up and there are medical workforce issues. Francis has made it harder as it has led to loss of confidence in us as leaders and made it difficult to change the face of the service.”

His prediction was that by the next two years the trust has now invested several million pounds in making ward

"We need to look at reducing waste and eliminating unintended variation. That’s where we will get gains."

Yes, said David Loughton, chief executive of Royal Wolverhampton Hospitals, this was a good starting point – except for one thing. “My biggest concern is the management capacity to do anything,” he said. “Managers are spending all their time fire fighting. You become more inefficient as you do that and do not have time to look ahead.”

He agreed that Francis could potentially have a negative impact by reducing his flexibility. For example, the trust has now invested several million pounds in making ward

ROUNDTABLE PARTICIPANTS

Jan Filochowski chief executive, Great Ormond Street Hospital
David Loughton chief executive, Royal Wolverhampton Hospitals
Dr Keith McNeill chief executive officer, Cambridge University Hospitals
Kishamer Sidhu finance director, North West London Hospitals
Paul Mapson finance director, University Hospitals Bristol
Lee Outhwaite director of finance and information, Derby Hospitals Foundation Trust

Chris Calkin chair of policy, Healthcare Financial Management Association
Mike Farrar chief executive, NHS Confederation
Professor James Barlow Imperial Business School
Sandy Bradbrook senior adviser to Newton Europe Ltd
Andrew Hawes director, Newton Europe Ltd
Ed Burns associate director, Newton Europe Ltd
Alastair McLellan editor, HSJ
Managers of superannuation. “So there are now large parts of the workforce you cannot move.”

But Mr Loughton saw scope for more savings and was optimistic. Central to changing this was the need to change the way pathology services was a promising area as was making better use of clinical NP services, which form part of his trust. “We have set a target of 300 fewer people dying in hospital this year and that will start to take the pressure off.”

Jan Filochowski, chief executive of Great Ormond Street Hospital, said he had gone further up the ladder and say not only are there areas we cannot touch but there are areas where we need to invest to make improvements. “That’s hard.”

His trust had increased income from overseas patients by nearly 5 per cent. “We cannot do this every year as we need room for NHS patients,” he noted. “But we are sceptical about large-scale improvements such as pathology, which he said, “create mayhem”.

“When they tried to implement redesign we found a lack of will because if I win then you lose”

Mr Filochowski agreed that sustainability of funding required support from staff but after two years of hard graft “we haven’t changed minds. We believe it is doable they will get behind it but if they are tired of the charge they don’t think it is possible, then it is a worry.”

Clinical engagement was a running theme in the panel. Sandy Bradbrock, a former NHS chief financial officer and now senior advisor to Newton, said: “I believe there is still scope to make efficiencies, and the key thing is getting clinicians involved as they are the ones who know the process.”

Dr McNeil, however, argued that sustainability of funding was not the word “efficiency” if they were to engage clinicians: “Getting clinicians is the key, the most important. But if you use the word ‘efficiency’ we will run a mile.”

Chris Calkin, head of policy for the Healthcare Finance Association, wanted to know: surely we all wanted to work for an NHS that was lean, efficient and effective. “Why is it such a no-go area?” Mr Loughton countered: “I never talk about money in my organisation ever. I talk about quality and about reducing drowning.”

“You need to plan at local level”

Mr Filochowski’s focus was on avoiding delays and blockages by creating ways to release patients who no longer needed your care. He also wanted to see better use of capital and buildings and more accurate pricing. “If we paid what it cost for emergency work then care could really work,” he said.

Mr Mapson returned to the theme that “substituting activity” could be a way out. Too many hospital groups had been brought into management consultancies at too great a cost. Mr Farrar raised overall reasoning: “People have to act locally to re-considerate separate budget strands. We need to look at the total resource available and discuss how much we have and how we can best use it.”

He said: “If we plan on 4 per cent of the task. Yes, it can improve productivity but it often also drives up costs because it allows you to do more.”

For this group, moving from strategy to action is already happening. It is hard, and it will require some national guidance and discussion, particularly on plurality, the turf and emergency care. But it is, they think, just about doable. 

Clockwise from bottom: Alastair McLellan, Keith McNeil, Kishamer Sidhu, Ed Burn, David Loughton