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21st December 2011, London

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Send us your feedback on the journal, ideas, suggestions or comments to: fraser@clinicalbusinessexcellence.co.uk

WELCOME TO CLINICAL BUSINESS EXCELLENCE

I am delighted to release the inaugural edition of the Clinical Business Excellence Journal, a monthly periodical with big aims and important subject matter.

Regardless of the outcome of discussions surrounding the Health Bill, clinical services need to consider both their clinical effectiveness and their business approach to ensure that they survive and thrive in an increasingly tough climate that is unlikely to soften any time soon. The journal seeks to bring both clinical and business considerations alongside each other by:

- Educating
- Highlighting best practise
- Identifying risks
- Offering insight
- Promoting a balanced view
- Opening eyes

Editorially, it will take a warts and all approach without succumbing to political or service sensitivity. Personally, I believe there needs to be more open dialogue focused on the real issues at hand and a lot less misinformation, which tends to paralyse rather than inform. I will endeavour to keep these principles at the fore, as we grow the journal into a prominent force for positive change both internally and externally. Everyone has a viewpoint and we will seek to bring balance to debates and accuracy to reporting, not sensationalism.

I welcome your input and feedback. We need a forum for discussion of clinical business matters and so I'd like to know what you want addressed. Tell me your thoughts, fears and indeed aspirations and we'll ensure that the journal reflects this.

I hope you enjoy this first edition.



Mr Andrew Vincent

Editor-in-Chief,

Clinical Business Excellence Journal, Insights Publishing Ltd

Head of Clinical Business Excellence, Medicology Ltd

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CHANGING THE WAY CLINICAL & MANAGEMENT TEAMS COLLABORATE

THE PREMISE FOR CLINICAL BUSINESS EXCELLENCE

Think of it this way. A decent-sized acute Trust with a turnover of £320 million may have around 40 distinct and identifiable clinical services within it. In effect, it has 40 x £8 million businesses under the banner of its Trust name. It's a crude analogy but helps us ask a very pertinent question; just how effective is the working relationship between the 'business executive' of the service (Clinical Director, Consultants, Matron, Directorate Manager) and the management infrastructure of the parent? Moreover, if you owned that 'Group' would you be happy with its performance, adaptability, strategic effectiveness etc? For most, the answer would be a resounding 'no' and whereas that didn't mean much historically, it means a whole heap in a competitive market economy with financial scarcity.

We have now had voracious competition for many years, only internally rather than externally. For decades, different clinical teams have competed internally for limited financial resources, new consultants and more equipment. Each service may say that it was simply trying to create the best for its own group of patients and we wouldn't deny the positive intent in each business case. However, survival of the parent tomorrow will be based on the collective performance of its basket of services and not the ability of some to shout louder than others. This requires a collaborative approach internally, not a competitive one.

If you ask a management team about their greatest challenges, they'll often include the difficulty of bringing clinical teams into line with Trust plans, over-coming

inertia, resistance from the consultant body and huge issues around motivation, morale and disengagement. It seems that clinical teams are the problem. However, we'd ask "are you really sure you've created the conditions, environment and working relationships that produce engagement, collaboration and adaptability? If you ask the clinical teams, they'll suggest that management doesn't understand their service, takes poor decisions, has little sensible strategy, wants to meddle in clinical matters, it's all about the money and they just won't let go. It seems that management is the problem. We'd ask those same clinical teams "have you really approached working with management collaboratively and have you demonstrated that you can be trusted, beyond question with stewardship of your £8 million business?" In essence, the

Clinical Business Excellence Journal

Core Aims & Aspirations

- Platform for better learning about business in health
- Forum for ideas and exchange of best practise
- Fostering a common understanding of complex problems
- Encouraging a meeting of clinical and managerial minds
- Fostering collaboration, especially between clinical and managerial teams
- Asking better questions, to develop deeper insight
- Stimulating innovation, adaptation and evolution
- Encouraging intelligent action, not dangerous reactivity

current way of working is frequently at odds with what really needs to be done.

In times of abundance, management teams are often asking their 'services' what else can we do to push forward our business but in times of financial scarcity, something we have lived with for longer than most can remember, they tend to focus on what we should stop doing, cut or reduce to save money. It is not surprising that clinical reactions to this are resistive but it does have an impact, emotionally more so than rationally, on how clinical teams and managers feel about each other and this has resulted in an often adversarial relationship between them, commonly referred to, of course, as the clinical-managerial divide. In times of turbulence, with an acute need for rapid reform, this gets in the way of what needs to happen and results in inertia or even stalemate, risking the survival of both service and Trust. It has to change.

So, let's conclude at this point that both clinical and managerial teams have a positive motivation to their behaviour but the manner in which they go about their work and relate to each other

causes an unhelpful tension between them at a time when all parties need to be working closely together. If we also subscribe to the notion that the present output of those interactions falls short of what may be in a provider's survival interests (adaptation, reform, mitigating risk, seizing opportunity), then mentally we need to move beyond the historical perspective and consider what will effect a change. It's quite common for each group to harbour feelings that the other group is the primary problem. Regardless of factual correctness in specific circumstances, it leads to a less defined but particularly powerful sense that the 'other' group needs to make the first move towards improvement. The result, of course, is persistence of the relationship ineffectiveness i.e. nothing changes, as each waits for the other to 'see the light' (whilst further embedding this by active or passive criticism of the other groups actions and behaviour). So, what's the answer?

The complexity of the behavioural issues involved is significant. Of course, there isn't just one answer to this pervasive problem and that leads us neatly to the

premise for Clinical Business Excellence, a journal designed to bring together the apparently conflicting arenas of clinical medicine and business and, by definition, bring together the frequently conflicting groups of clinical staff and management. Currently, each group plays in a different part of the playground with very little common space and when they meet at the fence it is often to argue over who is in charge of the playground. Perhaps the start then is play, learn and grow in the same space, developing a common understanding of the problems we face and at the same time learning a great deal about each other, including all of those worries, fears, hopes, dreams and aspirations. With each group quick to accuse the other of acting in its own interest at the expense of theirs, all groups appear to ignore the inescapable truth that their interests and fortunes are inseparably joined at the hip and that the success of both can be achieved through effective collaboration.

Clinical Business Excellence is designed to be a common platform for the sharing of knowledge, insight and ideas, with both clinical effectiveness and business



success enjoying joint and equal billing. It is designed to help management better understand how to steer and drive the organisation with clinical teams, rather than in spite of them and for clinical teams to learn how to ensure that their services are clinical excellent, stable, sustainable and safe whilst developing the knowledge, skills and insight to better utilise business effectiveness to further those aims.

Our advice to clinical leaders (Clinical Directors, Service Leads, Consultants, Matrons, Sisters etc) is read with an open mind and encourage your management counterparts to do the same, encouraging discussion of what it means to you, your service and Trust. Go on, take the first step, not because it 'should' be you but because it's in everyone's interests and in truth, that's the mark of a leader – to step aside from the historical baggage and make a small step in the right direction, perhaps by moving towards an adversary that really needs to become and ally and advocate. If Clinical Business Excellence provides guidance and means to do this, we are happy and moving in the right direction.

Our advice to management is to step back just a little. Take the time out to reflect, learn and discuss in collaboration with clinical teams, rather than relentlessly focussing on doing. Rather than delaying the 'doing' you may just find that it helps to overcome the current blocks – frenetic activity with a relatively low level of achievement. We're advocating more progress, actions and strategies better thought through, with less resistance, achieved by learning how to resolve this insidious block to progress. You might just be surprised what can be achieved.

OK, enough rhetoric. Let's consider a final few practical points and I'll let you inside the inaugural edition.

Clinical Business Excellence goes well beyond just acting as a platform. The issues we face are immensely complex and the solutions to many have not yet been discovered, let alone discussed. It is in everyone's interests to gain clarity on what makes a successful service and Trust in an environment we are not used to. Clinical teams need to learn the art and science of business effectiveness in a competitive market economy and

everyone needs to discover solutions to the more complex challenges of reducing financial footprint without impacting quality, addressing the needs of an ageing population and ensuring stability and certainty in an increasingly unpredictable and dynamic environment. Clinical Business Excellence aims to contribute to all of these areas, making it:

- A platform for learning
- A forum for ideas
- An ambassador for common understanding and collaboration
- A stimulator of innovation

It will achieve these aims with your participation and so we encourage you to read, discuss and debate. Feedback is vital for improvement and we would be delighted to hear your initial thoughts, positive or otherwise. Spread the word – don't assume someone has their own copy. If something sparks and interest, we encourage you to get better at saying to others "did you see that article in Clinical Business Excellence? What do you think?" Above all else, please enjoy it.

Mr Andrew Vincent
Editor-in-Chief,
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Head of Clinical Business Excellence,
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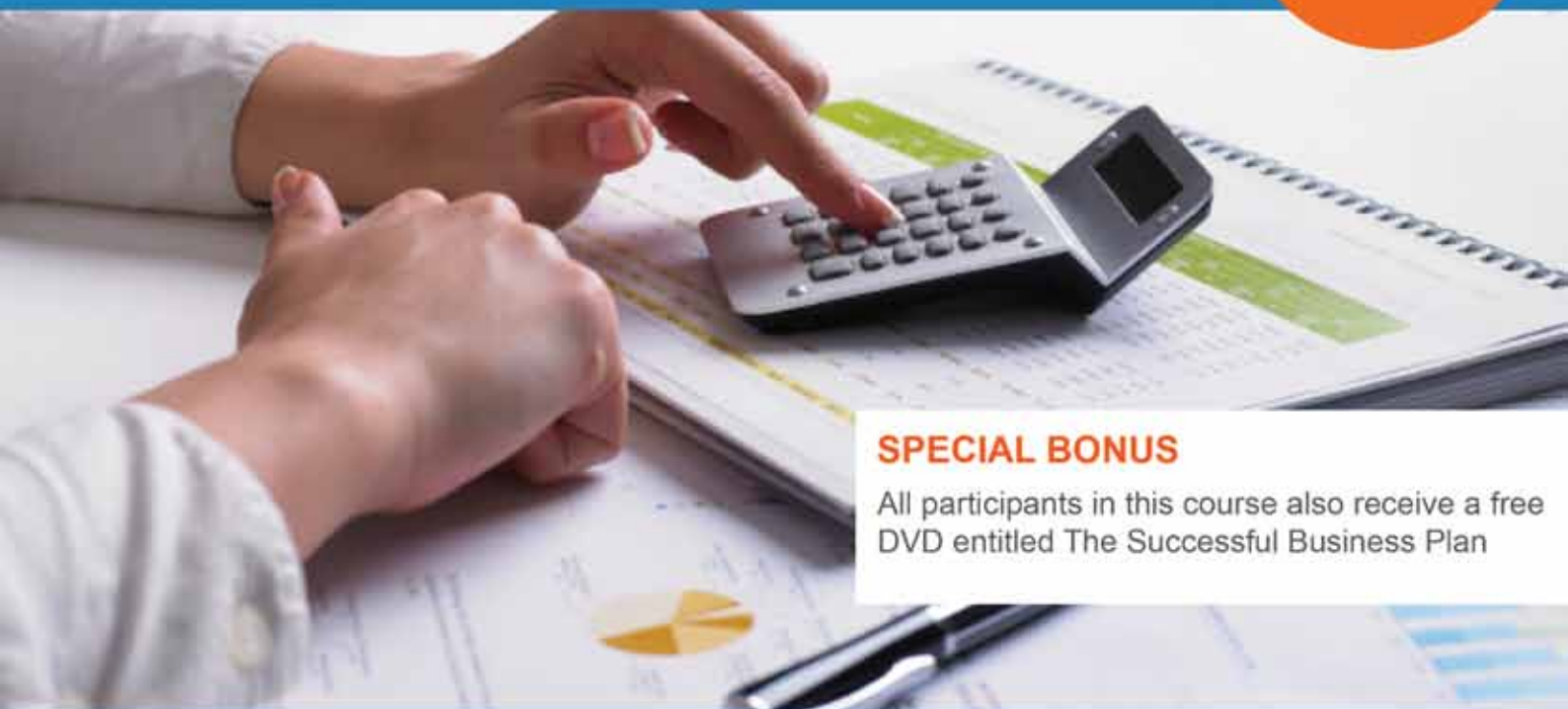
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RADICALLY RE-THINKING THE CLINICAL-MANAGERIAL RELATIONSHIP

MORE TRUST, LESS CONTROL,
LOWER COSTS

The NHS is currently facing the massive challenge of plugging a funding shortfall of £20+ billion over the next four years at a time when UK healthcare cost is increasing due to a myriad of factors such as the cost of new drugs, increased life expectancy and the greater expectations placed on healthcare. It's very clear that unless we re-think how we do things, that magnitude of savings is going to cause a great deal of pain.

In the run up to the 2012 NHS Leadership Summit, Andrew Vincent, Head of Clinical Business Excellence and Managing Director of Medicology, met with Ali Parsa, Chief Executive of Circle Health, to compare their respective entrepreneurial outlooks and to discuss their shared passion for adopting a different approach to healthcare - an approach based on a remarkable and refreshing re-think on the challenge of keeping services on the straight and narrow.

From the outset it was clear that both Andrew and Mr Parsa believe that the current relationship between management and medical staff is an unsustainable dynamic. Mr Parsa clearly feels that a different approach to healthcare management is desperately required - one that extols the virtues of placing trust in people and providing them with the freedom to operate effectively.

“Basically we believe in people,” says Mr Parsa unequivocally. “If I were to ask you: what turns you on about your job? A lot of research says its three things. Autonomy, complexity, and relativity between efforts and rewards. And a reward doesn’t just mean money. It can also mean recognition.

“Now, how do we manage people in most of our institutions? It’s a systematic way of taking things away from them. We try to micromanage them and take their autonomy away. We try to simplify their jobs and take their complexity away. We reward everyone in the same way regardless of whether they work hard or not. So you basically fail on all three fronts.”

At Circle, a very different approach is adopted. Some might almost call it experimental as it appears to fly in the face of the methods and ethos of almost every NHS organisation you might think of, so we wanted to know more.

“At Circle, all we are saying is treat adults like adults. Our units run themselves and we try not to interfere. On the other hand though, we do give them a target of what they have to achieve. And our targets are very simple. If you think you can run a unit and if my mum for example, wants to come to that, then it has to have the best clinical outcome and best patient experience for my mother. It needs to have the most productivity gain in the region so that my mother is not wasting her money. And it needs to have the most engaged staff so that people are serving rather than worrying. As long as you’re number one in your region, we leave you alone. So, that’s kind of our philosophy. The truth is that being number one doesn’t happen by chance. You need to follow a pretty systematic method of management. We call it the Circle Operating System, which basically says we turn you into small groups

so everyone feels like an owner and entrepreneur.”

Andrew agrees that this sense of ownership needs to be transferred to clinical services but raises the suggestion that it is a fear of what clinicians given freedom to operate managerially might do with that freedom that is getting in the way. In effect, management worries that letting go will cause havoc.



Ali Parsa (left) with Andrew Vincent

“Actually, we have a more rigid approach than the system because the system assumes how you make decisions in life. People always use to say there are three steps in making a decision. Number one is your perception of the problem or your understanding of the issue. Number two is spending a lot of time analysing it. And number three is you execute on it. In the 19th century, the Victorians believed that number three was all that mattered. In the 20th century, it was number two. And now, increasingly, behavioural psychologists are telling us that it’s actually all about number one.

“My approach is to create a framework for people so that they do the right thing to start with. What we actually say is ‘Look, let’s agree together what is the right thing.’ Everybody agrees with that. So, we came up with our credo together - everybody in our partnerships. As I said, I don’t want my mother to go to a place that is second best in clinical outcome. So if we don’t believe that we run the best solution for you, we don’t run it. Even if it’s the second best service, we shut it

down. We absolutely believe that we offer the best patient experience you ever will get anywhere. Once we all agree on a criteria of how to work, then the job is to maintain and deliver that criteria. So, we’re focused - relentlessly focused on the outcome.”

That focus on the outcome rather than the process and control is a refreshing one and as Andrew pointed out we have seen an enormous proliferation of ‘over-burdensome management layers that sit above clinical services’ including a multitude of control mechanisms and bureaucracy such as workforce panels that



stifles both freedom to operate and a sense of ownership. So what, asks Andrew, does Circle have in terms of support functions that sit above a clinical service?

“Almost everything sits in the clinical services. Going back to the decision-making process, if you decide that you want to manage people then that’s a difficult thing to do. If you decided that every article that has been written in your magazine (Clinical Business Excellence) needs to be read [by the Editor] as opposed to trusting the people who write the articles, what do you have to do? You have to pass it all to the Editor to read and check. They will never have the time to do that. So, the Editor then needs to set up a sub-committee for people to do that. These guys will specialise in different areas. So then, each of them will set something up and before you know it you have a whole group of people who are checking everything in the journal. Now the writers will be feeling particularly disempowered because they are saying

‘why should I write? This guy is going to change it anyway.’ So why should I be passionate about what I write?” So now you have a whole layer of bureaucracy and the system is not actually working because the initial work is not being done with care and ownership. All we are saying is that actually you turn back and say ‘whatever you do is perfectly good as long as it is done within this framework.’ Then you’ve saved yourself all of that nonsense. The Editor doesn’t have to work so hard because he/she doesn’t have to read everything. You don’t need subcommittees in between. And the people, who have the job, love the job because what they write gets printed.”

That de-layering of bureaucracy provides the potential for significant cost reduction whilst freeing leaders to actually lead in the area they are passionate about, Andrew points out, although it would be naïve to think that everything always runs smoothly. Mr Parsa agreed and went on to explain the Circle approach to rectifying issues.

“Within the clinical service we have people who are in charge of making sure that leaders become an agent of my patient and the job is to do the best for the patient. Therefore, your target is to provide the best clinical outcome. Compliance then becomes a day-to-day affair, rather than something you write about. It’s making this part of peoples’ nature, their behaviour, rather than writing something to comply with. Invariably, there will be many areas in our hospital where things don’t work as they should. We have learnt that these things always solve themselves, not with how much you police them, but by how transparent they are.”

There’s no question that Circle Health is delivering a level of quality and experience that most would aspire to and as an organisation with shareholders it will need to do so at a profit. We certainly came away with the impression that Mr Parsa was bullish about the future and far from thinking that clinical staff will run amuck when placed firmly at the helm, it was abundantly clear that he felt this was essential if you wanted to be successful.

In the next edition of Clinical Business Excellence, Ali Parsa and Andrew Vincent discuss future plans and we gain an early insight into the how Circle might approach Hinchingsbrooke Hospital, a wholly different scale of operation.

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THE ELEPHANT IN THE ROOM

SHRINKING THE ACUTE SECTOR

As we travel the length and breadth of the country, we are struck by how little acknowledgement there seems to be that the acute sector, particularly in the District General Hospitals group, will need to shrink as routine or simple care is redistributed away from hospitals and into the community. To us, it feels like an elephant in the room - everybody knows that it's there but nobody really wants to talk about it. However, by leaving this elephant un-discussed in the corner of the room we run the risk of undermining the very changes that a Trust or service needs to make to ensure that it survives and thrives.

What does 'shrink' really mean?

In the eyes of most Trusts shrinking means financial reform i.e. lowering your overall financial footprint. However, in truth, when initial triage and treatment, routine diagnostics and follow up are all moved largely to community locations, then we simply have too many acute trusts for the level of work and available funding.

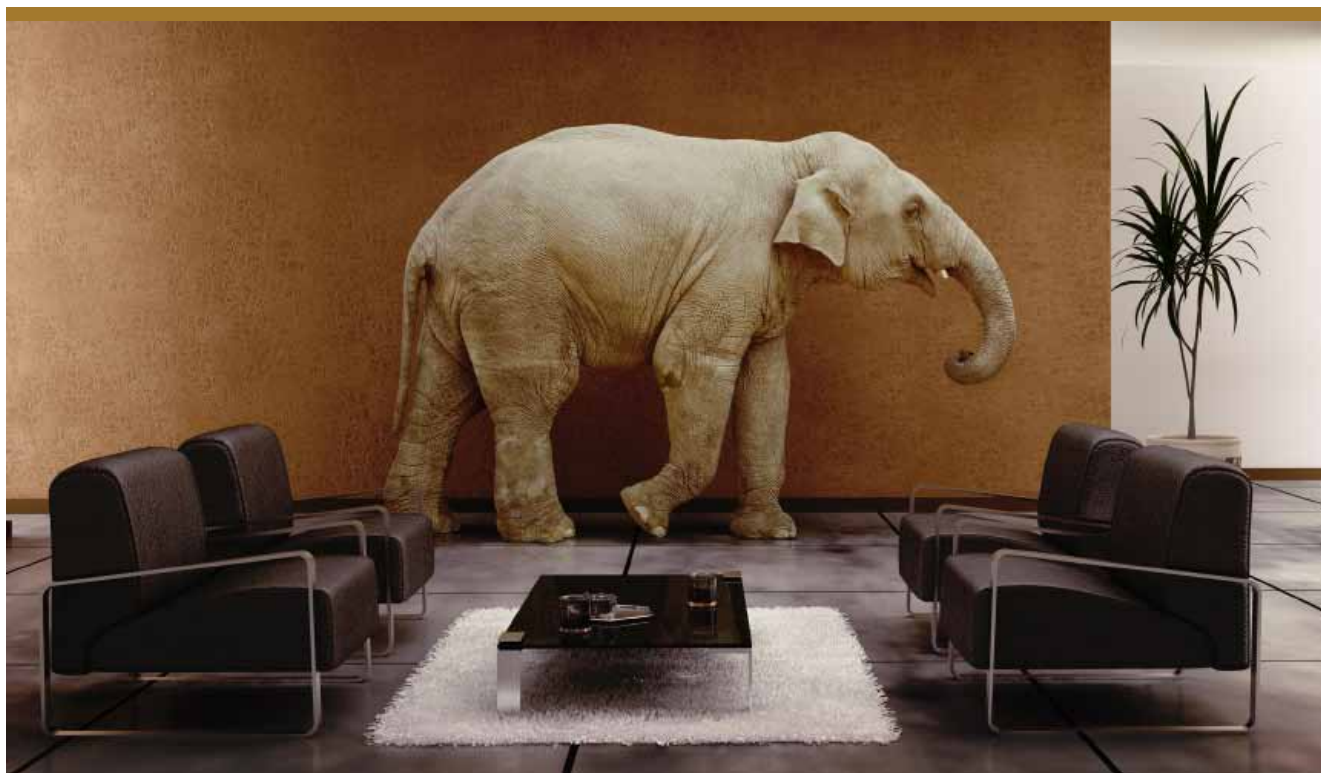
The second big misunderstanding surrounding shrinking is the methodology by which shrinking will be achieved. Traditionally, a reconfiguration of local healthcare services involved in a formal planning process, public consultation and a distinct commissioning process often with a tendering exercise. However, in the new healthcare economy change will also come from the impact of market forces and a provider's ability to stay in business. In effect, the root of demise for a particular secondary care provider may not be a well-organised planning process but instead a distressed closure arising out of consistent imbalance between income and expenditure i.e. bankruptcy.

Increasingly, providers are developing an awareness about the possibility that they could go bankrupt and not be rescued. Indeed, Andrew Lansley and David Cameron have both made it explicitly clear that we must cease to continue to support failing Trusts. Healthcare professionals from all sectors have spent many months arguing that the introduction of competition will

destabilise the healthcare economy and that this is a real risk of the new legislation. I believe that this fails to recognise that destabilisation and demise of secondary care providers is an intended consequence of the reforms. Rather than engaging in a bitter and somewhat academic debate about which services should stay and which services should go, market forces simply allows the natural selection of winners over losers. A reduction in size for the secondary care sector is inevitability in the absence of sufficient funding and a redistribution of care into alternative locations.

The real risk in the new order

There are two emerging risks, not from the health legislation itself but from the behaviours of the providers within the evolving landscape. The first arises out of the continued search for healthcare solutions that preserve the integrity of the whole system i.e. all providers within it, rather than simply accepting that some of them must go. Given our near bankrupt status as a country and the



rapidly increasing demand for healthcare services, it is abundantly clear that we cannot pour money in at the top end of health at a sufficient rate to cope with the utilisation of that money at the bottom. However, the search and debate for the right solution rages fiercely and is the equivalent of trying to determine how to rearrange the sandbags in the New Orleans levees when in fact a better solution is to accept that they are broken and adapt accordingly, in their case by moving to higher ground and in our case by adapting the organisation to ensure that it falls into the category of winner, rather than loser. That's a very different approach to simply reducing cost.

The second emerging risk is indeed the collapse of the system. This is not a result of the new legislation but the reaction of providers to that legislation and their ensuing behaviour i.e. what they do about it. To illustrate this I'll use the analogy of a small town in rural England. It has a little population that supports a small local economy of typical businesses. Currently, there are three restaurants in the town

and each of them is enjoying a degree of prosperity, feeling secure because people will always need to eat. However, employment in the town is largely centred on a single manufacturing organisation. This organisation goes into liquidation and the factory closes, resulting in a markedly reduced availability of free cash to be spent in this local market economy.

It is not the closure of the factory that specifically causes the demise of any one of our three restaurants but at some stage there needs to be an acceptance that this small town can no longer support three. The ensuing fight for survival places all three restaurants at risk, not because any of specifically is unviable but because together they have insufficient distributed cash to keep them alive. The big question, of course, is how do you determine who should go? In this market economy, eventually two winners will emerge and one restaurant will go out of business. However, it is perfectly possible for all three restaurants to go out of business before a clear winner emerges.

Determining the winners from the losers

Continuing with our analogy of three restaurants in the small market town, you might say that we simply have to reduce the organisational size in each of those restaurants so that each is viable, much akin to the predominant behaviour of our current acute sector. In some cases that may well be possible but in many instances this behaviour is flawed, as each restaurant will end up also reducing its capacity to earn, whilst losing its economies of scale as it downsizes. At the end of the day, each restaurant still needs tables for the clientele to sit at, a chef and other kitchen staff, waiting staff and a front of house person. Reducing in size means reducing the ability to serve as many people and so risks the eventuality that both financial footprint and income reduce at similar rates. In effect, the restaurant may find itself with a reduced ability to do a good job and be no better off financially.

A better solution might be to find an alternative business model and a competitive edge over the competition. In our restaurants that could involve adding in takeaway food, for instance, or starting a low-cost meal delivery service. In terms of competition it could be the establishment of a loyalty scheme along with a redesign of the premises to become the de facto most pleasant place to eat. The best strategy is clear; this restaurant must take a higher share of the available clientele whilst also adapting itself services so as to be less reliant on its traditional sources of income. If this strategic thought process is working really effectively, the restaurant may consider which parts of the population have been least affected by the factory closure and reconfigure itself to be most attractive to them. The establishment of its Monday night Bridge Club now starts to draw out the more senior members of the community i.e. those who are not reliant on employment. As an alternative another restaurant creates a discount scheme for individuals employed in the town, thus targeting the group that continues to enjoy sufficient free cash to go out to dinner.

Our third restaurant, which has failed to adapt or aggressively go after the remaining share, now finds itself in severe financial trouble and goes out of business. This event, whilst tragic for that particular restaurant owner, serves the positive purpose of preserving the other two restaurants - the market economy has determine the right level of provision and rearranged the pieces.

Key message for providers in today's healthcare market economy

There are a number of lessons that we can draw from this analogy, as well as some distinctions to. The first lesson is that continued debate and search for a

solution that preserves the whole could in fact collapse the whole system. Given how difficult it is to deny that we have a limited ability to raise more money as a country and that our population is continuing to grow and that there is a significant age demographic shift towards the elderly, would it not therefore simply be more wise to accept this situation and commence the adaptation process based not on simply becoming cheaper but by changing form, function and services to ensure that you prevail whilst accepting that others may not.

Considering our restaurants just one more time, an alternative may have been for two restaurants to collaborate or integrate, the first opening from Tuesday to Friday and the second opening from Saturday through to Monday. This combined approach allows them to utilise the same waiting staff, the same chairs and even the same laundry. Although this will have altered the fortunes of each restaurant owner, they have at least preserved their ability to survive through an effective partnership or collaboration. Healthcare organisations need to consider the possibility of merger, acquisition, collaboration and integration from the twofold perspective of driving change in their financial metrics and securing business through the development of partnerships or relationships with those that carry influence with the clientele they wish to serve.

In conclusion, the likelihood of any particular provider making these adaptations will most likely be determined by how well clinical services accept the situation and understand what do, along with the vanity of the board and senior managers. There are emerging examples of Trusts with persistent financial challenge, not because the business cannot be turned around but because the board are unwilling to let go of the

empire they have grown. Regardless of whether inertia is a function of clinical resistance or inarticulate managerial decision-making, the result is the same; either adapt and compete, or accept that your days are numbered. That a tough message to take on an empty stomach but then if it wasn't, it probably wouldn't be the elephant in the room.

Mr Andrew Vincent
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Clinical Business Excellence Journal,
Insights Publishing Ltd
Head of Clinical Business Excellence,
Medicology Ltd

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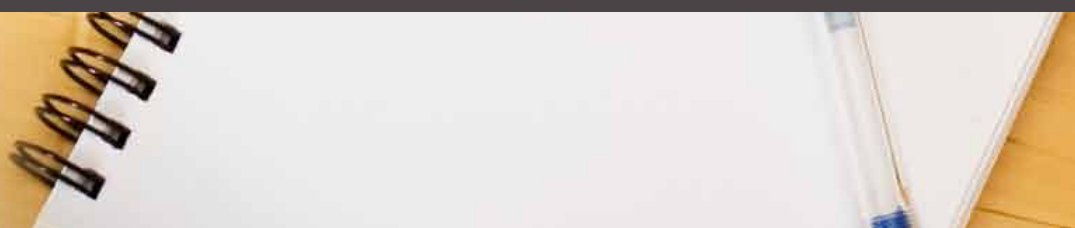


NEXT MONTH

Interview with Bob Ricketts, Director of Provider Policy at DH – What is the emerging picture for acute provider services?

Interview with Mike Farrar, NHS Confederation Chief Executive – How are acute providers leaving themselves vulnerable?

Services that don't fit the mould – Mental Health & Competition (Interview with Pete Sudbury, Barnet Enfield & Haringey)





THE CHIEF EXECUTIVE'S TRAP

The results are in and there's trouble. Expenditure is above income for the third consecutive month despite a range of cost control measures and it is clear that the Trust is heading for a significant deficit. An emergency Board meeting is called to discuss the crisis and implement an emergency plan. Little does this CEO know that he might be about to inadvertently set in motion a series of interrelated changes that could precipitate an unrelenting, irrecoverable slide.

The underlying backdrop of severe financial pressure in the system, PCT budget shortfall and a gradually worsening income-expenditure imbalance is all too familiar to many CEOs today but less familiar is the Chief Executive's Trap. The term 'trap' suggests that the CEO literally falls into it, suddenly,

and yet many have been blindly assembling their own time bomb for quite some time. Moreover, if they don't start defusing it soon, they could find themselves picking through the pieces wondering why it all went so wrong.

How do you recognise this insidious rot?

There are a number of tell tale signs that should give cause for alarm. Their individual presence does not explicitly foretell trap formation but an emerging pattern of these symptoms should start ringing alarm bells.

Examples include:

- Existence of a workforce panel to control job recruitment
- Consideration of the need for a turnaround specialist, committee or board

- Evenly applied cost improvement targets e.g. 4% in each service
- Bans on agency staff usage

The critical misassumption is the belief that these are simply symptomatic of austere times; necessary measures driven by environmental factors, rather than indicators of a damaging behavioural spiral. The underlying thought pattern runs a script along the lines of "I can't see an alternative", reinforced by gloomy messages climbing through the management layer, suggesting that change is happening too slowly and clinical services are reluctant, lethargic engagers.

What is a Chief Executive to do?

Based on a damning, projected Trust deficit of £30 million, on a cost-base of £300 million, the CEO instigates the

turnaround team, a collection of Board, senior & middle managers drawn from across the organisational infrastructure. His opening address is succinct and direct "The fate of the Trust is in your hands. You must reduce expenditure by 10% to bring us back into balance. Everyone must understand our predicament and take their fair share of the pain". The turnaround team set to work.

Their early work focuses on significant areas of expenditure, with the early hit list involving:

- Discretionary pay
- Individuals on higher PAs, especially SPAs
- Agency & locum staff
- Recruitment

Approval mechanisms are rapidly introduced to reign in service-level spend in many of the above areas and the Operations Director calls the Clinical Directors to order, demanding emergency cost improvement plans of 8% in short order. Progress seems swift and action is being taken. Cancellation of the contract with a provider of social care bed identification saves more money and two theatres are closed out of financial necessity. The year progresses and everyone holds their breath for the next set of figures.

Excitement! Expenditure is down to £275 million and the CEO's task is achieved. But wait a minute. Crisis! Income is down by £30 million and the new projected deficit is £35 million. There's also a worrying set of trends in the operational data. Sickness and absence is up, morale is down and an alarming rate of 'never events' develops. The CEO calls an emergency session of the turnaround team and the message is clear "Team, you've done an excellent job of reigning in the costs but the problem is worse than we thought. The deficit is extending and we have no choice but

to introduce significant redundancies. Cut deep and hard but try to be fair."

The Clinical Director's meeting is a sombre affair. Each service is informed that they must reduce their workforce by 10%. The turnaround team explain the predicament and reinforce the CEO's message that the cuts are inevitable but must be handled sensitively. The CDs table a motion to increase income but the Finance Director says that the PCT is essentially broke and it isn't an option. There is growing disquiet and rumours of a no-confidence vote amongst senior clinicians. Morale is at rock bottom but the changes are made and the costs come down. When the new figures are in, the cost base has tumbled but the income has eroded still further.

The CEO's career epitaph made reference to a miserable few years that saw a trail of destruction through the Trust. "We introduced the tightest of controls and made sweeping cuts but every time we regained control over the expenses, the income had dropped further. Our weighting lists climbed, our bed base was maxed out and our tertiary surgical referrals declined. With the pressure everyone was under we saw an increase in resignations from clinical directors and reluctance in others to step into the roles. This made it more difficult to push forward initiatives and in the end this slide got the better of us."

It's abundantly clear that this Chief Executive feels victim to a series of environmental factors that were so unprecedented that he just couldn't pull the Trust out of its nose dive. The irony is that he inadvertently stimulated the nose dive with his series of decisions and actions. He had fallen into the Chief Executive's Trap and even now couldn't quite comprehend how. If this is already uncomfortable reading, then

we urge you to read on. This is a trap you need to understand to avoid. It's not a finance trap, or a market-place trap; it's a behavioural trap. It stems from the natural tendency to hold on ever tighter the more you feel you are losing control.

The purpose of a Trust is to provide healthcare services to a population, whilst doing so within a viable and sustainable financial envelope. In the Payment-by-Results era, the organisation gets paid for delivering on that purpose, patient by patient. This 'best healthcare' versus 'lowest cost' is a tough balance to achieve today but suffice to say that successful Trusts maximise income whilst minimising cost. Income is driven by a modern, market-appropriate business strategy and highly productive delivery of its portfolio of services, requiring service-level strategic drive, innovation and adaptation based on the changing pattern and trends in healthcare delivery e.g. use of the community. Operational costs, at a service-level, are most influenced by the judicious use of resources i.e. responsible behaviour by those at the coalface.

The trap that this CEO fell into was to effectively mandate a purpose based on cost and to ensure that everything else was subservient to this driver. In fact, he targeted a whole team of people to focus on nothing but cost and they, in turn, passed this down the line into services. This loses sight of the fact that fiscal balance is indeed that – a balance between income and expenditure. Our CEO is entirely right to recognise that costs are too high but he has done nothing to address the balance between income and cost. In fact, almost every cost-cutting decision made had an adverse impact on income, by eroding productivity still further. In effect, he was simply shifting the curve.

The income-cost mismatch arises out of having a cost base beyond the income earning potential of the Trust. A typical Trust has a significant management layer, existing mostly to manage and control the service-delivery layer. In essence, the proportion of the organisation engaged in income-earning work is too small and almost certainly not sufficiently productive. However, that productivity is undermined BY the management layer, as it asks the service layer to jump through an ever increasing number of hoops and controls to get anything done. The management layer will no doubt reflect that if they didn't exert these controls, then the costs would spiral out of control. In times of trouble, rather than recognising that this management layer is unaffordable, we ask it to introduce even more control measures, effectively migrating more bureaucracy and hoops to the service-layer, reducing still further the proportion of the organisation devoted to income-earning activity i.e. exacerbating the imbalance.

In part, the solution is to significantly reduce the management layer to redress the balance i.e. reduce cost but NOT undermine productivity in services. However, there is a significant behavioural block to this eventuality that results from charging that same management layer with resolving the problem. Their natural tendency is towards self-preservation and so a greater proportion of the cuts get fed down to services, meaning a greater proportionate reduction in the Trust's income-earning engine than in its organisational running costs i.e. greater imbalance. The management layer defends its worth by emphasising the risk associated with simply trusting clinical services to operate responsibly and therefore how necessary its existence is to keep them in check. In truth, currently very few clinical services have the mindset and skills necessary to be given freedom

to operate and so the management layer has a point.

So, what's the solution to the Chief Executive's Trap?

The solution is comparatively simple. However, execution of the solution is not, as it requires a sensitive and planned shift of power from management to services and a massive mindset change in all concerned, not to mention a consequential 'stripping out' of the management layer. There's a definite chronology involved because it's difficult to let go of control until the skills and responsible behaviours are in place at the service level. Consequently, an early step has to be a complex behavioural and mindset change process at a clinical service level, coupled to a programme of development designed to equip that service with all of the skills it will need to operate autonomously. Services will need careful support, guidance and nurturing to help them learn how to fly, along with a rekindling of their passion for excellence and success. It's vital that services operate with a robust business model and that all staff exhibit a sense of stewardship over their service and the Trust, not just the patient.

For many Chief Executives, the above transition looks like an impossible dream, especially when currently faced with significant clinical-managerial divide and a workforce that appears to be disengaged, inflexible and resistive of change. However, these conditions are again purely symptomatic of the mismatch between required versus experienced leadership relationships i.e. well-meaning Board & management behaviour disenfranchises a highly articulate, intellectual workforce that often places patient advocacy above organisational stewardship. There are many factors and steps critical to the success of this transition but the very first

step is acceptance by the Chief Executive that the management layer and their control is part of the problem and not the solution.

Mr Andrew Vincent
Editor-in-Chief,
Clinical Business Excellence Journal,
Insights Publishing Ltd
Head of Clinical Business Excellence,
Medicology Ltd

Did this article resonate with you?

If so, then make sure you see our 'WANTED' poster opposite.

— WANTED! —

Do you worry about the 'state' of your Trust (or service)?
Are you concerned that your leaders aren't doing the right things?
Does the level of inertia or direction of travel concern you?
Are you frightened by the over-focus on cost?
Do you feel vulnerable in the emerging landscape?

If you answered 'yes' to some or all of the above questions then we'd like you to answer an even more important one:



Are you motivated enough to do something positive about it?

If you answered 'yes' to the last one, we'd like to invite you to at least discover what we're doing with a select but growing group of like-minded individuals who know there must be a better alternative to the current situation. Whether it's extending their knowledge of the real problems we face or discovering how to exert more influence, it's a journey they're deciding is better done in collaboration than isolation.

To find out more, drop a quick email to andrew@medicology.co.uk and I'll happily send you more information.



Important Foot note

What I won't do is try to sell you anything. I want to be clear that this is not what this is about. Despite this assurance, many will not have the motivation to email and that's fine because we're only interested in individuals with the motivation to act and the open-mindedness not to pre-judge.

Background

The (mysterious) project or movement in question is a collaboration between Andrew Vincent, Head of Clinical Business Excellence at Medicology and Dr Steve Allder, Assistant Medical Director & Consultant Neurologist, Plymouth Hospitals NHS Trust, both of whom believe that the right answers, approaches and adaptations are not gaining momentum. We're doing something about it. Are you?



Clinicians voice concerns after MPs pass NHS reforms bill

Healthcare professionals - including representatives from the Royal College of Nursing (RCN) and the Royal College of General Practitioners (RCGP) - have voiced concerns about the Government's controversial Health and Social Care Bill after it was passed this week by MPs.

The Bill, which will replace primary care trusts with clinical commissioning groups, went back to the Commons after the Government agreed to make changes following its much criticised 'listening exercise' on the reforms.

It was approved by MPs by a majority of 65 votes and will now go back to Lords. Dr Clare Gerada, Chair of the RCGP, said the College supported the move to put clinicians, including GPs, at the centre of planning health services but continued to have "a number of concerns" about the reforms agenda.

She continued: "As a college we are extremely worried that these reforms, if implemented in their current format, will lead to an increase in damaging competition, an increase in health inequalities, and to massively increased costs in implementing this new system.

"As independent research demonstrates, the NHS is one of the most efficient health care systems in the world and we must keep it that way."

The RCN also voiced its concerns following David Cameron's suggestion that the College supported the implementation of the Bill.

RCN General Secretary Dr Peter Carter said that while the government had listened in a number of areas, there remained "very serious concerns about where these reforms leave a health service already facing an unprecedented financial challenge."

Carter warned that patients' and nurses' interests were under threat through the combined effects of health service cuts, waste and bureaucracy.

He added: "We will continue to present detailed argument and analysis to Parliament on the detail of the Bill to try and build on the changes that have been made and secure a change of direction on some of the most worrying aspects of the reforms."

NHS leaders worried over waiting times, says Farrar

New NHS (Pharmaceutical Services) Amendment Regulations laid before Parliament this week have been welcomed by the Royal Pharmaceutical Society (RPS).

Commenting on the Regulations, Lindsey Gilpin from the RPS English Pharmacy Board said: "It is clear that the spirit of these regulations is to introduce measures which further protect the public and foster an environment which will enhance the service that patients receive. This is to be welcomed.

"It is important that clinical governance and quality improvement keep step with the increasingly clinical role of the pharmacist.

"Both the public and commissioners can be assured that community pharmacy is taking the issue of public safety and quality very seriously indeed. However, sensitive implementation will be critical and I would ask employers and NHS managers to think about how they can remove the bureaucratic burden from frontline professionals, rather than how much more paperwork will be needed to implement these regulations.

Passage of Health Bill means “big opportunities” for private sector says Howe



The passing of the Health and Social Care Bill will create “big opportunities” for the private sector says the health minister in charge of steering the NHS reform bill through the House of Lords.

Former banker Lord Howe told an audience of private sector providers that though the NHS “will not give up their patients easily”, there were opportunities for those wishing to ‘enter the fray’.

He said: “The opening up of the NHS creates genuine opportunities for those of you who can offer high quality, convenient services that compete favourably with current NHS care. If you can do that then you can do well.

“But you know that won’t be easy, the NHS isn’t a place to earn a fast buck and as I said there are some outstanding performers in the NHS and they will not give up their patients easily, but I know that those who are serious about entering the fray are also determined to rise to the challenge, to deliver excellent care, to stand on your own merits against the best the public sector has to offer to bring new levels of choice and quality to patients.”

Responding to Earl Howe’s comments, John Healey MP, Labour’s Shadow Health Secretary, said: “Time and time again, David Cameron has tried to claim that his reckless reorganisation is not about privatising the NHS - but now his own health minister has exposed the true purpose of the Tories NHS plans, saying that the reorganisation presents ‘huge opportunities’ for the private sector.

“This confirms what doctors, nurses, health professionals, patients’ groups and Labour have all warned – the Tories’ NHS plans will fragment our health service by placing competition ahead of patient care.

“David Cameron is undermining the NHS with an incompetent and bureaucratic reorganisation which puts profit before patients.”

Mental health problems affect one in three Europeans finds major new study

More than a third of people in Europe (38.2 per cent) are affected by mental disorders according to a major new study.

People in all age groups are affected, with the most frequent problems including anxiety disorders (14 per cent), insomnia (seven per cent) and major depression (6.9 per cent).

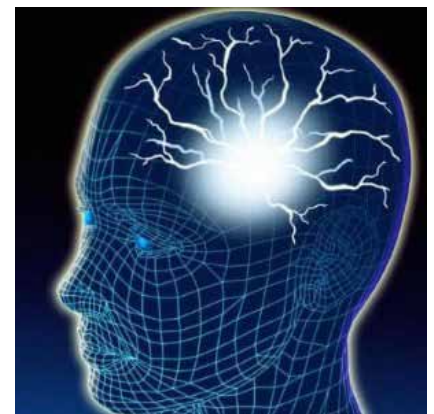
Mental disorders are now Europe’s largest health challenge, with the majority remaining untreated, according to the three-year study which has been published in the journal: *European Neuropsychopharmacology*.

Researchers looked at 30 countries and

514 million people, recording all major mental disorders for children, adolescents, adults and the elderly. They observed that rates of mental disorders do not appear to be rising, with the exception of dementia, which is becoming more common due to increases in life expectancy.

The study’s principal investigator and joint first author, Hans-Ulrich Wittchen, said the “immense” treatment gap for mental disorders must be addressed and also called for increased funding of research into the causes and treatment of brain disorders, as well as better allocation of treatment resources.

Paul Farmer, Chief Executive of mental health charity Mind, said: “With only one



in three people with a mental health problem receiving treatment for their condition, it is essential that significant investment is made into improving these rates so that mental health is given a parity of esteem with physical health.”



Doctors and fellow healthcare professionals urged to get flu jab

Healthcare professionals - including doctors, GPs, hospital nurses and midwives - are among those least likely to have the seasonal flu jab according to a new Department of Health report published this week.

The latest seasonal flu vaccine uptake reports show, for the first time, those healthcare workers by occupation who accepted the scientific advice and who chose to protect themselves against flu last winter. Uptake was revealed as:

- 30 per cent of nurses, including hospital nurses and midwives
- 42.5 per cent of GP practice nurses
- 38.2 per cent of GPs
- 37 per cent of doctors excluding GPs

The number of healthcare workers getting the vaccine had increased from 26.4 per cent in the 2009 winter to 34.7 per cent in 2010. However the majority of nurses who work with the most critically ill over the winter months and midwives who work with pregnant women, were left vulnerable to flu, its potentially life

threatening complications and passing it onto patients and family.

Chief Medical Officer Dame Sally Davies added: "NHS staff face increased pressure over winter, especially if there is a severe flu season. They keep the NHS running and it is vital that they protect themselves, their patients and families from the potentially serious effects of flu that they are exposed to over the winter period.

"It is never too early to start thinking about flu. So as NHS staff return from their holidays, I urge them to plan ahead and get vaccinated."

Public Health Minister Anne Milton added: "I urge all of our dedicated nurses, especially those who work with the sickest patients and midwives working with pregnant women, to protect themselves and their patients from flu. I hope these figures will provide a reminder for all healthcare professionals to start thinking about flu now and plan when they will get vaccinated this year."

Ministers meet healthcare entrepreneurs in Northern Ireland

Health and Enterprise Ministers in Northern Ireland met with local healthcare entrepreneurs this week to see how using technology can enhance patient care.

During a visit to Connected Health Ltd in the town of Lisnaskea, Edwin Poots and Arlene Foster met with the entrepreneurs who established the company (which provides domiciliary care) and toured the facilities. The Ministers then met to discuss how their Departments' agendas of enhancing patient care and improving the economy can overlap and be mutually beneficial in this area.

Health Minister Edwin Poots said: "Connected Health aims to improve patient care through the use of technology. My Department established the European Centre for Connected Health in 2008 and since then, the Centre has piloted a remote telemonitoring service for people with chronic disease in Northern Ireland.

"Evidence shows that when technology is used for remote monitoring of patients' vital signs in their homes, we can intervene early when problems arise and avoid hospital admissions."

The Ministers then met with Invest Northern Ireland and Department of Health, Social Services and Public Safety officials to discuss how both Departments can work together to deliver improvements to people's health whilst also contributing to the economy.

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A primary purpose of the journal is to increase clinical-managerial collaboration. Our reach into management is not as strong as with clinical teams and so if the articles resonate, please do pass on the link or journal reference to your managerial counterparts.

WAKING UP CREATIVITY

IS TRUST COMPETITIVENESS BEING UNDERMINED BY A LACK OF FOCUS?

Within moments of meeting Patrick Harris it is clear that here is a man in possession of a formidable intellect; someone with an extensive track record of achievement in the upper echelons of the commercial world. A specialist in strategy and future trends, Patrick's enviable CV boasts a number of highly successful roles, including: running his own consultancy, thoughtengine; as a founding member of Leadership Works, a Holland-based think tank focused on the future of leadership, and as Director of Creativity with the telecom giant Orange where he helped create the Orange Strategic Think Tank – the mechanism which underpinned the company's group wide strategy.

All of these he performed with considerable professionalism and distinction, traits he has carried forward to his current role as the UK Director of the global foresight and futures consultancy, The Futures Company – an organisation that has worked closely with many leading private and public sector healthcare bodies including BUPA, the Teenage Cancer Trust and the Department of Health's Maternity Policy Team.

It is in his capacity as Director of The Futures Company's UK operations and his experience with Orange that Patrick

has been invited to speak at the 2012 NHS Leadership Summit – an event which has been specifically designed for NHS services and Trusts and at which Patrick will act as a guide on the topic: Developing Customer-Centric, Trend-leading Innovation for Competitive Advantage.

During his time at Orange, Patrick was an expert in the field of disruptive innovation (i.e. the term used to describe innovations that improve a product or service in ways that a market does not expect) and was renowned for offering something a bit different – zagging whilst the rest of the world zigs – to attract customers. At the Summit Patrick will warn of the future changes, challenges and opportunities. He will discuss examples of people-centric innovation that led to competitive advantage and outline how this would look in the healthcare arena. With a finite pool and a finite budget, Trusts are under increasing pressure to innovate and the area of patient and public centricity will be vital to ensuring that a Trust develops a sustainable form of service that is appealing to service users.

Ahead of this much anticipated appearance, Clinical Business Excellence caught up with Patrick in the heart of London's financial sector to discuss,

amongst other things, how the conformist outlook found in many Trusts must change so that competitiveness flourishes and services can survive in a harsh winners and loser's environment.

"How can you conform in a (healthcare) market where competition is meant to be the driver?" asks Patrick by way of an opening salvo. "That jars with me straightaway. I think organisations that play in that space have to know and announce their differentiation. I can imagine some players being able to work diligently on the service they provide, the service they give, to make it the best that they possibly can provide. I can imagine another player responding in a completely different way with a branded response with maybe not as much time on the service. We're talking more about the great things that they do. So one has a different view based on the reality of the service and another has a view based on the perception of the service. I like that. Isn't that what's going to drive a market-based economy, a market-based system?"

Andrew Vincent, Editor-in-Chief of Clinical Business Excellence, put it to Patrick that: "The way healthcare has traditionally been organised has been based on conformity. Something is discovered in the evidence, then in reality that's what you want everyone to do and that's fallen

over from the clinical work where you determine what is the best treatment and you want everyone to use it consistently. So all the systems get set up the same, the pathways are the same and that's been convenient to organise when you're commissioning an actual system because then you can have a series of regional commissioners and each one kind of knows what they've got to commission, there's a class.

"And yet, if everybody is the same, then the ability to differentiate and move ahead is very, very difficult. So this is the innovation question. When you've been used to operating in this very fixed mode, and I completely agree with there being potential winners and losers in the market, how do you start to initiate that change and what sorts of things need to be happening to make an organisation change that way of working?"

Patrick pauses for a moment to let his thoughts find their target. He is clear that without a long-term focus about what the real issues are, many organisations will operate with a short-term, reactive, rather than proactive, outlook.

"The other thing I would qualify is medium to long-term. So if we look short-term, then what we need is a medium to long-term. Not necessarily just long-term. The medium to long-term future I think is very, very helpful. There's a lovely phrase that goes something like: 'we only look at the future to make better decisions today.' I think that's a wonderful example of what we're trying to do. No one wants to look at the future and fall in love with the process just for that reason. We do that to make better decisions today."

So how would Patrick advise a service to organise and go beyond its internal interests and historical perspectives and access trends for the people it serves,



which is an uncomfortable process in health generally due to the ancillary mindsets involved?

"I think it's important for an organisation to look beyond the areas it can control. Think of three concentric circles. The first (circle) is - what are we and what can we do about it? I think most organisations find it comfortable there. The danger is that they ignore what's happening in the external environment and its stakeholders.

"The next circle - what stakeholders are involved and what do they need from this process? That's not necessarily out of your control, but you certainly have less control over it. You need to think about what they want, what they need, and that might be patients, it might be providers, and it might be investors.

"The third circle is about the environment. You have no control at all over this area. These are things you prepare for, adapt to, or strategise around. Some of these things look pretty straightforward, like the current financial crisis we're in. Some of them are uncertainties that you don't know how they'll play out, such as how we're going to deal with climate change.

"How you deal with those uncertain areas is very, very different and you need to get a view on them so you that you can prepare for what might happen. A phrase that I like to use, which I think I've stolen from Arie de Geus who wrote *The Living Company*, says, 'If you can have memories of the past, it's also enormously important to have memories of the future.'

"And a memory of the future is to consider possible scenes or scenarios, or drivers or forces of change that might be important, and to understand trigger points and how they may develop, and then you can see them develop in front of you. And when they do, you can adapt and respond. So working with that outer circle - the organisation, the stakeholders and the environment - is not about being right, it's not about predicting, it's about understanding, so you're ready to respond and adapt at the right time and place."

So, Patrick's certainly a man with his mind in the future and with such a powerful history of leading success for organisations based on that mind, we are certain there will be some profound insights shared at the Healthcare Leadership Summit.

WHAT DO YOU THINK MAKES A SUCCESSFUL CLINICAL SERVICE TODAY?

QUICK Q & A WITH DR SARA WATKIN, CONSULTANT NEONATOLOGIST & CLINICAL SERVICE LEAD, UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION

In a highly pertinent and deliberately to the point interview, we wanted to delve a little further into the question of what makes a successful clinical service today. Not every service falls neatly into the standard mould of a typical medical or surgical service and as we seek to provide more clarity on how to think about current healthcare reform, it is vital that we consider both mainstream, typical services and those that are slightly left of centre. Dr Watkins service is a somewhat unique, highly specialist tertiary service with a very famous paediatric and neonatal neighbour in the form of Great Ormond Street Hospital.

So what makes a successful clinical service today?

(Dr Watkin) A service needs to be very clear about where it wants to go and what its vision is, as well as who its customers are and what type of customers it really wants to attract. I also think that it's vision ideally should be one that it can share with its key stakeholders. For instance, neonatal services absolutely

need to work closely with their obstetric counterparts. If we each end up with incompatible visions then it's not can to make it easy for either office. The service also needs to be realistic about it can or should do, given that everything it would like to do is probably well beyond the level of funding or resources that will be available. I think it is really important that it has happy, well-motivated staff and that the team works well together.

You touched on making an active choice about what type of customers you wish to attract. Can you give me an example?

Certainly. We need to be clear whether our core focus is lots of well women, each having babies with a relatively low likelihood of serious problems, or much sicker women, with all likely to have infants with complex problems. If you haven't decided on things like this is really easy to make the wrong decisions or end up doing predominantly the wrong type of work.

These are big strategic questions. How does a successful service ensure it makes the right decisions or decisions that are in its best interests?

Well, in truth there are lots of services at the moment struggling to work out what the right decisions are. I think it is really important to consider what sorts of things will influence you and what you do in the future. I mean things like, in our environment, changes to the birth rate or macroeconomic conditions that could impact available funding. Also, you have to make sure you properly understand the business you are in, as well as any major factors within your own specialty that are likely to influence you in the future.

Can you give me an example?

Sure. You may have seen that there is some debate at the moment about what babies should be treated and where to treat them most appropriately. If we were a smaller, locally focused NICU I would be particularly worried about the possibility that commissioners might

choose to stop funding only care of very small babies in these types of units. At our level, a commissioning decision like that might mean we start to get an increase of babies at the margins of viability. If you're going to get strategy right then you at least need to consider what the sorts of things might mean to your service.

You have a number of fellow consultants, some with academic interests, as well as NHS ones. Just how easy is it to get people to agree or reach consensus on what the strategy should be?

It's not always easy but you have to persevere. If you don't have consensus on what you should be doing and where you should be going then you find individuals are going off at tangents and investing time and sometimes money in things that just won't do you any good in the future. This is vanity rather than strategy and really everybody needs to agree with the vision and throw their all into making it happen. It's really difficult to maintain a consistent course or path when everybody has a different idea about what we need to do.

It sounds like this is a leadership and change issue. How do you approach it?

Well, significant change is not easy. It's easier when everybody at least accepts the need to change and sees change as an everyday activity or the norm, rather than something more episodic and painful. I think that it is important to invest time and effort in building the need to change. It doesn't really work simply telling people what to do or where we are going and I find it better to try to build a desire to change and then harness that desire or drive to make things happen. Sometimes, it seems like two paces forward and one pace back and you just have to accept that different people see things in a very different light. However, this is far more likely when you haven't taken the trouble

to ensure everybody fully understands what's going on.

So where do you find that it gets stuck?

I find that there are always negative detractors, for instance someone who is stuck in the past and won't even look at new options with an open mind. However, after many years in different leadership roles have come to believe that this is most likely when people don't recognise what is happening around them or don't see it as relevant to them, or affecting them. If you put more effort into educating them and ensuring that they genuinely see what is going on, they develop a desire to change and start encouraging you, rather than the other way round.

Let me ask you about competition and how this agenda influences something like a neonatal service?

I think that many neonatologists would say that we aren't in competition with each other and you have to remember that we are organised into collaborative networks. However, if you look at London as an example, there are lots of level 3 neonatal units wanting to care for a very finite number of babies. I think that we have always competed internally for limited resources, especially for capital funding. I believe that part of the bigger picture changes that we need to make is to reconsider how we make sure we look after the whole and not just our individual little bit. I do think that we compete for the best trainees and that this influences our success. So, were not really competing for cash in the same way that many other services are but how competitive we are does influence whether we get the best people, which has a knock-on effect on how easy it is to get the care right.

So what you are saying is that all services effectively compete with each other, no matter what type or specialty, because there isn't sufficient funding in the system for everybody to get what they want?

Yes that is broadly true or true enough that we do need to pay attention to how attractive we are from both the staff and patient / parents perspective, as well as corporately. Many individuals within management don't really understand a neonatal service beyond what it costs and what it brings in in income. However, I'd say to them if you get neonatal care right then you can create the most immense sense of loyalty that ensures the family and possibly relatives become lifelong committed supporters of the Trust. The flipside of this is that if you really don't get it right it, they probably won't revisit again themselves and they are quite likely to go onto the web and social networking sites to tell everybody about the experience they had.

So, a successful service today is one that is acutely aware of what is going on around it and has a propensity to adapt proactively, rather than waiting to see what happens to everyone else. It has a highly committed team, takes decisions utilising consensus and invests time in ensuring everyone understands the bigger picture. It's very clear that success comes from addressing the bigger picture and not necessary from remaining blinkered and embroiled in the detail.

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