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Upcoming Date
21st December 2011, London

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WELCOME TO CLINICAL BUSINESS EXCELLENCE

I am delighted to welcome you to the second 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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THE DISRUPTIVE INNOVATOR'S APPROACH

HOW CIRCLE HEALTH IS RADICALLY CHANGING THE DELIVERY MODEL

In the first of our series of interviews with Mr Ali Parsa, Social Entrepreneur and Chief Executive of Circle, Mr Parsa discussed the importance of the clinical-managerial role dynamic with Andrew Vincent, Head of Clinical Business Excellence and Managing Director of Medicology (Clinical Business Excellence, September 2011).

In part 2, Andrew examines how the methodology Mr Parsa employs in Circle helps lead to real competitive advantage and how slower moving organisations - riddled with inertia, resistant to change and not fit for purpose - are at serious

risk of operational and financial oblivion in a system that increasingly takes no prisoners.

With a clear like-mindedness between both of these organisational leaders, Andrew was keen to learn what Mr Parsa lent his time, effort, and focus to, as micromanagement clearly does not play a part in the Circle way of doing things. It turns out that Mr Parsa spends a good deal of time leading innovation and improvement on critical elements of competitiveness.

"We need to figure out our model and to me, this is about reinventing how you manage a product in healthcare," explains Mr Parsa. "That's our big model. So, we have an idea of how much money we should spend to build it [a hospital], how much money we should spend to commission it, how much money we should lose operating it, and what it should make eventually."

"When you add up all of the money we spend on commissioning it, building it, and losing money on it, it's still significantly less than what our competitors may do in

buying a private hospital next door to us – a 44 year-old building. So we create, from scratch, a state of the art hospital that is significantly better than the old hospital at a lot less cost. So, by that measure we are a tremendous success.”

Of course, true success in a commercial organisation isn't just measured in whether it did what it set out to do. Did it make money at it? Did it create shareholder value? Anyone examining the business performance of Circle will see that it isn't entirely plain sailing, despite the successful attainment of some very clear aims. Mr Parsa was philosophical about the ups and downs in the business metrics of a business clearly innovating in a difficult area.

“So, we've done that [created the better hospital at lower cost]...that's where we thought we were going to be. However, you look at any disruptive innovation. You look at the share price and it tells you a great story. We just went through a gigantic rise. Why? Because everyone bought into the euphoria. They bought into the great idea. Then it's a complete collapse [the share price]. Why? Because it's a lot more difficult to do it than it was to talk about it. Then it's about five or six years of the share price not moving, basically just going up and down, up and down, up and down. That's the story of almost any company that needs to reengineer a process or build anything.”

“Now, this doesn't happen with Facebook or Google because they were moving into a market that doesn't exist, they created a new market and what they benefited from is a migration of value into that new market. But if you're in an existing market and you're reengineering it, you're always going to have euphoria.”

“It's the same for me. We build at £3,500 per square meter. The NHS builds at £5,000 per

square meter and we are geniuses. How much more expensive should a hospital be? Now, I have a competitive advantage over everybody else. I can build hospitals at £2,500 per square meter and everyone else does it at £5,000 per square meter. Now, I've made money. Now, I've created value because I've figured out how you go from what it takes everybody else to do to what it takes me to do.”

Nodding profusely, Andrew suggests to Mr Parsa that his approach sits very closely to the disruptive innovation model as a whole, in particular the commoditisation of aspects of health, something that has always been vigorously resisted by the system. Andrew highlights the fact that many aspects of diagnosis and treatment have a robust evidence-base and deep understanding behind them and a simply pathway to execute to deliver the healthcare interventions and yet Trusts remain hell-bent on retaining these elements of healthcare in expensive-to-run, inefficient organisations, delivered by expert, expensive individuals that would be better re-tasked onto work that better stretches their expertise.

“The problem with the system is not the people in the system”, ventures Mr Parsa. “The problem with the system is the system. The system says because IBM was a great company, we should all be like IBM. And the truth of the matter is 90% of global profitability in technology belonged to IBM. Globally, they dominated everything.”

“But in 1975 someone invented the PC. What did the PC do? It meant that now everyone could play. And you didn't need IBM's permission as you did in the past when if you wanted technology and you had great ideas, you had to get hired by IBM. Whatever great idea you had you had to present to a committee. Then what happened? Then you had Microsoft, then you had Oracle, then you had Yahoo,

then Yahoo didn't do what Google did, then Google didn't do what YouTube did, YouTube didn't do what Facebook did etc.”

“All of this innovation came about because we unleashed the process. For every Facebook that you and I know about, there are thousands that fail and nobody knows about that, but who cares? That's the rule of biology. For every cell that exists, for every human being or animal, there are many that are eliminated because they were just not right. So that's what we have got in the system.”

“Google, when it was created, went to Yahoo and said 'buy me for a million dollars.' These wise guys, who were at the forefront of internet innovation, turned around and said it was never going to work – they were not going to buy it. They believed that what they had was good enough. Now look where Yahoo is and look where Google is. Now, what is it about our systems that make us believe we are never going to do a Yahoo. Microsoft couldn't figure out what Yahoo did or what Google did. All of us believe that Bill Gates is one of the most creative people in technology and as a result he's a super billionaire, but he couldn't figure it out. This is why Facebook and all of that happened.”

Making references to his own experiences trying to help Trusts adapt to a new environment, Andrew talks about the necessity for Google-like system reform – a whole new approach to healthcare organisation and delivery – that just isn't happening. Pointing out that Trusts seem to simply keep tightening their belt financially without ever re-visiting whether or not they need to complete change the way they do things, Andrew questions why innovation is so difficult to encourage in the NHS, especially given its huge density of highly intellectual minds.

“Try being a senior manager in an NHS



hospital with so many organisations, associations, regulators, busy bodies that you have to respond to," proposes Mr Parsa. "Will you ever get the time to walk the floor? Will you ever get the time to know every doctor? This idea that the NHS has bad managers really upsets me because the NHS employs 1.4 million people, perhaps 1,400 very senior managers. So, out of every thousand people that work there, one has risen to the very top. In any institution, in any place that you're one in a thousand, you're an extraordinary person."

Reflecting on these discussions with a social entrepreneur clearly unshackled from a system that seems to prefer conformity over diversity, Andrew shares his own perspective on the difficulty of creating genuine change, regardless of the necessity to do so.

"There are so many challenges to genuine innovation, not least of which is that highly intelligent individuals, both clinical and managerial, get precious little time to devote to new ideas and it's been getting worse recently. There are very real blocks to realising an innovation, for instance payment systems pay you to do

one thing and they aren't geared towards supporting a different thing. That's something that has to change or we end up with a system hard-wired to remain the same – it penalises the innovators."

"I am perhaps most worried about the way we lead clinical services. We put a Clinical Director in place, given them precious little time to do the job and what little they have we tie in knots getting them to jump through administrative hoops rather than genuinely lead. How much time do they spend reforming services? What do we do to foster innovation at the service level? Most of the focus is on taking away things that are important to consultants and then we wonder why they resist change, rather than lead it. I believe that every innovation we need is currently sitting inside the minds of the immensely intellectual front line teams. If we're not seeing it then it's because we're not releasing it. It certainly isn't because it's not there."

Fraser Tennant,
Medicology Ltd

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graph LR; IDEA[IDEA] --> ANALYSIS[ANALYSIS]; ANALYSIS --> DEVELOP[DEVELOP]; DEVELOP --> IN[IN];
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HONOURING THE INNOVATOR'S PRESCRIPTION

THE BEGINNING OF A NEW ERA OF UNDERSTANDING HEALTHCARE PROVISION

'Disruptive innovation' is a term that is starting to appear with more frequency in the NHS arena. Paul Corrigan, health advisor to Tony Blair under the Labour government, has recently published a paper entitled 'The hospital is dead; long live the hospital', which bases its argument around the content of Clayton Christensen's book 'The Innovator's Prescription'. Mark Britnell, Chair of Global Healthcare Practice at KPMG, also quoted The Innovator's Prescription in a recent article in the Health Service Journal (HSJ). So what is disruptive innovation and what can it tell us about the challenges that we face in healthcare and, specifically, those that we face in the modern NHS?

The Innovator's Prescription is a serious endeavour. This is how Clayton Christensen introduces his book:

I was an innocent bystander in 1998, happily ensconced in the study of innovation at Harvard Business School, when Professor Elizabeth Armstrong, of the Harvard Medical School, changed

my career with an irresistible invitation "Everyone else is trying to solve the problems of expensive healthcare by studying healthcare. I'd bet if you stood aside the industry and examined it through the lens of your research on innovation, you'd be able to see things that others can't". A short while later Dr Jerry Grossman, then a Fellow at Harvard's Kennedy School of Government, made the same invitation. Rising to their challenge and producing this book has taken ten years.

As you read the book, you become aware that you are reading something with profound implications. However, while the individual components of the ideas are not too complicated to grasp, the historical lessons from other sectors paint a vivid picture of how complicated and turbulent the adoption of this approach would be to healthcare. The book also contains definitive statements at times, often stating that certain things have "never happened" and in other cases stating that things are "almost always" determined

in a particular fashion, with few specific exceptions. Such clear assertions stand out and as a result the book demands the close attention of its readers in a way that few others of its ilk require.

The introduction to the book is available on 'The Innovator's Prescription' website and gives a very thorough overview of the concepts and content of the whole book. It also sets out a 'roadmap' to affordable healthcare. This article is taken from the mini summary described at the end of the introduction. I believe it is absolutely vital to stress that adopting this approach will only be a success if the whole of the message is incorporated; it cannot be hived off and applied in discrete elements. However, for ease of introduction and in order to ensure the message of the book is translated clearly, I will describe each of the elements below.

Almost every industry has faced the challenge healthcare faces today

The challenge that healthcare faces today is making 'products' affordable and conveniently accessible to most people.



The transformational force that has led to this achievement in other industries is 'disruptive innovation'.

Disruptive innovation occurs when three enablers emerge:

- Simplifying technology;
- Business model innovation; and
- A disruptive value network.

The key technological enablers for health, which will transform the problem of healthcare from something that requires deep training, intuition and iteration to resolve into a problem that can be addressed in a predictable, rule based way, are diagnostic abilities. The precise definition of the problem has been the prerequisite to the development of a predictably effective solution in every industry that has been studied; this is the starting point.

The example given by Christensen is of how cancer treatment is moving towards precision medicine, with the specific

example of Imatinib being used as a treatment for chronic myeloid leukaemia and Herceptin for HER-2 receptor positive breast cancer. Applying these treatments effectively has only been possible because of the precise nature of the diagnosis; the more that medicine moves in this direction, so the potential impact of disruptive innovation becomes increasingly apparent.

However, leveraging the improved quality and reduced cost will only be possible if the second of the enablers has been put into place; this is business model innovation. There are three types of business model:

- **Solution shops** – an example would be management consultancy;
- **Value added process** – car manufacturing provides the best example of this business model; and
- **Facilitated network** – EBAY or Amazon operate according to the final business model.

The reason why it is vital to make the distinction between these business

models lies in the fact that the way that we pay for the value associated with each of the models is different.

For example, in solution shops, the value comes from taking a complicated problem, solving it precisely, and reducing the downstream costs associated with that problem. This is best illustrated by considering the diagnosis of a recent patient, who was admitted on multiple occasions for long stays (over 180 days a year) with difficult to control seizures. He was transferred to a national centre for more detailed assessment, which identified a focal abnormality that was amenable to surgery. Since surgery, there have been no subsequent inpatient admissions and his quality of life and prospects for work are completely transformed. So, while the diagnostic workup may seem expensive in the short term, the downstream benefits more than justify the investment.

In a value added process business model, it is possible to offer the customer a fixed price for a service and, often, even a

guarantee after the service. This is because the process is so well understood that the cost and outcome can be accurately predicted ahead of time. This business model could apply to most elective surgery in healthcare today.

The reason that this is important lies in a very interesting concept, termed 'overhead burden'. Research has shown that as the number of product lines one organisation runs doubles, so the overhead costs associated with running the organisation increases by 27%. In *The Innovator's Prescription* the example of inguinal hernia repair is cited; in a hospital in Canada that only does hernia repairs, the cost for a procedure was \$2,000. In a standard American hospital, the cost is \$7,000. The standard hospital is running 75 different surgical 'product lines', the Canadian hospital only one. The difference in cost is solely determined by the overhead burden. This is clearly an essential insight and offers a radically different explanation for the spiralling costs associated with healthcare provision.

The final business model is termed 'facilitated networks'. Most healthcare cost today relates to patients with chronic and multiple conditions. Care of these patients would be hugely enhanced through networks that provide patients', and the clinicians treating them, with accurate, accessible and timely information. A real example of this in the NHS would be the adoption of the Picture Archiving and Communications System (PACS), which in my own experience has completely transformed the accessibility of scans and x-rays. The way that facilitated networks tend to be funded is through a fee for membership or fee per transaction.

The importance of business model innovation cannot be overstated. To quote Christensen:

Many who have written about the problems of healthcare decry the fact that the value of healthcare services being offered by hospitals and doctors is not being measured. To them, we would explain that the reason isn't that these providers don't want to provide measurable value; they simply can't, because under the same roof, they have conflated fundamentally different business models whose metrics of output, value, and payment are incompatible with one another (2009; page xxvi)

The final enabler of the disruptive innovation is the 'disruptive value network'. The book makes it clear that individual players, who develop either disruptive technological enablers or disruptive business models, only succeed when the system within which they are attempting to embed these disruptive approaches, becomes receptive. This is challenging because such a development runs counter to how people conceive free markets.

These concepts are new to healthcare. They are also complicated and rub up against conventional orthodoxy. However, Christensen points out that there are three additional, specific lessons to which healthcare must pay particular heed:

1. The technical enablers almost always emerge from within the leading institutions in the industry. However, the business model innovations do not. Almost always, these are forged by new entrants to the industry. Therefore, regulators must be aware of the attempts of leading institutions to outlaw business model innovation. Regulation should facilitate new entrants;
2. Disruption rarely happens on a piecemeal basis. Therefore, disruptive business models such as value added process clinics and facilitated networks must be married with disruptive

innovations in reimbursement to produce the full impact. Furthermore, this will require a much higher degree of integration than has been the norm in the healthcare industry to date. Importantly, difficult though it will be, providers will need to disrupt themselves.

3. In every industry, the energy, talent, and resources of the leading organisations in the established system always concentrate on improving their best products. When a disruptive technological enabler emerges, the leaders in the established system disparage and discourage it because, with the orientation towards simplicity, the disruption does not appear to solve the complicated problems on which the leading experts work. This highlights another pervasive pattern; disruptive innovations are always successfully deployed against the systems' simplest problems first.

In my next article, I will relate what this roadmap might mean for the current healthcare reforms and developments in the NHS over the next decade.

¹ *The hospital is dead, long live the hospital* (2011) Reform – see <http://www.reform.co.uk/Research/ResearchArticles/tabid/82/smId/378/ArticleID/1559/refTab/161/t/The%20hospital%20is%20dead%20long%20live%20the%20hospital/Default.aspx> for more details

² *The Innovator's Prescription: a disruptive solution for health care* (2009) Christensen, C., Grossman, J.H., and Hwanh, J., McGraw-Hill Books

³ *This marriage is going to take work* (22 September 2011) *Health Service Journal* – see <http://www.hsj.co.uk/> for further details

By Dr Steve Allder, Assistant Medical Director & Consultant Neurologist, Plymouth Hospitals NHS Trust



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WILL YOUR SERVICE LEARN TO FLY, RAPIDLY, OR SIMPLY FALTER?

WE'D LIKE TO ARGUE THAT THE ANSWER MIGHT JUST LIE WITHIN. WHETHER YOU FIND OUT WILL BE BASED ON A DECISION – DO I READ OR DO I DELETE?

The context in a nutshell

I think that it's important to appreciate that as we enter a period of enormous financial scarcity, with growing demand and an ageing population time bomb, the system that we have, however good we may think it is, just isn't going to be sustainable. Sustainability would require the ability to tighten up efficiency and cut cost to the point that available funding covers the cost of service provision. However, the way in which we organise services, including who undertakes what aspects of care, virtually precludes that from the get go. Even if this were not true, it is difficult to ignore that we have spent a decade ploughing more money into health whilst watching efficiency decline, rather than improve. It is very difficult to imagine that this trend

will suddenly reverse, simply because belts are a little tighter than before. In reality, the more likely outcome is that Trusts, in their attempts to sufficiently cut costs in this impossible equation, will precipitate with ever more frequency the sort of clinical quality collapse that we have seen in Mid Staffordshire Hospital. Succinctly put, the system will break unless the system changes and even change may not completely stop it from breaking.

You don't need to be a rocket scientist to understand what this picture is telling you but you do need to be brave to acknowledge what it really means.

The system will break and probably in

many places. The critical question is will it break in your service or Trust? That very much depends on the choices you and your colleagues make because it is by no means inevitable but currently it may well be highly likely.

Government solution in a nutshell

Firstly, let's get a few things straight. This is a problem the likes of which we have never seen before and so it's no real surprise that we're struggling to find a solution. Government are used to pulling many levers to resolve challenges but let's consider today's levers and whether they can be pulled at all:

- Government can't influence the ageing population
 - Changing population behaviour
-

We encourage everyone to do the maths:

- ☹️ 17% growth in population in next 25 years
- ☹️ 63% rise in aged over 65s
- ☹️ 100+% rise in aged over 85s
- ☹️ Obesity – rising
- ☹️ Diabetes – rising
- ☹️ Healthcare inflation – 4.7 to 7+% depending on who you ask
- ☹️ Rate of increase of funding – 0%
- ☹️ Rate of growth of GDP – flat (and possibly declining)
- ☹️ Ability of Government to add more cash – no chance

to effect a change in health status is hugely difficult

- Government can't influence inbound migration whilst we are in the EU
- Government is fundamentally struggling to influence our economic circumstances because of global financial turmoil, not just local

As a country, we're already broke and if we borrow more money the global economy will likely catch a cold of class 4 hurricane magnitude. We can already see how much it is sneezing with Greece, Italy, Portugal and Ireland. I think we have to conclude they don't have many levers to pull. Under these circumstances, just what do you do?

So, the challenge facing government is twofold:

- What do you do when faced with the perfect storm?
- Just how do you change a system that shows a remarkable ability to subvert change?

The answer is really very simple and it's exactly what successive Governments have been doing, as they have watched the crisis deepen. It involves two core

principles and it is vital you understand these:

1. Reduce political fallout by removing the health system from Government control

Succinctly, this involves devolving responsibility for the system to the system itself i.e. breaking it into a myriad of individual components, each responsible for their own wellbeing and each equally responsible for any 'self-inflicted' or 'market-inflicted' failures. Not only does this distance Government from failure but potentially removes the financial liability for it too, as each organisation operates as an independent 'company' enabling them to go bankrupt, just like other companies. The critical conclusion though is the likelihood that Government expects failure to occur i.e. it knows this isn't a solution.

2. Create a set of conditions that force change, rather than 'request' or 'advise' it

Whereas the above sounds very negative, what we are really saying is that a rationalisation of the NHS is

inevitable when you can't afford all of it and so you can choose to design it (carrying the political consequences of this) or let it happen. If you were faced with changing a system that is hell bent on staying the same and remarkably successful at it, what would you do? Right, exactly what Government has done –hurl it into a dynamic environment in which you either change or falter – a market economy which, by default, has winners and losers. It has further added to this dynamism by placing control in the hands of GPs and tying their personal livelihoods to balancing a Clinical Commissioning Group's budget. The potential for loss of personal livelihood is enormously significant because it will virtually guarantee that GP Commissioners are hot on the trail of cost savings across the system and if the providers don't play ball they will find themselves being designed 'around' or left out of the meeting!

So, healthcare gets a market economy, tightly capped by a fixed national settlement but with increasing demand through population dynamics and disease burden progression. This is the equivalent of loading too much into your

old and not particularly strong pressure cooker and then gradually turning up the heat, whilst selling the house in the meantime so you no longer 'own' the pressure cooker when it blows.

The challenges succinctly described

Most providers face one or more of five highly prevalent challenges. Each is serious in its own right in a market economy that doesn't believe in taking prisoners and therefore resolution of these represents the immediate imperative for most. Those challenges are:

A lack of embedded understanding throughout the organisation of the problems we face, the emerging system and the new rules of the game, resulting in poor decision-making, internal conflict and generally low motivation to act

A mindset at odds with a competitive market, leading to an over-focus on the search for a solution that preserves the whole and a massive under-focus on becoming competitive and seizing opportunities

A bureaucratic management regime based on restricting and controlling the behaviour of a highly intellectual clinical workforce, resulting in a low sense of ownership, clinical-managerial divide (internal competition), disenfranchised, demoralised workforce and poor use of the collective intellects available

A propensity to organise and run services in a self-centric manner i.e. based on the convenience of the service, leading to too many instances of poor patient experience and resulting in a highly unattractive service presentation compared to

more customer-centric commercial competitors

A tendency to manage services based on immediate cost rather than longer term value, resulting in valuable interventions being cancelled to save money, genuinely beneficial innovations failing to gain traction because they require pump-priming and a fundamental failure to alter the value equation that links income, cost and productivity with quality of outcome

The successful providers in the new market economy will be the ones that resolve these challenges and go on to be front runners in introducing innovation, adaptation and reform that is consistent with the more macro-level challenges facing the NHS as a whole. So, where do you find the sorts of answers that address this magnitude of problem? Again, the answer is relatively simple – at The Healthcare Leadership Summit 2012, specifically designed to address these very challenges.

5 challenges, 4 themes, genuine solutions

For the first time, The Healthcare Leadership Summit brings together the foremost experts at addressing the above 5 challenges onto a single platform designed to enable leaders to get a clear view of just how to overcome these seemingly intractable problems. The five challenges are addressed across 4 distinct themes:

Emerging Reality – Understanding & Seizing the Future

All participants in this session will emerge with a crystal-clear view of the emerging economic landscape, what this means for providers and services and how providers need to adapt, act and behave to genuinely seize the future,

rather than falling foul of it. Experts include Roger Bootle, Economic Advisor to the Treasury, who will thoroughly examine the emerging global, local and healthcare economic environment, Bob Ricketts, Director of Provider Policy at the DH, who will provide guidance and direction on how services need to think and act, Mark Attah, a leading force and architect in GP-led Commissioning discussing how services need to interact with Clinical Commissioning Groups and the sorts of opportunities that may become available for the right kind of provider and Massoud Fouladi, Medical Director and Co-Founder of Circle Health, outlining how to re-think patient pathways and services in line with the emerging system.

The output from the session will be a cohort of well-informed individuals that understand the challenges, know what needs to be done and who can act as a force for the sort of positive adaptation and evolution necessary today.

Mobilising Hearts, Minds and Behaviour to Overcome Inertia

Commencing with Roger Black, the truly inspirational Olympic & Commonwealth Medal Holder, who will examine adopting a positive, winning mindset, the session as a whole will examine how to unstick largely inert Trusts and services to create the sort of positive change needed to succeed today. It will pay special attention to genuinely mobilising the collective efforts of clinical workforce by overcoming resistance, fostering genuine, meaningful engagement and developing the propensity to push change forward. Fran Woodward, Director of the Cancer Programme at the South-East London Integrated Cancer Centre (ICC) will examine the sort of leadership that genuinely inspires collaboration and action across a service,



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CORE SKILLS IN PEOPLE EFFECTIVENESS

Thursday 12th January 2012 in London - 6 CPD Points

MASTERING BUSINESS DEVELOPMENT, PARTNERSHIPS & TENDERING

Friday 13th January 2012 in London - 6 CPD Points

whilst Andrew Vincent, Head of Clinical Business Excellence at Medicology will provide practical insight into how to drive change swiftly but intelligently to create maximum impact in a timescale that is short.

Participants will emerge inspired to lead reform, as well as informed in just how to go about overcoming the inertia and resistance that is holding so many services in current suspension.

Patient & Public Centricity

Without question, in a market economy services must adequately service their clientele or risk losing them to other providers. Andrew McMillan, who formerly led John Lewis Partnership's evolution into probably the single most respected organisation for the customer service, will thoroughly examine just what needs to happen in health for providers to become world-class customer service organisations. He will be followed by Patrick Harris, who is famous for leading innovation at Orange (called creaticity) in the era that saw them make huge gains in market share by adapting their service to better match emerging behavioural trends in the public. Patrick will look at the same process for healthcare and provider invaluable insight into how services can create competitive advantage through better customer centricity.

This session will drive new thinking in how to reform services with the customer in mind and lead to a cohort of innovators in patient experience and competitive advantage.

Liberating Value – Better Care, Less Cost

Finally, we tackle the difficult issue of just how to deliver more healthcare at lower cost but with better outcomes – the Holy Grail combination that represents value

to those that fund the NHS. Steve Alder, Assistant Medical Director at Plymouth Hospitals NHS Trust will provide inspiration and a sense of possibility by examining just how much improvement is possible with the right approach, having himself reduced his neurology & stroke bed base by 50% permanently whilst simultaneously improving quality and experience. Ali Parsa, CEO and Co-Founder of Circle Health will demonstrate how fundamentally changing the way we lead and manage clinical staff can address virtually all aspects of the value equation by lowering cost, improving efficiency, reducing sickness and absence, improving quality and experience, increasing a sense of ownership and stewardship and fundamentally liberating and harnessing the intellectual capability of clinicians.

Participants will emerge inspired to go out and create very different results both by addressing how we deliver healthcare and by improving how we drive the workforce.

Guaranteed & value-packed

We're pretty sure that virtually all clinical and non-clinical leaders will be able to see the true value of tabling these challenges with such an inspiring group of experts to provide answers. However, uniquely, The Healthcare Leadership Summit 2012 comes with a guarantee.

If after the first morning you are not totally convinced this is worth every penny you have paid to register, we will refund your registration fee in full.

Besides this unique level of assurance, The Summit also overcomes one of the greatest challenges facing services and Trusts; just how do you get implementation of the ideas and insight afterwards? Frequently, individuals

attend with no mechanism to share and move forward the conference ideas. All participants at The Healthcare Leadership Summit will receive a complete DVD set of the proceedings, enabling them to hold the necessary conversations with colleagues, fellow leaders and other staff. The value that this adds could almost be viewed as priceless, given the massive cost of failure today and the huge levels of service vulnerability of these issues are not addressed. Every service needs to send someone to ensure that these answers are captured and brought back to benefit that service.

At the start of this article we alluded to the solutions being based on the decision you take. If you're reading this you clearly took a decision to read, not delete. What will you decide to do now?

Will you book, seek to understand, go find answers and lead positive change or will you confine it to the 'interesting' box of possibilities not seized? It's all up to you.

Andrew Vincent, specialises in readying services for successful engagement in a competitive healthcare market economy, including assessment of readiness, strategy development, establishment of an appropriate operational business model and equipping leaders and other staff with the requisite understanding, skills and mindset. He heads up the Clinical Business Excellence Centre of Excellence for Medicology Ltd.

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T: 07775 646947

W: www.medicology.co.uk

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?

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Dr Mark Attah, GP Principal, Bretton Medical Practice & Chair of Central City HealthCare Group Commissioning Cluster in Peterborough looks at how services can seize the future



Steve Alder, Steve is Consultant Neurologist with a sub-specialist interest in acute stroke at Plymouth Hospitals NHS Trust.



Ali Parsa, CEO Circle Health, Ali will demonstrate how you can deliver the highest possible quality & experience at a surplus by changing the nature of the relationship staff have with employer



Roger Bootle, Roger Bootle is one of the City of London's best known economists. He is also Managing Director of the Centre for Economic and Financial Research, a Specialist Adviser to the House of Commons Treasury Committee



Andrew McMillan, The inspiration behind John Lewis's leadership in customer experience examines what needs to happen in health to ensure patient loyalty



Andrew Vincent, Andrew is Chairman of Medicology Ltd and Head of the Centre for Excellence in Health Care. He is also a member of the Excellence Centre of Excellence in assisting clinical services in a provider-based market economy

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NHS EVIDENCE: GETTING EVIDENCE INTO PRACTICE



A valuable tool in supporting evidence based care decisions, NHS Evidence is a comprehensive service provided by the National Institute for Clinical Excellence (NICE) to ensure healthcare professionals have online

access to the most up-to-date, high quality information and support tools to help implement best practice.

A simple search function on NHS Evidence enables identification of a broad range of information across clinical topic areas including diabetes, cancer and cardiovascular disease. This includes clinical guidelines, systematic reviews and medicines information. These have all been carefully selected from sources of information that are high quality and directly relevant to the National Health Service.

NHS Evidence topic pages are a new visual display of relevant quality assured information in over 120 key specialist areas, including the latest guidance, commissioning guides, medicines and patient information. There is online access to the British National Formulary (BNF), National electronic Library for Medicines (NeLM), the electronic Medicines Compendium (eMC) and the National Prescribing Centre (NPC).

The NHS Evidence 'My Evidence' functionality provides the option of

creating a personal log to save and share searches, and setup alerts when new information relating to any saved searches becomes available. This is an important facility in terms of saving information for Continuing Professional Development (CPD) and revalidation.

For those who need more comprehensive information NHS Evidence also provides access to a number of journals and databases such as MEDLINE, the Journal of American Medical Association (JAMA), PsycINFO and Pubmed. These resources are procured by NHS Evidence on behalf of the NHS and require a NHS Athens password which is available free to all eligible NHS employees.

Keeping up with clinical practice

Keeping up to date with NICE guidance can be a difficult task. Since its formation, NICE has produced over 700 pieces of separate but interrelated guidance. In May NICE launched a new presentation of NICE guidance, as online interactive pathways. These bring together all related guidance in a particular topic area, including relevant implementation tools and Quality Standards. NHS Evidence provides access to NICE Pathways to allow visualisation and browsing of associated NICE products.

The pathways cover all NICE products including:

- Technology appraisals
- Interventional procedures
- Clinical guidelines
- Medical technology and diagnostics guidance
- Public health guidance
- Quality standards
- Accompanying tools produced by NICE to support implementation.

NHS Evidence Accreditation Scheme - Driving up the standards of guideline production



A key vision described in the Equity and Excellence: Liberating the NHS White Paper is to achieve quality and outcomes that are among the best in the world. To realise this goal, healthcare professionals will need to adhere to best practice guidance. To help identify high quality

guidance, organisations that have applied for, and fulfilled the criteria for high quality guidance production, are awarded the

NHS Evidence Accreditation Mark, which is displayed on relevant guidance. To date 17 organisations and a total of 26 processes have already been awarded the NHS Evidence Accreditation Mark and many guidance producers are reviewing their processes in line with the accreditation criteria.

NHS Evidence is currently evaluating how its accreditation programme can be extended to cover processes used to develop other types of guidance and advice, for example commissioning guidance.

The accreditation scheme is gaining recognition throughout the world, and applications are currently being considered from international guidance producers. In September, Duodecim, a Finnish publisher in medicine became our first internationally accredited producer and we look forward to receiving interest from other organisations across the globe.

Other developments planned for the NHS Evidence Accreditation Scheme include clinical decision support tools which can bring substantial benefits to patients. We are currently working on an accreditation process to assess the information that underpins clinical decision support tools and are undertaking a pilot with a number of leading providers. The focus of the pilot is to look at how the information contained in these decision support tools is collected and quality assured for inclusion.

Improving quality and productivity

A challenge facing the NHS is to increase efficiency whilst improving the quality of care. The Quality and Productivity collection on NHS Evidence provides access to a range of relevant information, including disinvestment products from NICE and Cochrane.



In addition, around 108 Quality, Innovation, Productivity and Prevention (QIPP) case studies appear on NHS Evidence. The initiatives have all been evaluated, and range from one-off studies in single organisations to large-scale changes that have been replicated in multiple organisations with results published in academic journals. The QIPP case studies cover the whole range of health care, with some examples demonstrating how interaction between primary and secondary care can be more effective, improving both use of resources and patient care.

Dr Gillian Leng CBE is the Director of Evidence and Practice, a role which encompasses the NICE implementation function, the National Prescribing Centre and NHS Evidence. NHS Evidence is a service designed to improve use of, and access to, evidence-based information about health and social care. It provides access to a range of evidence-based information - primary research, summarised evidence, reports and practical evidence-based tools to support implementation. A formal programme accredits external guidance producers. The NICE implementation programme provides support to key audiences and organisations, within and beyond the NHS, to maximise uptake and use of evidence and guidance. The programme aims to motivate and encourage change in practice by working through other organisations and systems within the NHS and partner organisations, to provide practical support, and monitor uptake of the recommendations to inform future work. Gillian is also the Deputy Chief Executive of NICE, a role encompassing strategic planning plus other general corporate responsibilities. Previously, Gillian worked as the Guidelines Programme Director at NICE, and before that at Bedfordshire Health Authority as a consultant in public

health medicine with responsibility for clinical governance and implementing national service frameworks. She is also an editor of the Cochrane Review Group on peripheral vascular diseases and an honorary senior lecturer at the London School of Hygiene and Tropical Medicine. Research interests include the methodology for evaluating and reviewing evidence, clinical trials and implementation science. She was

awarded her CBE for services to the NHS in the Queen's Birthday Honours in 2011.

Start your search today
www.evidence.nhs.uk

By Dr Gillian Leng CBE, Deputy Chief Executive and Director of Evidence and Practice, National Institute for Clinical Excellence

QIPP case study: Bradford Teaching Hospitals NHS Trust has introduced a new electronic consultation system to increase the speed of access to specialist renal opinion for patients with chronic kidney disease (CKD). The system was developed as part of a local initiative driven by recommendations in the National Framework for Renal Services and the Quality and Outcomes Framework for CKD. The example involves sharing electronic health records, with the patient's consent, between primary care physicians and hospital specialists, enabling a specialist to decide whether a patient should be referred to clinic or to undergo tests or interventions in primary care (econsultation).

Case Study: Dr Kate Willmer - Consultant Acute Physician – Royal Wolverhampton Hospitals NHS trust

Why I use NHS Evidence

"As a Consultant Acute Physician I often; on a daily basis, see and care for a variety of patients displaying a wide range of ailments who come to me directly or through referrals from colleagues.

With such variety in my role, NHS Evidence allows me to quickly and easily look up conditions and other information I'm unsure about in the treatment of a patient – either pre, post or during consultation. And because the information is high quality and British based it's relevant to the work we do here.

I recently used NHS Evidence to look up information on 'alcohol related portal hypertension' and found the information I was looking for straight away with results that were relevant and up-to-date.

In terms of answering direct questions NHS Evidence is also excellent. Following a Magnetic Resonance Angiogram I used NHS Evidence to look up whether aspirin or warfarin would be better to treat a patient with carotid artery dissection. The results of my search helped me to clarify the best form of treatment.

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“THE PRIVATE SECTOR SHOULD BE PROMOTED BY THE GOVERNMENT AND THE NHS AS A PILLAR RATHER THAN A PARIAN ON SOCIETY”

As part of the drive to improve the patient experience, the delivery of health-related services via the use of telecommunications or ‘Telehealth’ has become increasingly prevalent. Newly arrived on the scene is The Clinic Finder, an online search engine designed for those seeking healthcare specialists, both locally and internationally. One of its founders, David Nicholls, a Director of the learning disability charity Harrow Mencap and someone well versed in the frustrations of dealing with Clinical Care, spoke to Clinical Business Excellence about the potential risks and costs associated with the venture and just how the patient could ultimately benefit...

How does The Clinic Finder support the patient choice regarding healthcare decisions?

When the concept of The Clinic Finder had been discussed by the four Directors, one of the central selling points had always been to give people the broadest range of options, be that locally or internationally. A good example of this philosophy can be seen with the forthcoming launch of our Medical Tourism section. We initially felt that a separately branded site for Medical Tourism would be the way to go, even having a totally separate branded website. However our thinking

dramatically changed when it became apparent during our initial research and having spoken to both the public and medical specialists that in most cases the search for an appropriate treatment will start locally, with Medical Tourism research ‘possibly’ coming later in the process. Although most of the existing sites specialising in Medical Tourism are exceptionally good in being able to offer both very informative information along with lists of overseas specialists, we felt that by being able to put the Medical Tourism option forward as an integral part of The Clinic Finder site, the public—

whilst still at the ‘local’ search stage—could at least consider the overseas option earlier than they would normally. This strategy would firstly achieve our overall objective of giving the widest choices available, along with the ability of overseas specialists to put themselves in front of an audience who in many cases wouldn’t have considered the Medical Tourism option at all.

How reliant is the NHS on private sector healthcare provision?

It’s an interesting question. Everyone is aware that although the NHS is an



amazing institution, it is clearly under great pressure and the latest round of government cutbacks and spending reviews will undoubtedly make things harder. The private sector already contributes massively to the good of public health – all of the drugs we use come from private companies who have been forced to innovate in response to market forces. That innovation leads to amazing technology being invented that helps beat cancer and prolong our lives. If the private sector didn't exist and patients had to depend totally on the NHS, I don't believe it's an exaggeration to say that the system would have collapsed many years ago. It is for this reason that I truly believe that the private sector should be promoted by the government and the NHS rather than being seen as a pariah on society, it should be seen as pillar that is holding up the NHS.

Why is The Clinic Finder necessary? - is this a unique service?

Necessary may be too strong a word and no, this is not a unique service; we have established competitors. We have three

key differences. Firstly, our pricing model is unique. We're always free to customers; our revenue comes from clinics. A local listing is completely free; we only charge a (small) fee when we introduce a paying customer to a clinic. We think it's fair and the right way. Secondly we are going to be a universal service both in terms of services and geography. This means we can operate in many countries and offer a full range of professions and services; we're not limiting ourselves to popular services like dentistry and cosmetic surgery. This also means we can promote a clinic in one country to patients in another via our Medical Tourism section. Thirdly, the site is new from the ground up using the latest technologies, which means it integrates well with social media and search engines; we see those as essential and valuable marketing avenues. Another advantage is that our site will let a client search for a condition/ ailment, a service/treatment/procedure or a profession. Our search engine ties everything together and offers a full list of clinics that might be able to help.

How should a patient/clinic use The Clinic Finder?

Our site has been designed to be easy to use. The concept is simple; a patient is looking for healthcare, and rather than trawling through lots of potentially irrelevant results in a normal search engine, we can give them finely targeted results appropriate to them. A patient might or might know what profession, service or treatment they need, but some don't. As well as letting a patient do a direct search like this they can also search based on their condition or ailment. We link everything together and make suggestions for them. From a clinics' perspective, it's really a win, win scenario. Apart from the Medical Tourism section, the basic entry is free of charge and a clinic ONLY pays when a successful introduction has been made; so there's no reason for any clinic not to take advantage of this site.

How will this impact on the patient's healthcare experience?

If you believe that choice, ease and speed

of accessing information can improve patients' healthcare experience, then I would have to say that this demonstrates how the Internet can really be of benefit to those seeking out information.

We are not associated with any medical facilities, but we do provide a single port of call to enable the patient to make a more informed choice about who, when and where they receive their treatment. We'll also make suggestions that perhaps they hadn't thought of, or didn't know existed, such as alternative healthcare or travelling overseas. We think it opens the market right up.

The NHS ethos is universal healthcare for all - how can this be maintained if only those that can afford to do so have recourse to the private sector?

I refer back to my first answer. If the NHS had the capacity to cope with all and every demand on it on time, to budget

and to consistently high standards, the private sector would not be thriving. The fact that it is thriving indicates the demand. Much private sector treatment is funded by insurance, often provided by employers. An employer wants to demonstrate pastoral care for its staff, and it wants them back to work quickly, fit and well. Far from undermining the NHS, this relieves the pressure on it enabling it to better serve those that rely on it.

Is a patients' financial status probed before a referral is made? How is this done?

Not at all. We simply offer choice and it is up to the patient and the clinic how they proceed. We have no barriers to entry.

Does The Clinic Finder cater only for those who can afford it?

In the sense that the clinics who register are private, yes it does. However we wouldn't dream of marketing our site to

only those over a certain income. Each and every person determines their own priority when it comes to their health and this doesn't mean that only people in a specific demographic category can benefit from these services.

Is the fee paid by clinics to The Clinic Finder for sourcing patients a one off or paid as a retainer?

This is one of our key differences. We find it hard to justify taking money from a clinic with no guaranteed results. That traditional model worked well for print advertising such as phone directories when it was hard to track or quantify the return on investment. The web is a different place, and it's where most people now look for answers. A clinic will know precisely how much business we send them, and what they pay us is directly related to it. We ask for a small one off fee each time we send a new introduction to the clinic. Our pricing

model tries to reflect the revenue a clinic is likely to earn from a patient, so our fees fit into three bands. When a clinic signs up to The Clinic Finder, they have nothing to lose. They are not risking any investment and only pay for what they get.

What are the current facts and figures regarding registrations by clinics? How do you persuade them as to the benefits of using the service to them?

We are still just six months old, so our business is not yet mature. We are honest enough to say that we are small and growing. We don't want to dupe clinics into thinking we are bigger than we are. Our clinics are in the hundreds and growing quickly, which is a great start. We are also getting thousands of patient searches each week, so both sides of the model are growing well. We don't think we'll be able to issue any meaningful statistics until we are at least a year old.

Because of our unique package of being able to register for free and only having to pay when a successful introduction has been made, we have found that we haven't had to 'persuade' anyone. It's not rocket science to see that clinics have nothing to lose and everything to gain.

How do you guard against potential accusations of conflicts of interest such as referrals based on business rather than medical reasons?

We do not influence the patient's choice at all. We don't have any links with any clinics, we don't have preferred facilities and we don't offer any incentives to choose one clinic over another. We also don't offer advertising spots that could distract or influence a patient. We believe that by returning a list of appropriate clinics based on the patient's search term it is the patient who is making the choice.

What happens to a patient's query if The Clinic Finder feels unable to help for whatever reason?

If a patient searches and can't see anything that might be able to help, we cannot help that patient further. However, we do track all generic (non personal) search activity to help us identify common searches where we could not help. We can use that information to reach out to clinics to help us fill those gaps; be it treatments or professions we don't yet have or in towns or postcodes where we have no clinics but strong demand. It should also be recognised that we are not arbiters of a medical condition or treatment and can only deal with queries relating to our introduction. Obviously we would look into any complaints that are made and if it transpires a clinic hasn't met their obligations, we would take them off the site.

Many people in the NHS and beyond are highly critical of the reforms agenda and the suspicion that it represents a back door for privatisation – how does The Clinic Finder fit into this scenario?

That's something that we can't influence. We acknowledge that the private sector exists and is growing. Right now, the private and voluntary sectors provide about 5% of NHS healthcare. We also recognise that many more people are travelling overseas for treatment. We are happy to meet that demand by offering a patient who has already decided to search private or international healthcare the widest possible choice we can. We—in common with most observers—don't believe the NHS will be privatised, but a strong and thriving private sector is essential for the continued success of the NHS.

What lessons could The Clinic Finder glean from the demise of Google Health? - If any?

We don't feel that this will affect us at all.

Is increased competition/marketisation the road to follow – what will happen if this road is not taken?

Yes, we think it is. The Clinic Finder is in the market to meet—rather than create—demand. Our search engine is a place where clinics can compete for business from each search that a patient does. We believe that it is the patient who should both have and make that choice.

www.theclinicfinder.com

Interview by Fraser Tennant



Monitor reveals first quarter challenges facing NHS Foundation Trusts

Monitor has published its review of NHS foundation trusts for the first quarter of 2011/12 revealing a variety of emerging challenges.

On finances, the results for the first three months indicate that overall the foundation trust sector is performing slightly ahead of plan. This is encouraging in the context of the financial pressure on the NHS. However, there is an increase in the number of trusts facing financial risk and subject to regulatory scrutiny. Additionally the complexity of some of the issues means that they are likely to take longer to resolve.

Commenting on the results, Monitor's Chief Operating Officer Stephen Hay, said: "It's encouraging that the sector is in overall surplus and ahead of plan for the first quarter - although surpluses are lower than last year due to the economic environment. But there are a number of foundation trusts that are beginning to struggle and we are looking closely at these and taking regulatory action in several cases to make sure that the issues are addressed."



Stephen Hay

Planning for a clinically led NHS

Plans to hand more power to clinicians and modernise the NHS have moved a step closer with the latest draft guidance to support emerging clinical commissioning groups.

It is the latest stage in the Government's ambition to make the NHS world-class by giving patients more power, focussing on quality, and giving frontline clinicians greater freedom and a strong leadership role.

There are now more than 253 groups of GP practices across the country which have come forward to directly commission services, focused on delivering the best results for their patients. Once authorised as Clinical Commissioning Groups they will take on responsibility for health care budgets from April 2013.

Health Secretary Andrew Lansley said: "Clinical commissioning groups are at the heart of our NHS modernisation plans. They will put healthcare professionals in the driving seat so that they have the freedom and responsibility to design services on behalf of their patients - delivering better quality and integrated care.

"We strengthened our plans following the listening exercise to ensure there will be wider clinical leadership within clinical commissioning groups which will lead to stronger collaboration at a local level.

"Above all, our plans will safeguard the future of our NHS so that it is able to meet the challenges of rising demand, an ageing population and the increasing costs of treatment."

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CHECK IT OUT

Foreign doctors to face language tests announces Lansley

Foreign doctors will be required to take language tests before starting work in the NHS under strict new guidelines being introduced following a number of scandals involving overseas medical practitioners.

Speaking at the Conservative Party Conference in Manchester, Health Secretary Andrew Lansley said that although the Government appreciated the work performed by many foreign doctors, he was acting to prevent anyone with a "poor grasp" of English from treating patients in future following cases like that of German doctor Daniel Ubani.

Dr Ubani killed 70-year-old David Gray with a painkiller overdose on his first and only shift in the UK in February 2008.

Under the new regime, language skills will be added to the required checks by the 'responsible officers' in each local area responsible for ensuring doctors are appropriately trained and qualified for the role.

The GMC will also be given explicit new powers to take action against doctors when there are concerns about their ability to speak English.

Niall Dickson, Chief Executive of the GMC, said: "This is good news for patients - the Government is now committed both to changing the Medical Act, giving the GMC new powers, as well as creating a better system to make sure employers in England only take on doctors who are competent and up to date.



Niall Dickson

Cameron and Lansley announce new commitments on 24/7 NHS care

Prime Minister David Cameron and the Health Secretary Andrew Lansley have announced that patients will be able to access the NHS 24/7 through the new free to call NHS '111' service – the number to call for all non-emergency NHS care and advice.



The new service means that if a patient needed to see a GP urgently, the NHS 111 service will make sure this happens. Similarly, if a nurse was required for an urgent home visit in the middle of the night, NHS 111 will also organise that.

NHS 111 content will be available online, enabling people to access health information via a directory of local services, as well as being able to connect directly to a 111 call adviser to assess the help they need.

The NHS 111 service will even allow GPs the option of linking their own booking systems to the new service, allowing their patients to book an urgent appointment with their local GP through 111.

The service will be available to over 10 million people across the country by April

2012 and will be free to call.

The Prime Minister said: "I believe people should get the care they need, when and where they need it. However, too many people are confused about what is available to them or how best to get

it, especially at night or if they are away from home.

"That's why we are introducing NHS 111. The new service will make sure callers can access the care and advice that is right for them, 24 hours a day, 365 days a year."

Dr Clare Gerada, Chair of the Royal College of General Practitioners, added: "NHS 111, as a single point of access for patients with urgent care needs, with a memorable telephone number linked to an up to date directory of services, is a major step forward. Not only will callers to the service be advised on what to do but also be directed to the appropriate local service to address their need consistently. However, patients should be aware that this is not a replacement for the current system and that they can continue to call their GP practice as normal."

Revalidation pilots to test new Medical Appraisal Guide

The NHS Revalidation Support Team has launched the final round of pilots for revalidation which will test the appraisal process described in the NHS Revalidation Support Team's (RST) draft Medical Appraisal Guide, which aims to provide clear and effective guidance for medical appraisal.

The RST will also examine how a model for revalidation will fit within existing organisational systems and processes.

The guidance will be tested with doctors in a wide range of settings, including: locum GPs and consultants; locum doctors who qualified outside of the UK but practice as a locum in England; doctors in the independent healthcare sector; SAS grade doctors; mental health consultants; NHS doctors in primary and secondary care; and clinical academics.

Dr Nick Lyons, Programme Director for Testing and Piloting at the RST, said: "We are working closely with the medical community to ensure we have a revalidation system that is efficient, streamlined and supports high quality care. Participants in the pilot will have a very real opportunity to help shape the future of revalidation by providing their feedback. These pilots will help ensure that revalidation systems are right for all doctors, regardless of their specialty or the context in which they practice."

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HOW ARE WE FEELING TODAY?

CATCHING UP WITH THE BOORMAN REVIEW ON THE APPROACH TO ITS SECOND BIRTHDAY

'How are we feeling today?' In a healthcare context you'd expect this question to be asked of the patient as opposed to the carer, but with sickness rates in the NHS in a state of flux, there is a very real danger that absenteeism will place an unsustainable burden on remaining staff as they strive to provide good patient care at a time when the Government is looking to shave an estimated £20 billion from the NHS budget over the next four years.

In a search for persuasive solutions to this sickness malaise, in November 2008, the Department of Health commissioned a detailed examination of how the health of NHS staff impacts on the quality of service provided for patients - a commission inspired partly by the work undertaken by Dame Carol Black's in which she highlighted the burgeoning costs associated with the high rates of illness amongst the working population.

The subsequent report, the NHS Health and Well-being Review (November 2009), put the immediate cost of staff sickness in the NHS at an eye watering £1.7 billion. Now, when one considers the environment in which NHS staff operate

- face-to-face public interaction, highly stressful conditions, unpredictable hours, all of which can lead to muscular skeletal problems and mental health and stress issues - it's fair to say that a higher than average sickness rate is an occupational hazard that comes with a high degree of probability attached.

In his forward to the Review, Dr Steven Boorman stated unequivocally that if the NHS could reduce levels of sickness absence by a third it would lead to: 3.4 million additional available working days a year for NHS staff; equivalent to an extra 14,900 whole-time equivalent staff; with an estimated annual direct cost saving of £555 million.

In addition to Boorman's findings, a recent report by the Audit Commission suggested that £290 million of savings could be made if the NHS were to get a handle on the problem - an outcome that would not only have a substantial financial impact on services but also in terms of productivity.

So now, almost two years on from its original publication, it would seem an appropriate time to ask the Review's prime

mover as to how the recommendations listed therein have actually been acted upon and implemented.

"When the Review was first delivered there was a very prompt acceptance by the then Secretary of State for Health (Burnham) but, very shortly afterwards, we went into an election period and there was a change of administration," recalls Steve Boorman. "The good news is that the subsequent Secretary of State for Health (Lansley) also accepted the conclusions of the report. So both White Papers - Liberating the NHS and the subsequent Public Health White Paper - both contained specific commitments to implement, in full, the recommendations of the Review.

"The Department of Health established an innovation scrutiny group under the chairmanship of Dame Carol Black that has been working over the last 18 months on developing minimum standards for occupational health and for making a case for improved workplace health and wellbeing support. That work culminated in the publication in July this year of two key documents: Healthy Staff, Better Care for Patients - Realignment of Occupational Health Services to the NHS



in England and the NHS Health and Well-being Improvement Framework. Both documents constitute a road-map for Trusts to follow.

“There’s also been some work done looking at the indications used by the Care Quality Commission for monitoring Trusts’ performance and they now include staff health and wellbeing as one of the key areas monitored on a monthly basis.

“Like many large organisations, it is actually quite difficult to actively manage sickness within the NHS. We need to remember that sickness absence isn’t just about sickness, it’s actually about broader aspects of how people feel about the organisation that they actually work in and the NHS still has issues. Although sickness absence has improved since the Review, the NHS is still behind its staff health targets in terms of the target improvement it set itself following the conclusions of the Review. The reality is that all the recommendations are still being pursued and there has been some good progress made, particularly in the last six months or so.”

So how does Steve respond to those who would claim that given the current upheaval in the NHS with the reform agenda and all the issues that entails,

the implementation of the Review’s recommendations is at odds with the Government’s long term plans?

“I think absolutely the opposite of that. I think that the full quick agenda in terms of taking an organisation forward in a time of extreme financial challenge relies on basically being able to ensure that the staff that you have are maximally productive, maximally efficient and so it is absolutely core to all that’s going on in the NHS at the moment. I don’t think you can deliver that agenda without focussing on the health and wellbeing of the staff involved.”

Since its publication, Steve has continued to be associated with the Review through his work with the Department of Health’s Sickness Absence Scrutiny Group. Although pleased with the progress of the Review’s recommendations so far, he remains aware of a lack of consistency across the NHS spectrum.

“I think there are pockets of excellence where it is quite clear there are very good examples of looking after sick staff.

We have highlighted and published 60 case studies of excellence, but in terms of consistency across 400 or so Trusts that we looked at in England, it was inconsistent. It was highly variable and there were many areas where it was well below par.”

Since 2009, the NHS Information Centre has published information from the Electronic Staff Record on a quarterly basis as experimental statistics. The latest figures, published in July 2011 and covering the period January 2011 to March 2011, are available at the following link: <http://www.ic.nhs.uk/statistics-and-data-collections/workforce/sickness-absence/sickness-absence-rates-in-the-nhs-october--december-2010> and are summarised on the right.

By Fraser Tennant

NHS Staff Sickness Rates: summary

The following information relates to sickness absence rates for staff at NHS organisations on the Electronic Staff Record (ESR) between January and March 2011.

Key facts:

- Between January and March 2011 the average sickness absence rate for the NHS in England was 4.24 per cent falling from 4.48 per cent for the same period in 2010
- The North East SHA area had the highest average sickness absence rate with its organisations averaging 4.81 per cent. The London SHA area had the lowest average at 3.50 per cent
- Ambulance Staff were the staff group with the highest average sickness absence rate with an average of 6.30 per cent. Nursing, Midwifery and Health Visiting Learners had the lowest average at 1.05 per cent
- Amongst types of organisation, Ambulance Trusts had the highest average sickness absence rate with an average of 5.94 per cent. Strategic Health Authorities had the lowest average with a rate of 2.25 per cent

THE TRANSFORMATIONAL JOURNEY

HOW NHS FOUNDATION TRUSTS BECAME RESPECTABLE

As Chief Executive of the Foundation Trust Network, a position she has held since 2005 and one she has announced her departure from in early 2012, Sue Slipman is ideally placed to pass comment on the burning issues currently threatening the healthcare community at a time of deep insecurity and widespread controversy. Amidst a busy schedule of networking events and fringe meetings at the Liberal Democrat Conference in Birmingham, Sue graciously made room in her diary to speak to Clinical Business Excellence and wasted no time in making the case for the role of NHS Foundation Trusts in the evolving healthcare landscape.

“The Health and Social Care Bill makes it very clear that the only model for the public provision of health services in England is that of the Foundation Trust,” says Sue without hesitation. “That’s an enormous step forward. If you remember, when they were first created in 2003/2004, they were hugely controversial and were seen as a move towards privatisation. There was a lot of discussion about the nature of the model itself. But this time around, there’s no controversy about the model whatsoever. So I think Foundation Trusts have proved their worth to everyone - to politicians, to the treasury, and to the people that they serve.

“The other thing to say is that the Government isn’t just looking at Foundation Trusts in the health service, but as a model for public provision of health public services. So these are really interesting times and I think I’m leaving foundation trusts in a very healthy state in terms of their future.”

So just how have Foundation Trusts become an ideal model of healthcare? Once viewed as troublesome and problematic, what path has been steered to get to them to where they are now?

“They’ve gone through a huge transformational journey from being NHS Trusts under the performance management of strategic health providers to becoming independent organisations managed by an independent board, accountable to a regulator at national level and to their governors representing patients, public and staff at a local level,” explains Sue. “They’re a very different kind of animal to NHS Trusts. They have a lot more freedom to really deliver services to the people who matter in local communities that don’t have an NHS Trust. I think it’s been this that has really won us the support we have.”

The issue(s) of commissioning and commissioners is of course the one that is virtually guaranteed to cause

consternation amongst the healthcare fraternity and is a topic on which Sue remains resolutely open-minded. “Clearly, we don’t quite know how commissioning is going to shape up. It certainly won’t develop in a linear way as there are going to be pockets of the country where it’s really good and others where it will take a much longer time to develop. And it appears that one of the key things, particularly given the problem we’ve got with money in the NHS right now, is that providers are going to have to move quite quickly to change their services in order to be producing the new pathways of care that patients need, but commissioners may not yet grasp the need for this if they don’t as yet understand the critical issues of financial risk that foundation trusts are facing.”

“We know that we’ve got an oversupply of hospital services in certain parts of the country, London being an obvious example. In a cash strapped environment, we’ve got to try to make sure that services are being produced in the most cost-efficient way and that we don’t have inefficient organisations continuing to swallow up resources which might put the best quality and most efficient organisations in jeopardy.

“Organisations have to really start dealing

with their efficiency and they've got to look at productivity improvement in the way they operate as organisations. That means adopting the best clinical practices, cutting out waste and so on. It's a dual-pronged process. One is about organisations becoming the most efficient they can be, and the other is about health economies themselves becoming more efficient.

"There has to be a much bigger driver behind this now than there has been to date. If we don't act on efficiency, now we're in an environment where organisations can fail, then we risk pushing some of the best NHS organisations towards failure unless we deal with those problems that we know we've got within the NHS in England."

The cash strapped, uncertain environment in which the NHS is currently operating and the increased risk of failure it engenders, must of course be taking its toll on staff in terms of morale - a scenario which Sue is acutely aware of. "No doubt there are some extremely difficult situations being faced currently. And clearly, you can only really tackle these issues if you've got the clinicians involved because clinicians know where failures can happen and how to reorganise in the most efficient way possible and get the right kind of staff mix to get the best results for patients and the best results for the organisations themselves. What we've got to see is that level of participation and involvement in making those changes and also the incentive in working the right way to encourage them to happen."

As she enters the final six months of her tenure as Chief Executive of the Foundation Trust Network, Sue is optimistic, whilst being realistic, as to the challenges ahead. "My biggest fear is the trickiness around money. If there is no political will to deal with the necessary service changes then some really good



organisations will be pushed to failure. We need to bring that reconfiguration upstream; otherwise we will be pushing people into failure. On the other side of these reforms, we need to see organisations being able to do their best and to succeed with the provision of their services in a way that benefits patients, staff and local communities as a whole. I really do believe that Foundation Trusts have the ability to do all of these things."

Prior to becoming Chief Executive of the Foundation Trust Network - set up seven years ago to represent and promote the common interests of NHS foundation trusts and those aspiring to foundation trust status - Sue was Chair of the Financial Ombudsman Service, an Executive Director with Camelot Group responsible for social responsibility and external affairs, Chief Executive of the Gas Consumers Council, the London TEC Council and the National Council for One Parent Families. She has also held a number of public appointments including as a member of the government's Better Regulation Task Force, chair of the Corporate Responsibility Group, chair of the Department for Trade and Industry's

Working Group on corporate social responsibility and chair of the National Consumer Council's Policy commission on Public Services.

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