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AN HSJ SUPPLEMENT/17 JUNE 2010

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References: 1. NHS 2010–2015: from good to great. Preventative, people-centred, productive. London: Department of Health; 2009. 2. The National Service Framework for Renal Services. Part One: Dialysis and Transplantation. London: Department of Health; 2004. 3. Data on file 2010, Baxter Healthcare. 4. Renal Association Working Party on Peritoneal Dialysis. Final Report. November 2009. 5. Marrón B *et al. Kidney Int* 2008;73(Suppl 108):S42–S51. 6. Culleton BF *et al. JAMA* 2007;298:1291–1299.
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QUALITY AND PRODUCTIVITY

A GUIDE TO DIFFICULT CHOICES

Enforcing savings while raising quality is a tough call – but that is the challenge. Daloni Carlisle asks seven leaders how they believe the task can be tackled

A lot has been written about how much the NHS needs to save; less about how, exactly, to do it.

As the NHS Confederation pre-election paper *Rising to the Challenge: health priorities for the government and the NHS* concluded: "The quality of the public debate about finding solutions to the funding problems has been very poor. While protected funding for the NHS has been promised from all sides in the political debate, these promises are not seen as credible."

So where can savings be made? *HSJ* asked seven leaders for their views about the seven strands of this year's annual NHS Confederation meeting.

Improving quality

The best way to improve quality in the NHS is not to buy in another improvement programme or through wholesale reorganisation but to pay attention to the cost of variation in healthcare delivery.

This is argued by King's Fund director of healthcare improvement Mark Jennings, who says: "The NHS has taken the view that quality costs. Now we need a new paradigm: that care can only be considered high quality if it is efficient and effective."

His thesis is that much medical practice is not based on evidence but on whether there is enough money in the system to pay for it and on the idiosyncrasies of local medical practitioners.

This leads to huge variation, which is neither efficient nor effective. What we need is standardisation.

As examples, he cites the NHS Institute's Better Care, Better Value indicators (which Mr Jennings helped develop before joining the King's Fund).

"These cover a limited range of activities across the NHS but indicate that if all NHS organisations were to operate at the level of the top quartile this could save £3.5bn," he says. "Extend that principle to other activities and the savings would flow out."

The quality and productivity series now available on NHS Evidence highlights how quality and efficiency go hand in hand, he adds: "The series on hip fracture shows that rapid improvements have been made that lead to lower length of stay and better outcomes."

Driving this change through will require clinical leadership and clinical engagement to obtain agreement on what are the best standards in any given area and then to obtain adherence to them.

"It is not easy and that's perhaps why it has not been done already," he says. "But it will be essential."

Improving health

NHS Alliance president Chris Drinkwater, a former inner city GP and emeritus professor of primary care development at Northumbria University in Newcastle, says that significant savings could be made to NHS expenditure by focusing upstream action on the health of older people.

"There is now good evidence to show that 15 minutes' exercise three times a week reduces your chances of developing dementia by 40 per cent," he says. "Personally, I would rather reduce my chances of dementia than increase my chances of having it diagnosed."

It is not just a matter of physical activity though; maintaining social networks is also a vital component of independence.

Rising to the Challenge **criticised the quality of debate**

Professor Drinkwater says: "We need to start preparing people for old age by getting those who are aged 50 now to start thinking about their next 50 years. We need to start helping them stay active and maintain their social networks."

Too much of the emphasis on physical activity is on sport and it excludes older people.

"Free swimming for older people is a start," he says. "Nordic walking has taken off in a big way in Newcastle too."

Health commissioners also need to find better ways to identify older people who are vulnerable to becoming dependent.

"If you live on your own, are prescribed more than four medications and have had a recent close bereavement, you are by definition vulnerable," he says. "It should be relatively easy to pick these people up."

Much of the evidence comes from the Partnerships for Older People Projects – POPPs – which make a strong economic case for this kind of upstream work.

"We need to move away from a disease-specific focus and start to think about co-morbidities, and the psychological aspects of getting old. We have to build on the consensus that exists; most people do not want to end up in long term care."

Improving efficiency

Asking the NHS to use methods from the private sector has something of a bad name in the organisation. Nevertheless, Simpler Consulting vice president Chris Lloyd thinks it is worth another go, particularly when it comes to eliminating waste. Mr Lloyd's particular bandwagon is Lean, developed by Toyota in the mid-20th century and now being used by healthcare systems worldwide, not least the NHS. He is willing to admit, though, that other methodologies may also deliver results.

He says: "We convince clinicians they have to start by defining value in the eyes of the patient or service user."

It is a viewpoint that makes the waste in the system very apparent and helps clinicians and managers to eliminate it.

"You need to engage clinicians on waste because basically that is what infuriates them," he says.

Then they can move to eliminate waste. "This is not done by tinkering around the edges but by re-engineering and whole system redesign," says Mr Lloyd.

He cites a North West hospital that applied Lean to its stroke pathway and reduced length of stay, readmissions and mortality while improving patient feedback.

"The physiotherapy time spent with patients was doubled not by doubling the number of physios but by improving how they worked," says Mr Lloyd.

He argues that the NHS now needs to apply improvement methodologies to the interfaces between providers.

"Every interface is fraught with waste. This is where we need to focus next."

New priorities

Here are some numbers to play with. The NHS spends about £600m a year on patient and public involvement activities, over £1bn on the litigation industry and £100m-plus on the service improvement industry.

Patient-feedback service Patient Opinion chief executive Paul Hodgkin, who is a Sheffield GP, thinks this could be slashed using Web 2.0 tools. He has no ready formed answers or models although he is actively exploring all these areas.

"The PALS/PPI [patient liaison and public involvement] function within the NHS could be radically redesigned," he says.

Just as the *Encyclopaedia Britannica* saw the impact of the internet, so could patient and public involvement in the NHS.

He says it is a classic case for the removal of intermediaries.

On the subject of reducing the cost of litigation, Dr Hodgkin draws on ideas of restorative justice.

"If we could find a way for clinicians and patients to have an open, honest conversation about what they both want, we could reduce the amount spent on lawyers' costs. Web platforms could play a part in that."

Finally, on service improvement, Dr Hodgkin is a great in believer patient-led service improvements.

"Patient Opinion had a story from a man who had a hip replacement at his local hospital and found that he could not use the commode provided. We took that story back to the ward. The ward nurses tried different commodes until they found one that worked for their patients.

"It cost nothing. It will improve patients' experiences and hygiene, with fewer spillages to mop up."

There are thousands of examples of such micro-improvements that together could have a huge impact not just on quality and efficiency but on the culture of the NHS.

Rethinking services

In January 2009 there were 2,932 people on GP dementia registers in Cornwall and the Isles of Scilly. A year later there were 3,474,

meaning over 500 more people were flagged up for an annual health check that would allow anticipatory planning and potentially avoid a crisis intervention.

This is the fruit of a major service redesign across the county in the wake of the 2009 Dementia Strategy. Along with mass publicity campaigns to encourage people to see their GP if they are worried about their memory and training for GPs, there are now 23 new dementia clinics, 24 memory cafés and peer support networks operating county-wide.

This is from a board report in February 2010: "The investment profile for dementia services has been one of service redesign rather than new investment. Services have been disinvested in to enable the commissioning of new and more personalised services."

NHS Cornwall and Isles of Scilly director of service improvement Carol Williams says it is all about helping people to stay at home longer by supporting them and their carers.

It is what people want and it should, in the long run, deliver significant savings for the NHS locally; an audit by the dementia clinical lead in Cornwall found that 62 per cent of 500 acute hospital admissions in the last year were inappropriate.

The primary care trust, along with partners in the county council and third sector, are a year into the redesign. Priorities for next year include developing end of life care for people with dementia and reducing admissions from care homes. It is an approach that could be extended to other long term conditions, says Ms Williams.

"It is really important that we promote self care and independence. The evidence is there to show that if you do that, you can sustain health and wellbeing longer. It is just a more cost effective use of NHS resources."

Reorganise workforce

Neil Lloyd could be said to have an axe to grind, but that doesn't necessarily mean he hasn't got a point. He is chief executive of NHS Professionals, which was set up in 2004 to provide a bank service for the NHS. He argues that trusts can save a packet by looking afresh at how they organise and use their nursing bank.

"The conventional wisdom is to lump banks and agencies together as a bad thing, expensive and difficult to manage," he says. "But if trusts could make a mental shift and see banks as part of their substantive workforce then there are some significant savings to be made."

All trusts need some flexibility in their workforce to deal with the natural peaks and troughs of activity.

Increasingly, staff want more flexibility to allow for a work-life balance and this has been delivered through new types of contract – annual hours contracts or term time only, for example.

This has served the needs of staff well but not necessarily those of the trust. And with demand by and large predictable, a well organised bank that includes a trust's own part time staff and bank only workers can respond in a cost effective way.

"Trusts need a contingent workforce able to manage peaks and troughs in demand and need to do it such a way that flexible workers are offered enough work to make it worthwhile," says Mr Lloyd.

"Ward managers can then get repeat bookings from nurses who know the procedures and protocols, cutting the burden for them and indirect costs even further."

He cites recent work with trusts who have invested in their bank service and developed a pool of flexible workers, half of whom come from their own part time workforce, and saved £1.6m a year as a result.

"This is not peanuts," says Mr Lloyd. "These savings can be made once a trust views the bank as an essential part of workforce planning rather than as an annoyance."

'Trusts can save a packet by looking afresh at how they organise their nursing bank, for example'

Redesigning systems

Eliminate waste, yes. Standardise care, yes. Streamline pathways, yes. But, says NHS Institute for Innovation and Improvement director of service transformation Helen Bevan, that is not going to be enough.

"We cannot just take existing systems and tinker round the edges if we are to make the kind of savings and quality improvements needed," she says. "We need a fundamental redesign."

Work by the institute and others has shown that raising quality leads to savings. It has also shown that redesigning a system surrounding a routine, discrete procedure such as a hip replacement is achievable and delivers on both fronts.

"But the higher up the system you go and the more complex the condition, the higher risk it becomes and the more likely you are to fail," she says.

Yet it is complex issues such as the care of people with long term conditions that we need to tackle.

Part of the problem is that to date improvement has been driven by targets and compliance, with shame and sanctions the punishment for not meeting them.

"We need to move away from compliance to commitment," says Ms Bevan. "We need to find what motivates people, get back to why they joined the NHS in the first place and energise and mobilise for change."

And that, she says, is the only way the NHS can deliver the wholesale service redesign needed to both make savings and raise quality. ●

FOTOLIA

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†excludes all oxybutynin preparations

Calceos® Chewable Tablets Prescribing Information Please refer to the Summary of Product Characteristics (SPC) before prescribing Calceos®. **Presentation**: Chewable tablets containing calcium carbonate 1250mg (i.e. 500mg of elemental calcium) and colecalciferol 10 micrograms (corresponding to 400 IU of vitamin D_3) for oral use. **Indications**: Correction of vitamin D and calcium deficiency in the elderly. Vitamin and calcium supplement as an adjunct to specific therapy for osteoporosis. **Dosage**: *Adults*: One tablet to be chewed and taken with a glass of water, twice per day. *Children*: Not recommended. **Contra-indications**: Calceos® is contra-indicated in patients with hypercalcaemia, hypercalciuria, calcium lithiasis, tissue calcification, vitamin D overdose, myeloma and bone metastases, renal insufficiency and hypersensitivity to any of the ingredients. This product contains partially hydrogenated soybean oil. Patients should not take this medicinal product if they are allergic to peanut or soya. **Warnings and Precautions**: Care should be taken with use of other medication containing vitamin D. Renal function, plasma calcium and urinary calcium levels should be monitored, especially in the elderly, in patients with renal failure or in cases of long-term treatment. This product contains sorbitol (E420) and sucrose. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine. The sucrose in this product may be harmful to teeth if taken chronically e.g. for two weeks or more. **Interactions**: Caution should be exercised when combining Calceos® with digitalis glycosides and thiazide diuretics. Calcium may impair the absorption of tetracyclines, etidronate, fluoride and iron and therefore allow at least 3 hours between Calceos® and these agents. **Pregnancy and lactation**: Calceos® may be prescribed during pregnancy and in nursing mothers but should be given at least 3 hours before or after any iron supplementation. Calcium is excreted in breast milk but not sufficiently to produce an adverse effect in the infant. **Effects on ability to drive and use machines**: None known. **Side effects**: Nausea, hypercalciuria, hypophosphataemia, hypercalcaemia and mild gastro-intestinal disturbances such as constipation. **Overdose**: Please refer to SPC. **Basic NHS cost**: Packs containing 4 tubes of 15 tablets £3.62. **Legal classification**: P. **Marketing Authorisation Holder**: Laboratoire Innotech International, 22 avenue Aristide Briand, 94110 Arcueil, France. **Marketing Authorisation Number**: PL 19152/0001. **Full prescribing information available from**: Galen Limited, Seagoe Industrial Estate, Craigavon, Northern Ireland, BT63 5UA. **Date of Preparation**: February 2010

Laxido Orange, powder for oral solution: Please refer to the Summary of Product Characteristics (SPC) before prescribing Laxido Orange. **Abbreviated Prescribing Information. Presentation:** Single-dose sachet, each containing a white powder composed of: Macrogol 3350 13.125g, sodium chloride 350.7mg, sodium hydrogen carbonate 178.5mg, and potassium chloride 46.6mg. **Indications:** Treatment of chronic constipation and faecal impaction. **Dosage:** **Chronic constipation:** A course of treatment for chronic constipation with Laxido Orange does not normally exceed 2 weeks, although this can be repeated if required. Extended use may be necessary in the care of patients with severe chronic or resistant constipation, secondary to multiple sclerosis or Parkinson's Disease, or induced by regular constipating medication in particular opioids and antimuscarinics. **Adults, adolescents and the elderly:** 1-3 sachets daily in divided doses, according to individual response. For extended use, the dose can be adjusted down to 1 or 2 sachets daily. **Children below 12 years old:** Not recommended. **Faecal Impaction:** A course of treatment for faecal impaction with Laxido Orange does not normally exceed 3 days. **Adults, adolescents and the elderly:** 8 sachets daily, all of which should be consumed within a 6 hour period. **Children below 12 years old:** Not recommended. **Patients with impaired cardiovascular function:** For the treatment of faecal impaction the dose should be divided so that not more than 2 sachets are taken in any one hour. **Administration:** Each sachet should be dissolved in 125 ml water. For use in faecal impaction, 8 sachets may be dissolved in 1 litre of water. The reconstituted solution should be stored covered in a refrigerator (2°C to 8°C), for up to six hours. **Contraindications:** Intestinal obstruction or perforation caused by functional or structural disorder of the gut wall, ileus and in patients with severe inflammatory conditions of the intestinal tract (e.g. ulcerative colitis, Crohn's disease and toxic megacolon). Hypersensitivity to the active substances or any of the excipients. **Warnings and Precautions:** The faecal impaction diagnosis should be confirmed by appropriate physical or radiological examination of the rectum and abdomen. If patients develop any symptoms indicating shifts of fluids/electrolytes, Laxido Orange should be stopped immediately. The orange flavour in Laxido Orange contains glucose. Patients with rare glucose-galactose malabsorption should not take this medicine. The orange flavour also contains sulphur dioxide (E220), which may rarely cause severe hypersensitivity reactions and bronchospasm. **Interactions:** There are no known interactions of Laxido Orange with other medicinal products. Alterations to the absorption of certain drugs administered concurrently cannot be excluded. Therefore, other medicines should not be taken orally for one hour before and for one hour after taking Laxido Orange. **Pregnancy and lactation:**

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There is no experience with the use of Laxido Orange during pregnancy and lactation and so it should not be used unless clearly necessary. **Effects on ability to drive and use machines:** Laxido Orange has no influence on the ability to drive and use machines. **Undesirable effects:** Allergic reactions are possible. Potential gastro-intestinal effects include abdominal distension and pain, borborygmi and nausea. Mild diarrhoea may also occur, but normally resolves after dose reduction. **Overdose:** Refer to SPC. **Legal Category:** P. **Pack Size:** Cartons of 20 or 30 sachets. **NHS Price:** 20 sachets: £3.56; 30 sachets: £5.34. **MA Number:** PL 21590/0087. **MA Holder:** Galen Limited, Seagoe Industrial Estate, Craigavon, BT63 5UA, UK. **Full prescribing information available from:** Galen Limited, Seagoe Industrial Estate, Craigavon, BT63 5UA, United Kingdom. **Date of Preparation:** October 2008

Flotros 20mg tablets Prescribing Information Please refer to the Summary of Product Characteristics (SPC) before prescribing Flotros 20mg tablets. **Presentation:** Round, white, film-coated tablets each containing 20mg trospium chloride. **Indications:** Symptomatic treatment of urge incontinence and/or increased urinary frequency and urgency as may occur in patients with overactive bladder (e.g. idiopathic or neurologic detrusor overactivity). **Dosage: Adults:** 20mg twice daily, except in patients with severe renal impairment where 20mg once daily or every second day is recommended. Tablets should be swallowed whole with a glass of water before meals on an empty stomach. Review treatment at intervals of 3-6 months. **Children under 12 years:** Not recommended. **Contra-indications:** Urinary retention, severe gastro-intestinal conditions (including toxic megacolon), myasthenia gravis, narrow-angle glaucoma, tachyarrhythmia and hypersensitivity to trospium chloride or any of the excipients. **Warnings and Precautions:** Gastro-intestinal obstructive conditions, urinary flow obstruction with risk of urinary retention, autonomic neuropathy, hiatus hernia, reflux oesophagitis, those in whom fast heart rates are undesirable (e.g. in hyperthyroidism, coronary artery disease, and congestive heart failure), renal impairment. Caution should also be exercised in patients with mild to moderate hepatic impairment. Use of Flotros 20mg tablets in cases of severe hepatic impairment is not recommended. Organic causes of frequency, urgency and urge incontinence should be considered before beginning treatment. Flotros 20mg tablets contain lactose; patients with rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption should not take this product. **Interactions:** Potentiation of the therapeutic effect of other drugs that possess anticholinergic properties; enhancement of the tachycardic action of ß-sympathomimetics; decrease in the efficacy of pro-kinetic agents. Alterations to the absorption of drugs administered concurrently cannot be excluded. Medications containing guar, colestyramine and colestipol may inhibit the absorption of Flotros 20mg tablets, so simultaneous administration is not recommended. Metabolic drug interactions are not expected with Flotros 20mg tablets. **Pregnancy and lactation:** Caution should be exercised with the use of Flotros 20mg tablets during pregnancy and lactation. **Effects on ability to drive and use machines:** Ability to operate a motor vehicle or machinery may be impaired by disturbance of visual accommodation. **Side effects: Very common (> 10%):** dry mouth; **common (> 1%):** dyspepsia, constipation, abdominal pain, nausea; **uncommon (< 1%):** flatulence, diarrhoea; **rare (< 0.1%):** micturition disorders, urinary retention, tachycardia, disorders of accommodation, dyspnoea, rash, asthenia, chest pain; **very rare (< 0.01%):** tachyarrhythmia, myalgia, arthralgia, angioedema, mild to moderate increase in serum transaminase levels, anaphylaxis, headache, dizziness. **Overdose:** Please refer to SPC. **Basic NHS cost:** £18.20. **Legal classification:** POM. **Marketing Authorisation Holder:** Galen Limited, Seagoe Industrial Estate, Craigavon, Northern Ireland, BT63 5UA. **Marketing Authorisation Number:** PL 27827/0025. **Full prescribing information available from:** Galen Limited, Seagoe Industrial Estate, Craigavon, Northern Ireland, BT63 5UA. **Date of Preparation:** August 2009.

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THE RISING VALUE OF THE BOTTOM LINE

New economic pressures are thrusting finance directors into the role of leaders who must enable their board to make the best possible decisions, says Noel Plumridge

Close your eyes. Imagine that you have been seconded – perhaps as a placement within a leadership development programme – away from the pressures of the local NHS, and into the general manager role of a large branch of Britain's favourite general store. As you come to terms with your new environment, what do you notice?

Some aspects of your new role immediately seem familiar. Whether it is prawn sandwiches or Y-fronts you are selling, there are targets to meet, and little allowance for the impact of an economic downturn. There is detailed guidance from regional office on positioning your products to maximise sales. Weekly returns to submit. Inspectors to please. Exacting cleanliness and hygiene standards, supported by a culture of rigorous enforcement.

Most of the staff have been around forever and seem certain they know best. The press retain a nostalgic view of how the place should be run, taking an unhealthy interest in all you do. Many of the customers are opinionated and voluble.

Just like home. Yet in other respects so different. Although there is a constant quest for cost efficiency, head office understands that 20 per cent doesn't come out of the cost base without affecting product quality or without some impact on staff. No politician will name and shame you for attempting to reduce your costs. Consolidating outlying small branches into new superstores is accepted, popular even. Price cuts are not muddled with "efficiency savings".

Open your eyes

And, if your income is as unpredictable as the customer demand, at least the financial regime is not a mish-mash of artificial caps, ceilings and resource allocation formulas.

Open your eyes again. The good news is that you have graduated to an executive director post in the NHS. Congratulations.

The bad news is... it is the finance director job. So, let's help you take stock. What is the role of the NHS finance director in these tighter times? What are the principal challenges of financial leadership?

The first challenge, predictably, is to understand the numbers. As a qualified and experienced accountant you are numerate, and expect financial figures to be clear and unambiguous.

But to be a competent NHS finance director, you need to grasp which figures are real and which are aspirational. Which are the numbers your board members need to worry about, and which are the numbers where the worrying can safely be left to someone else?

'To be a competent NHS finance director you need to grasp which figures are real and which are aspirational'

What about that daunting £15-20bn national savings target, for instance. Questions your board colleagues may ask include: where did it come from, why is it so impossibly scary, and what is your organisation's share? The short answers are:

- Management consultants (McKinsey in this case), reinforced last June by the Nuffield Trust (see Chris Ham's *Health in a Cold Climate*) and repeatedly since then by the Department of Health
- It is scary because it is meant to be. Rather like the War on Terror, it is loosely defined (a £5bn margin of error, unrefined in over a year?) and handy for justifying heroic initiatives that might otherwise be awkward to push through.
- We will probably never know. So don't worry – you will never need to reconcile it to your annual budget or your long term financial plan. Despite appearances and hype, that £15-20bn figure has only totemic significance at local level.

Scarce funding

Essentially it is a projection of some possible future costs identified in the 2002 Wanless report *Securing our Future Health* – especially the demographics of an ageing population and the effect of pay inflation – translated into the savings that would be needed to pay for them when funding growth dries up.

Now, funding growth will be scarce indeed during the next few years, but NHS pay inflation doesn't appear likely to return any time soon, as HM Treasury uses the recession to claw back some of its Agenda for Change and new GMS contract largesse.

In short, things may not actually be that bad. You can still wield the £15bn stick to frighten obstinate budget holders or recalcitrant clinical directors, of course.

But the numbers you probably need to worry about – like that store manager – are your projected 2010-11 and 2011-12 income, and whether you can contain the organisation's spending within it. What is more, the significance of financial measures can change over time. For a primary care trust, being above or below your weighted capitation target has temporarily become almost meaningless, since funding growth is negligible and ministers are reluctant to withdraw funding from affluent areas.

The board will look to its finance director to understand these dynamics.

How much of this subtlety you choose to communicate with managers and clinicians, and even with your board colleagues, is a matter of judgement.

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task is not to hit your targets, satisfying as that may be, or to demonstrate your mastery of the system, but to empower your board to take strategic decisions. This empowerment is your second major challenge. As the Audit Commission said in its 2006 report *Learning the Lessons from Financial Failure*, finance is everybody's business.

"In reality there are no financial problems, only management problems," says the commission, arguing that "the best finance directors will seek sound solutions by engaging their board colleagues".

This was originally intended as a warning for finance directors tempted by innovative short term accounting solutions.

Political uncertainty

We all wish to be popular, and NHS finance directors have traditionally been admired for knowing how to "play the system", or for "having a deep back pocket".

This, in times gone by, has sometimes led to underlying problems going unresolved as some financial fix – involving depreciation periods, say, or brokerage deals, or the classification of capital and revenue spending – gets the organisation off the hook for another year, only to postpone a crisis.

The present political uncertainty, however, makes full board engagement with the finances essential. Aiming for "efficiency savings" of four or five per cent or more per year, including 2010-11, implies radical cost cutting across the NHS, and major transfers of care provision from hospitals to community and primary care.

But there is little appetite for cuts. Politicians of all colours made bold pledges during the recent election campaign. Huge savings are apparently to be made, without harm to frontline services, by the simple and hardly original expedient of eliminating waste and duplication and by the trimming of "back office" functions.

The very phrase "efficiency savings" has been discredited. Meanwhile a recent *HSJ* survey suggests the highest priority of newly elected constituency MPs is the cessation of hospital closures. So there may be trouble ahead. In April 2010 *Private Eye* reported, for instance, that NHS London plans to cut spending by £5bn by 2017. But such strategic health authority decrees will run counter to the promises of MPs, councillors and in some cases NHS non-executives. As you know, plans for reconfiguring services in London have been shelved.

It will be a rash finance director who intervenes and takes responsibility for solving these conundrums without explicit board support. Why stand between a rock and a hard place?

In this uncertain environment, the third challenge – and arguably the biggest – is to find ways of living with uncertainty, and helping your colleagues and your support staff to do the same. What does this mean in practice? Good advice would seem to be:

● Understand that there are no "givens". Planned changes in reimbursement systems and whispered changes in PCT configuration are probably off, for the foreseeable future. Even the payment by results system and the purchaser-provider split, two fundamental NHS building blocks in England, are under scrutiny.

● Play the part. Tempting as it may be to share your uncertainties, a degree of conformity to stereotypical miserablism may actually reassure your colleagues all is under control. After all, many of them have never managed through times of retrenchment. For a finance director, it is in the genes.

● Encourage colleagues to work towards a more flexible cost base. That probably means fewer buildings, fewer permanent staff, active management of labour costs; and decent information systems. Then the organisation might be able to ride the financial waves instead of being swamped.

● Above all, maintain the emphasis on productivity, quality and effectiveness – values that are never out of fashion and which might convince battle weary clinical colleagues that management has something important to offer. ●

Noel Plumridge is an independent consultant and former NHS finance director, noelplumridge@aol.com

ALAMY

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THE BIG FOUR

The latest reports on public health argue for tackling smoking, physical inactivity, alcohol use and obesity with greater investment and more partnership working, says Noel Plumridge

Public health may not yet have the highest profile among the new government's health commitments. Yet it has a health minister of its own – Anne Milton, the MP for Guildford – and an economic significance (with impressively big numbers) that can easily compete with a £15-20bn efficiency target.

Three reports published almost simultaneously early this year arguably set the public health agenda for years to come. Their combined message can be seen as:

- health inequalities and poor lifestyle will swamp us unless we do something
- but investing in public health improvement pays dividends
- and partnership is probably the way to make it work.

First, the Marmot report, *Fair Society, Healthy Lives*, the culmination of an independent review of health inequalities in England led by Sir Michael Marmot of University College London, makes the case that "we cannot afford to do nothing". It was commissioned by Alan Johnson in 2008. Marmot estimates the additional annual cost to the NHS arising from inequality at more than £5.5bn, and suggests it will rise materially if no action is taken.

Health inequalities cost over £20bn per year in welfare payments and lost taxes, plus £31-33bn in lost economic productivity.

Linked inequalities

As with the 1980 Black report on health inequalities, which was never accepted as government policy, only parts of the Marmot report may prove to be influential. Marmot's emphasis on giving every child the best start in life may strike a chord in Westminster; but his linking of health inequality with economic inequality and his proposed minimum income for healthy living seem unlikely to find favour in Whitehall in the present climate.

Both Marmot and a second independent report commissioned by the former government, *Enabling Effective Delivery of Health and Wellbeing*, concur in their assessment of the impact of poor lifestyle.

This second report, co-authored by Alwen Williams (NHS Tower Hamlets chief executive), Paul Cosford (NHS East of England director of public health) and Sir Howard Bernstein (chief executive of Manchester City Council) identifies four behavioural risk factors – smoking, physical inactivity, alcohol consumption and poor diet – as by far the biggest behavioural contributors to preventable disease. They account for at least £9.4bn of direct costs to the NHS each year, and are major risk factors for life-threatening long term illness.

Reports stress the cost of health risk behaviours

Again, if broader social impact is included the costs are far greater. The social cost of alcohol misuse alone has been estimated by the Cabinet Office at £20bn per annum.

Yet Williams *et al* suggest the return on investment on prevention initiatives is sound. A primary care trust spending £3.1m over a five-year period on reducing alcohol consumption, tobacco use and obesity, they argue, can anticipate possible net savings of £6.7m. Specific projections are:

Alcohol: £3.3m savings from a £0.8m investment in primary care screening, brief interventions and specialist referrals

Smoking: £1.2m savings from a £0.3m investment in targeted services, support for pregnant women and tobacco control

Obesity: £2.2m savings from a £2m investment in targeted services for people with a body mass index of 30 or above, support for weight management and behaviour change and follow-up of patients.

First find your £3.1m, sceptics may say. But a third report, *Healthy Balance*, published in March by the Audit Commission, estimates that no less than £21bn of the English NHS's £98bn is already allocated to PCTs on the basis of health inequalities.

Seven PCTs in seriously deprived areas – Heart of Birmingham, Liverpool, Knowsley, Manchester and three east London PCTs – receive about £400 per head of population above the England average.

So where does this money go? Much of it appears to be paying for higher hospital costs and higher rates of hospital admission: the effects of inequality, rather than its root causes, and the predictable consequence of a funding system that prioritises acute hospital treatment and care. "Very little... was spent on direct public health interventions", the commission found, "where there could be local flexibility".

"One agency working alone cannot tackle problems of smoking, poor diet, physical inactivity, excessive alcohol consumption and child health", concludes the commission, arguing for "strong partnerships with well-developed performance arrangements". But who will lead them? The new government's emphasis on joint working between PCTs and local councils, perhaps underpinned by pooled budgets to aid transparency, may be timely.

There are perhaps other conclusions too. One is the need to prioritise Williams et al's four big challenges above other public health aspirations. Another is that improving public health needs to become the core business of PCTs, and is their best way of contributing to that big national efficiency target.

And finally, is there really any excuse for government not to re-introduce appropriate controls? We have not become a society of Mediterranean café-drinkers in the 21st century: we have simply become a nation of boozers. If the NHS and its partners do their bit, so must Westminster. ●

Noel Plumridge is an independent consultant and former NHS finance director, noelplumridge@aol.com

Informing healthier choices

Delivering better public health knowledge

A review of the Informing Healthier Choices programme

To achieve the best possible health outcomes and make the hard spending decisions, local partnerships need accessible, relevant, local evidence and information. They also need expertise and training in how to use it. The Informing Healthier Choices (IHC) programme brought leading public health organisations together to respond to these needs.

After five years of work, and a significant investment by the Department of Health, the result is a range of successful knowledge and intelligence products, training and other resources. Some highlights are:

- **Health Profiles*** for England give local authorities a concise, comparable and balanced snapshot of the health of their local population. With a 'traffic light' spine chart, they are helping local authorities and PCTs to see clearly where the real challenges lie. www.healthprofiles.org.uk
- **Disease Prevalence Models*** for major conditions (see below right) plus a range of other tools and datasets.
- Accessible, **easy-to-use, free online training** to support everybody working in health, social care and well-being (see below). www.healthknowledge.org.uk
- **A career framework for public health**, with model person specifications and job descriptions, and indicative salary scales. www.phru.nhs.uk
- The **National Library of Public Health***, a unique evidence base, with up-to-date guidelines, strategies, policies and systematic reviews. It is now part of NHS Evidence. www.library.nhs.uk/publichealth

**Developed for IHC by the Association of Public Health Observatories*

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www.phru.nhs.uk

HOW WE HELPED ....

Director of Public Health –
The Health Profiles have shown us a snapshot of health in areas we cover. The traffic light system tells us where we need to focus our efforts to address inequalities and improve health outcomes.

www.healthprofiles.org.uk

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All training available on www.healthknowledge.org.uk

HOW WE HELPED ....

PCT Commissioning Board Member –
We used the Health Service Planning workshop to learn as a group – not only Board members and PCT officers, but local GPs, hospital clinicians, the local authority and the voluntary sector. Working together must bring better health outcomes for our community.

www.healthknowledge.org.uk

www.informinghealthierchoices.net

- A new set of tools and evidence for **Health Impact Assessment** helps policymakers ensure that health and wellbeing stand alongside other objectives, whatever the policy topic. www.hiagateway.org.uk
- In development (in partnership with the NHS Information Centre) is a **public health portal**, to be delivered as part of myIC. www.ic.nhs.uk

HOW WE HELPED ....

Director of an Acute Trust –
PCTs are using these new tools to help them decide what services they want from us. So we too started checking the Health Profiles and Disease Prevalence information, not just to be up to speed but also to identify potential pressure points for the Trust's services.

IHC was a true collaboration, with a Steering Group including Primary Care Trusts, the Association of Public Health Observatories (APHO), the Faculty of Public Health and the NHS Information Centre. APHO was the key delivery partner for tools and datasets, and the programme was managed by Public Health Action Support Team CIC (PHAST).

The last phase of the IHC programme is to make sure everyone knows how to access these products and to develop a legacy programme – homes have been found where the work can continue. To see where everything is now, go to **www.informinghealthierchoices.net/legacy**

Summing up, Programme Director Sir Muir Gray said: "At the end of the IHC project we can show significant progress in delivering better health intelligence. Most importantly, IHC's successful outcomes illustrate what can be achieved through effective partnership working."

HOW WE HELPED ....

Public Health Registrar –
I am on the Public Health Training Programme and used all the products on the healthknowledge website to study for my FPH Part A examination. They really focused my mind – I passed first time!
www.healthknowledge.org.uk

For more information about IHC and its products go to www.informinghealthierchoices.net or contact Simone Ranson, Programme & Business Manager, PHAST CIC
Email: simone.ranson@imperial.ac.uk Tel: 020 7594 0838 Mobile: 07947 739 040

Top models help improve planning

Disease Prevalence Models (DPMs)* for major long term diseases are helping commissioners assess need, plan services and invest in prevention, case finding, early detection and treatment.

DPMs for Cancer, Chronic Kidney Disease, Diabetes, Dementia and Mental Illness provide prevalence estimates at PCT and local authority area level. Those for Chronic Obstructive Pulmonary Disease, Coronary Heart Disease, Hypertension and Stroke have been extended to provide prevalence estimates at GP Practice level.

They are being used in Joint Strategic Needs Assessments, preparing for the demands likely to arise from implementing the new NHS Health Checks. Some have been added to NHS Comparators†, where they are used to calculate the ratio of the actual number of patients in a GP Quality and Outcomes Framework (QOF) disease register to the expected number based upon the DPM. This helps to identify under-diagnosis and supports measures for detection.

The models are at – www.apho.org.uk/diseaseprevalencemodels – where users can also find case studies from PCTs and sign up to be informed of new products.

†NHS Comparators is compiled by The NHS Information Centre (IC) and is available to registered users with an NHS email address.

HOW WE HELPED ....

Senior Public Health Analyst at a PCT –
I've used the Disease Prevalence Model for Coronary Heart Disease to alert a group of local GPs to apparent under-diagnosis. We've started a programme of case-finding, because early diagnosis is good for the patient and for the budget.
www.apho.org.uk

NHS

Mersey Care NHS Trust

Nottinghamshire Healthcare NHS Trust

West London Mental Health NHS Trust

THREE BECOME ONE FOR THE CONFEDERATION CONFERENCE

Three NHS trusts from across the country have come together for the NHS Confederation Conference, taking the opportunity it offers to raise awareness of the special nature of mental health trusts that provide high secure care.

Mersey Care, Nottinghamshire Healthcare and **West London** are the only three NHS trusts of their kind in England and Wales which provide the full range of services for people with a mental health problem, from community care to treatment in special hospitals like Ashworth, Rampton and Broadmoor.

At last year's conference the chief executives of all three trusts pledged to take the opportunity to have a joint stand at this exhibition in an effort to dispel some of the myths around the specialist care they provide. They hope it will raise awareness of the benefits of these services being integrated into mainstream mental health care providers and demonstrate excellence in treating people who represent a high level of risk to themselves and others.

Sadly there are still people who believe that high secure hospitals are just like prisons, where criminally insane 'inmates' are locked up. This compounds poor understanding of the front-line nursing role and pioneering psychiatric treatment of these hospitals as part of the NHS, where patients are treated with dignity and a firm understanding of human rights. While it is true that all patients are detained under the Mental Health Act and that public safety is a key responsibility of these organisations, the hospitals themselves are not like the facilities portrayed in movies. The care provided is in safe and therapeutic environments, where recovery is a key goal. Re-conviction rates among patients leaving special hospitals have fallen for the past 20 years and are four to six times lower than for mentally ill people held in prison.

All of the special hospitals take a multi-disciplinary approach across a number of roles such as nurses, doctors, psychologists, social care workers, occupational therapists, teachers, pharmacists and security advisers, among others. This highly-skilled workforce provides a wide range of therapies, interventions, education, rehabilitation and support. But life in a high secure setting extends much further to supporting patients' wider needs too, through social events, advocacy and inviting ward representatives to a patients' council or forum. Strong academic links ensure innovative practice in both biological and psychological therapies, while models of care and leading treatment have set out these organisations as world leaders in this challenging area of healthcare.

At the heart of their approach is protecting and respecting human rights and promoting recovery. People detained under the Mental Health Act are vulnerable to having their human rights compromised, for instance they have lost their 'right to liberty'.

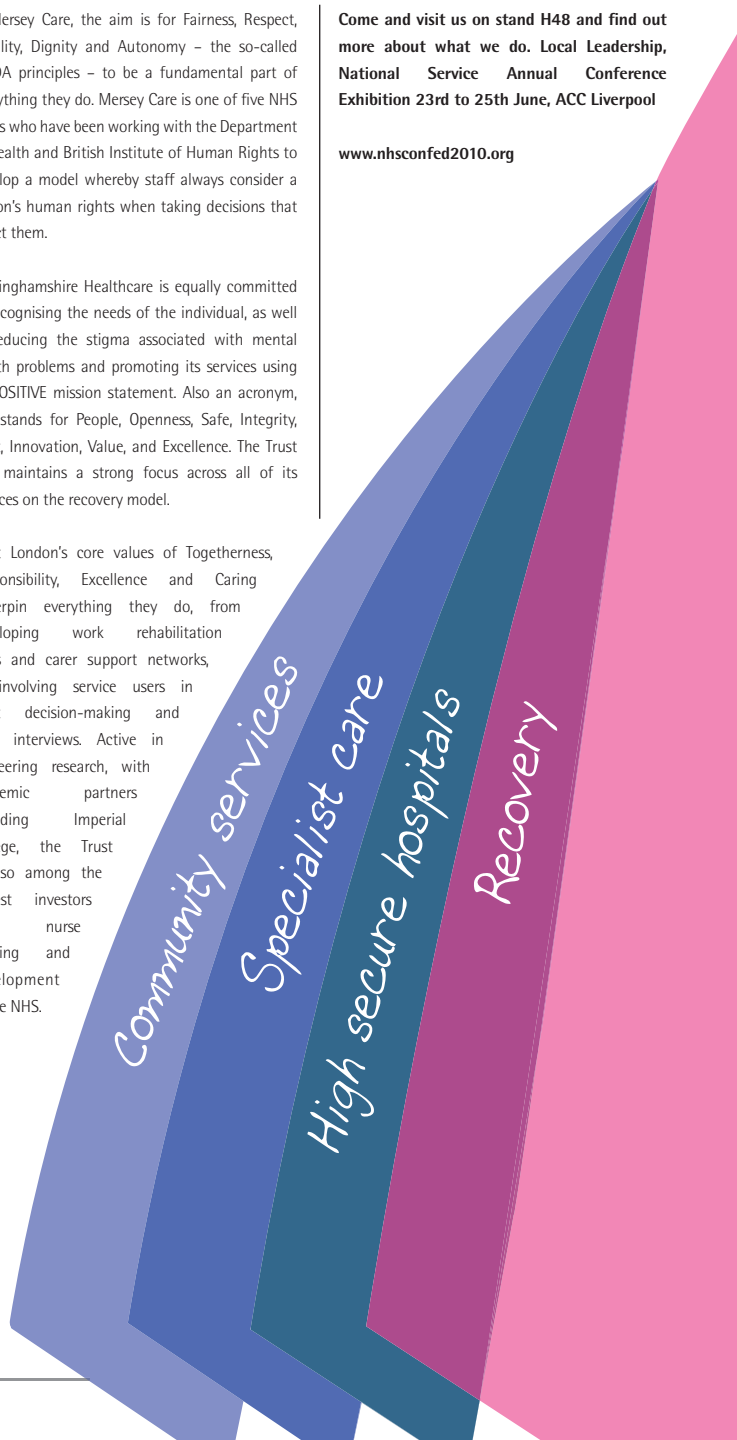
In Mersey Care, the aim is for Fairness, Respect, Equality, Dignity and Autonomy – the so-called FREDA principles – to be a fundamental part of everything they do. Mersey Care is one of five NHS trusts who have been working with the Department of Health and British Institute of Human Rights to develop a model whereby staff always consider a person's human rights when taking decisions that affect them.

Nottinghamshire Healthcare is equally committed to recognising the needs of the individual, as well as reducing the stigma associated with mental health problems and promoting its services using its POSITIVE mission statement. Also an acronym, this stands for People, Openness, Safe, Integrity, Trust, Innovation, Value, and Excellence. The Trust also maintains a strong focus across all of its services on the recovery model.

West London's core values of Togetherness, Responsibility, Excellence and Caring underpin everything they do, from developing work rehabilitation units and carer support networks, to involving service users in Trust decision-making and staff interviews. Active in pioneering research, with academic partners including Imperial College, the Trust is also among the largest investors in nurse training and development in the NHS.

Come and visit us on stand H48 and find out more about what we do. Local Leadership, National Service Annual Conference Exhibition 23rd to 25th June, ACC Liverpool

www.nhsconfed2010.org



FREED FROM THE BALANCE SHEET?

Is the political mood going to prove supportive of foundation trust autonomy despite public resistance to mergers and closures, asks Noel Plumridge

The essence of the hospital conundrum is that we have more of them than we now need, we can't afford to run them all, and clinical outcomes at some of the smaller ones are not always that great. If we are really to save £20bn over the next four years, around half a dozen hospitals in each strategic health authority need to go. Yet the political opprobrium attached to even hinting at closures sabotages such plans.

Ask Gloucestershire Hospitals. Ask NHS London. And there is no capital for new buildings to sweeten the closure pill.

The proposal that the assets and liabilities of all 130 foundation trusts in England should now be removed from the public sector balance sheet, put forward by the still relatively new Monitor chair Steve Bundred earlier this month, is made in this context. Not just private finance initiative funded hospital buildings, note: all of them.

Mr Bundred's language may be that of accountancy – a former finance director, his previous job was at the head of the Audit Commission – but his meaning is clear enough. Foundation hospitals would no longer form part of a publicly owned and publicly managed NHS. This does not necessarily imply privatisation: the formal model suggested is the legislation from 1992 that removed polytechnics from local authority control. But it does not preclude it.

Mr Bundred is known for taking an independent line. Last July, in an interview with *The Observer*, he called for a public sector pay freeze at a time when politicians still seemed in denial about the scale of the UK's fiscal deficit. But there are clear signals in the coalition's "programme for government", issued on 20 May, that the Monitor chair is "on message".

"We will develop Monitor into an economic regulator that will oversee aspects of access, competition and price setting in the NHS". The wording of the government's programme may appear cautious, opaque even. Certainly it suggests Monitor may soon wrest control of the payment by results tariff from the Department of Health, with implications for the extension of the tariff beyond acute hospitals, and may also subsume the role of the cooperation and competition panel. But the true significance lies in the term "economic regulator", which has a quite specific meaning in Whitehall.

Most economic regulators are essentially the legacy of the major privatisations of the 1980s and 1990s (the Civil Aviation Authority is a bit different). The first industry specific regulator was the Office of Telecommunications (Oftel), created in 1984 when 50 per cent of BT was sold off to the public. Regulators for gas (Ofgas) and electricity (Offer), which merged into Ofgem; for water (Ofwat); and the railways (ORR) followed between 1986 and 1993.

'Monitor's proposal raises issues. What would prevent FTs using their freedoms to shut services or sell buildings?'

In each case the newly privatised industry retained enough of a monopoly to suggest a need for regulation, on the grounds that the newly liberated giant might exploit its position via higher prices, lower standards of service, or both. Two core responsibilities were common: the protection of the public interest and the promotion of competition.

Now compare the state of the health "industry":

- There are now 130 foundation trusts but a diminishing number of new applicants, with boards perhaps deterred by Monitor's more stringent criteria (including a 5.1 per cent efficiency target in 2011-12).
- Prospects of growth via the acquisition of failing NHS trusts, and trusts judged incapable of ever meeting Monitor's criteria, seem to be receding. The risks of merger appear high, the rewards uncertain.
- Some very public lapses of quality leading to loss of reputation, most recently at Mid Staffordshire.
- A perception among commissioners, reinforced last November by the Audit Commission's *More for Less* report, that acute FTs are hindering the desired strategic shift from hospital to community settings.
- Primary care trusts unable to stimulate local competition and private providers, without growth funding, losing interest.

Is the public interest truly being served by the commissioner ineffectiveness lambasted in March by the health select committee? How genuine is "competition" in the health market, particularly in rural areas? And that is before the big new dilemma, of how to save £20bn without anyone really noticing, starts to dominate the post-election political scene.

Naturally Monitor's proposal raises technical, financial and governance issues. What would prevent foundation trusts using their "freedoms" to shut services or sell buildings? And the Bradford question: what would happen in the event of insolvency? But its real significance may be that the coalition, faced with its overriding need to balance the books, is now willing to treat healthcare not as a special case, but in precisely the same manner as other major sectors of the economy.

And if we do need to lose a few underproductive hospitals, what better way to do so at arm's length from ministers? ●

Noel Plumridge is an independent consultant and former NHS finance director.

FOTOLIA

DEADLY PATHOGENS HAVE A NEW ENEMY:
Introducing the GLOSAIR™ Area Decontamination Solution from ASP

While significant progress has been made in tackling healthcare associated infections (HCAIs), they continue to pose a serious risk to patient safety and require ongoing vigilance. According to the HCAI Research Network, patients with HCAIs are 7 times more likely to die in hospital than uninfected patients. These infections cost the NHS an estimated £1 billion a year[1].

One of the major reasons such a high prevalence of HCAIs remains in the UK is conventional disinfection methods of spraying and wiping do not fully protect patients, healthcare professionals or communities against major pathogens such as Meticillin-resistant *Staphylococcus aureus* (MRSA), Vancomycin-resistant *Enterococci* (VRE), *Acinetobacter baumanni* or *C. difficile*. A new impetus, focused on developing a holistic approach to area decontamination emphasizing prevention, is required to ensure both patients and healthcare professionals continue to be protected against the spread of deadly pathogens and microorganisms.

Area decontamination forms an important and complementary part of ASP's broader portfolio of surgical instrument sterilization, high-level disinfection and hand hygiene solutions. ASP's innovative solutions aim to provide a holistic approach to infection prevention.

Designed for small and large spaces in healthcare facilities, GLOSAIR™ technology (ASP's Area Decontamination Solution) provides the right balance of safety, efficacy and convenience. Using a low concentration hydrogen peroxide (H_2O_2) dry-mist technology to decontaminate surfaces, GLOSAIR™ technology has been proven a far more effective method of decontamination than conventional methods in tackling HCAIs.

"At the Royal Liverpool and Broadgreen University Hospitals NHS Trust we believe that innovative technology plays an integral part in empowering healthcare professionals to secure safe, clean environments. In the last year, we have halved our C.diff rates. With a greater emphasis on cleaning and cleaning standards, and the use of innovative solutions as provided by ASP such as the GLOSAIR™ 400, we have made tackling hospital infections our top priority. Our current performance clearly shows that our efforts are making a huge difference; we have gone from being one of the poorest to one of the best performing trusts in the country for infection prevention and control".

Diane Wake, Director of Infection Prevention and Control at the Royal Liverpool and Broadgreen University Hospitals NHS Trust

FOR MORE INFORMATION

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- Decontamination with dry-mist H_2O_2 is effective in eliminating MRSA[4]

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Recovery of *C. difficile* before and after hydrogen peroxide dry mist decontamination

	% (no.) of rooms positive for *C.difficile*	% (no.) of samples positive for *C.difficile*	Mean *C.difficile* cfu per 10 samples
Before H_2O_2 decontamination	100% (10/10)	24% (48/203)	6.8
After H_2O_2 decontamination	50% (5/10)	3% (7/203)	0.4

Shapey S, Machin K, Levi K, Boswell TC. Activity of a dry mist hydrogen peroxide system against environmental *Clostridium difficile* contamination in elderly care wards. *J Hosp Infect 2008; 70(2):136–41.*

1. Ref. http://www.hcainetwork.org/about%20hcai.htm (accessed on June 9, 2010)
2. Andersen BM, Rasch M, Hochlin K, et al. Decontamination of rooms, medical equipment and ambulances using an aerosol of hydrogen peroxide disinfectant. *J Hosp Infect 2006;62:149–55.*
3. Barbut F, Menuet D, Verachten M, Girou E. Comparison of the efficacy of a hydrogen peroxide dry-mist disinfection system and sodium hypochlorite solution for eradication of *Clostridium difficile* spores. *Infect Control Hosp Epidemiol 2009;30(6):507-14.*
4. Bartels D, Kristoffersen K, Slotsbjerg T et al. Environmental meticillin-resistant *Staphylococcus aureus* (MRSA) disinfection using dry-mist-generated hydrogen peroxide. *J Hosp Infect 2008;70:35–41.*

While care has been taken to present up-to-date and accurate information, we cannot guarantee that inaccuracies will not occur. Readers are encouraged to review the entire articles and form their own conclusions.

DON'T FEEL DOWN ABOUT BEING ON TOP

Why are managers so unloved by the public? John Carvel looks at why management has such an image problem and how strong leadership can change the stereotype

NHS managers should not be accused of paranoia when they complain about being unloved. They are just telling the truth. Opinion surveys commissioned by the Department of Health show the public is persistently critical of managers, who have never been able to attract the respect shown for doctors and nurses.

Several times a year since 2004, Ipsos MORI has asked samples of 1,000 adults across England what they think are the biggest problems facing the NHS. Each time the public's top three bugbears included "bureaucracy and top heavy management".

Optimists at the DH might fairly point out that only 20 per cent of the public complained about bureaucracy in the latest poll, compared with a peak of 40 per cent in the autumn of 2006. That is certainly an improvement.

But it must be galling for managers to learn they are still considered to be more of a problem for the NHS than the overstretching of the service caused by an ageing population – cited by only 10 per cent.

DH director of leadership Ross Baglin came to the NHS from a senior job in the oil industry and quickly noticed the fault line between managers and clinicians.

He says: "All great enterprises are built on teamwork, not on one group seeking primacy over another. We need to make the simple case that quality of leadership matters massively in the NHS, just as it does in business."

NHS Confederation policy director Nigel Edwards agrees that management's image problem is rooted in criticism from doctors, which he dates back to the reorganisation of the service in 1974.

"It was at this point that criticism of layers of bureaucracy entered the language and has never left it," says Mr Edwards.

Doctors believed they were accountable to their profession and they regarded accountability to managers as an invasion of their professional space, he says.

King's Fund chief economist John Appleby thinks the problem may have got worse over the last few years because people found it hard to understand why the number of managers increased faster than the number of doctors or nurses.

Raising esteem

According to the workforce census, the number of managers and senior managers rose from 33,810 in 2003 to 42,509 in 2009, representing 4 per cent of the workforce.

The DH view at the time was that more managers were needed to deliver NHS priorities, "including financial turnaround, record low waiting times, improved access to care and the lowest ever rate of healthcare associated infections". With less growth in the future, management costs are set to fall by 30 per cent by 2013-14.

What else can be done to improve the public's esteem for NHS managers? Several of the initiatives we are taking on at the National Leadership Council ought to help.

Strategic health authorities have been reporting an average of one appointable candidate for chief executive posts, but less than one for key director roles.

The NHS Top Leaders programme is designed to develop a supply of talented candidates to ensure that healthcare organisations are "spoilt for choice" when filling the most challenging jobs. If we can get more able, better prepared people into the top jobs, is it too much to hope the doctors and politicians will notice?

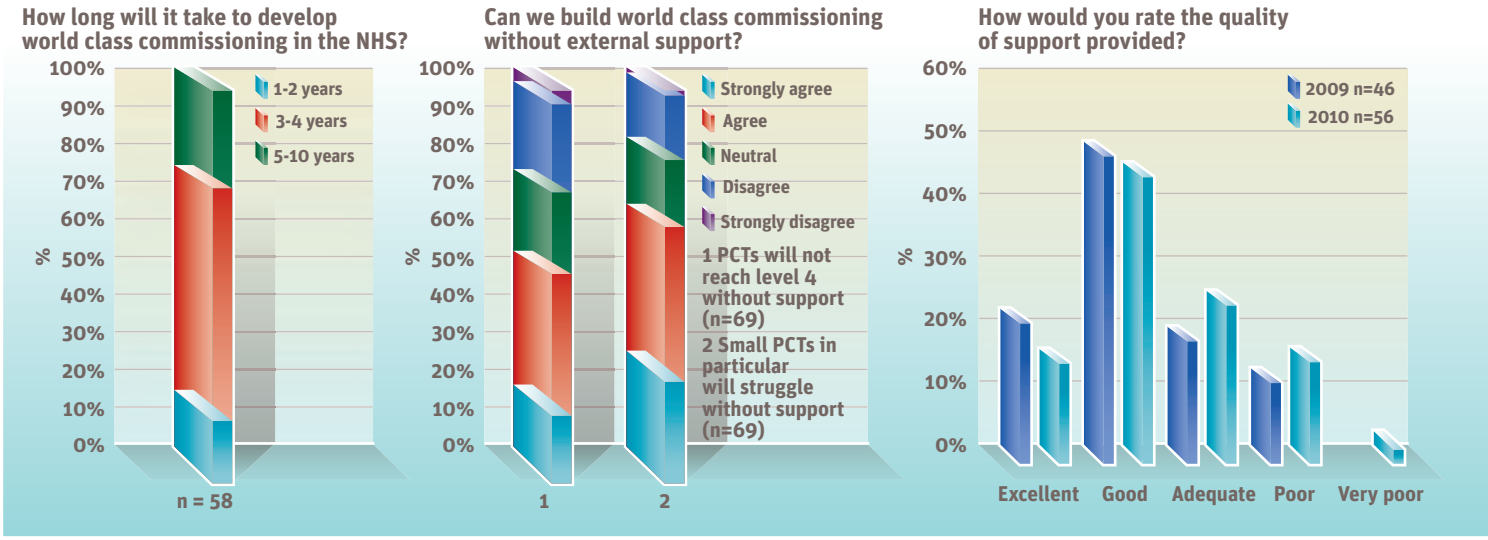
The Clinical Leadership Programme, meanwhile, is changing the training system to encourage more clinicians to spend at least part of their careers in management. We are looking at the DH advisory group's work on assuring the quality of managers and working with NHS boards to share best practice and learning on leadership.

Managers may also be able do more for themselves to raise morale and improve their reputation.

Managers in Partnership chief executive Jon Restell says: "Managers must become more visible to their staff, to the public and to local politicians. If we were known to them, they would find it a lot harder to attack us aggressively." ●

John Carvel was formerly social affairs editor of The Guardian and is now a member of the NHS's National Leadership Council, www.nhsleadership.org.uk

FOTOLIA



BRING THE OUTSIDE IN

External services can help PCTs and practices with the daunting task of commissioning. Chris Naylor of the King's Fund offers advice on how to buy in support effectively

Achieving world class commissioning presents a daunting challenge to primary care trusts and other commissioners. Soon to be published research from the King's Fund shows that it is becoming increasingly common for commissioners to buy in support from other organisations, including a range of private sector companies, freelance consultants and university based teams, to help them improve the way they commission. But does this work and, if so, what are the lessons so far for getting good value from external providers?

Around the country commissioners have adopted markedly different approaches towards using external support. Many have used consultants short term to help with a particular aspect of commissioning. Others have formed longer term partnerships which aim to transform the way they commission in a more profound and multifaceted way.

For example, NHS Northamptonshire has entered into a three year contract with UnitedHealthUK. The PCT used the Department of Health's *Framework for Procuring External Support for Commissioners* (FESC) to contract the service. Main elements of the project include:

- analytical support, eg health needs assessments and health equity audits;
- improving measurement of patient experience and using this to inform commissioning decisions;
- improving internal and external communications, including through using social marketing techniques targeted at specific population segments,
- performance management of service providers, including construction of an invoice validation system and a data warehouse to store hospital, GP and social care data.

As well as using external support to try to improve commissioning within the NHS, it is also becoming increasingly common to outsource certain aspects of commissioning. For example, PCTs in the East of England region have outsourced acute invoice validation to Humana.

The King's Fund's research examined the use of external support by a number of PCTs and strategic health authorities. In each site we spoke to NHS managers and representatives from companies providing support. Clear examples were given of external support having delivered improvements in a number of aspects of commissioning, including:

- data analysis and using data to drive decision making;
- commercial skills such as contract negotiation and monitoring;
- clinical engagement in practice based commissioning.

Success and failure

It was also clear that in some cases the use of external support had been more successful than others. Several examples were given of projects which failed to deliver the intended benefits. Based on what we heard, we have devised a number of principles for using external support effectively.

First, external support is best used to support long term strategic development.

Surveys were sent to all PCT chief executives and directors of commissioning (or equivalent). Responses were also accepted from other NHS staff working in commissioning. Responses to the surveys covered 53 per cent of PCTs in England in 2009, and 40 per cent in 2010. Where not stated otherwise, the graphs are based on 2010 data.

Source: King's Fund

'External support can add most value when it brings something new, by introducing new skills, tools and processes'

The ideal expressed by participants in our research is to have a vision for how commissioning should be performed in your organisation in five years, and then to consider whether and how external support might be used to work towards that ambition. There may also be an occasional need to use external support in a more reactive way, in response to short term imperatives, but the aim should be to minimise this.

Second, external support can add most value when it brings something new, by introducing new skills, tools and processes or by supporting structural or cultural change in your organisation. Our research suggests that often support is used to increase capacity to perform routine tasks. While there may be some value in this, doing more of the same may not represent the most cost effective way of using the skills in other organisations.

Third, it is important your organisation is in a position to benefit fully from the support services available. In the past, the impact of some projects has been limited because the client has lacked the managerial capacity or capability to implement or act on the work that external partners have produced. Organisational instability has also been a common stumbling block. Be sure to think about how work with external organisations will leave a lasting legacy, how skills and knowledge will be transferred, and whether projects will need an organisational development component if implementation is to be successful.

Fourth, be clear about what you need before issuing a tender for support services. Formal procurement processes are not the best channel for clarifying objectives and developing the specification for external support – it is better to do this through a more open dialogue with potential suppliers prior to tendering. If necessary, consider working with a consultancy to help develop the specification more clearly.

Fifth, do not underestimate the importance of investing in building good working relations between internal and external teams. Actively communicate the purpose of external support within the PCT before the start of the project, and help commissioners to see the project as an opportunity for personal development. Engage the clinical community with the work at an early stage, for example by including GPs on the selection panel during procurement of external support. A close partnership will make skills transfer easier and increase the likelihood of ideas being implemented successfully.

Finally, a central concern in the present financial climate will be the return on investment that external support offers. Commissioners will be under pressure to demonstrate that every pound spent on external support delivers measurable quality improvements or net budgetary savings. Working with external organisations on a longer term basis may provide a more cost effective way of getting help than using multiple short term consultancy contracts. If taking this approach, commissioners should explore risk sharing arrangements with potential suppliers, which can be used to make contracts more affordable.

If used appropriately, external support may help commissioners to respond more effectively to the twin challenges currently facing the NHS – developing better quality care and improving productivity. However, it is crucial that commissioners are aware of the pitfalls that need to be avoided in using external support. Learning from others' experience and spreading good practice will be important, especially as the major projects procured using FESC enter their final stages.

We hope that our research will help commissioners to get the most out of the range of services available. ●

Chris Naylor is senior researcher at the King's Fund.

Find out more

Building world class commissioning: what role can external organisations play? will be published soon by the King's Fund. Its findings will be presented at a conference on 13 July where a number of PCTs will also discuss their experiences

➔ **www.kingsfund.org.uk**

AL GRANT, FOTOLIA

NO MORE HEROES

New research has found engagement and relationship skills are the most valued management techniques, central to delivering improvement and value. Pippa Gough, Abigail Masterson and Jeanne Hardacre explain

Leadership of our health services must have quality improvement as its main aim. A recent investigation into how NHS leaders can embed quality into their organisation, undertaken by the Health Foundation, has reinforced this thinking.

The research illustrates the importance of leadership development programmes for both addressing personal development and relational ability, and for embedding the technical skills needed to deliver improvement and value.

A mix of relational and technical skills enables greater impact when translated into practice. One without the other may enhance intention and confidence in a leader but result in less effective quality improvement.

As resources for staff development become tight, it is increasingly important to understand how investment here can best impact on services. When considering leadership development, this has never been easy. Despite extensive evaluation by commissioners and providers of leadership programmes over the decades, there is limited consensus about what difference leadership development makes, and even less insight into how it impacts on services.

The researchers interviewed or surveyed 168 participants of the Health Foundation's leadership development schemes from 2001-08. They comprised practising clinicians and managers within the NHS, all engaged in service improvement work.

The findings indicate that certain engagement and relationship skills are fundamentally important to leading improvement (see box). The leaders in the study said these skills featured more prominently in their leadership approach than task related or conceptual skills.

Good leaders enable others to contribute their ideas

As quality improvement work becomes more complex, more effective NHS leaders increasingly appear to rely on their inter-personal and relational skills to bring about the changes involved. The key skill set includes self knowledge and empathy; appreciating others' perspectives; placing central importance on the skills and contributions of others; and encouraging processes which enable others to co-operate and collaborate in improvement work.

This means enabling others in the system to contribute their ideas. This is not only on a one to one basis, but by fostering networks and processes whereby people in the system can connect freely and openly, both formally and informally.

These findings resonate clearly with trends away from "leader as lone hero" towards leadership which embeds improvement into the culture of the system, so that it is not dependent on individual, often transitory, leaders.

The evidence supports the Health Foundation's shift towards investment in interventions designed to develop leadership skills for quality improvement and focus on the whole system as well as the individual as the target of change

The Health Foundation's flagship leadership programme, GenerationQ, incorporates not just the relational and technical aspects but two other leadership domains – personal leadership and contextual leadership (see box).

Personal leadership includes being highly self aware and authentic, and knowing one's own strengths, motivations and limitations. Contextual leadership focuses on enhancing local conditions (strategy, culture and environment) to be more conducive for quality improvement in the context of national policy and constraints. ●

Pippa Gough and Abigail Masterson are assistant directors at the Health Foundation. Jeanne Hardacre is an independent consultant and coach and an associate of researchers ORCNi.

Find out more

What's leadership got to do with it?
➔**www.health.org.uk**

MOST USED LEADERSHIP SKILLS

- Seeking, understanding and valuing the viewpoint of others
- Valuing the skills and expertise of others
- Creating networks for the creation and sharing of ideas
- Building structures that facilitate co-operation and collaboration
- Creating strategies to influence others through persuasive reasoning
- Building trust and confidence in others
- Tolerating ambiguity to promote creative solutions

LEADERSHIP – THE NEXT GENERATION

The GenerationQ programme aims to develop leaders in health organisations from a range of disciplines (including patient representative organisations) who will be confident and capable of responding to six key leadership challenges:

- Brokering sufficient multi-stakeholder participation and agreement
- Recognising and using the power of ambiguity and uncertainty
- Making informed and explicit choices about when and how to act
- Leading others in complex change
- Creating the conditions for "yes we can" local improvements in quality
- Embodying the personal qualities that sustain self and others

Recruitment to the next round of the GenerationQ programme will open in early 2011. Ongoing evaluation of the programme will reveal how investment in these activities has fulfilled our aspirations for improved value and quality of our health services.

ALAMY

Picker Institute Europe

Picker Institute Europe is a not-for-profit research organisation working to make patients' views count in healthcare. We specialise in patient research, and also undertake staff surveys and gather feedback from clinicians, other healthcare staff and the general public. Our clients include acute, mental health and primary care NHS Trusts, private sector providers, academic institutions and patient charities.

We offer a full research service – from designing the questionnaire and sampling strategy through to analysis, presentation of results and action planning workshops to make best use of your results.

We have developed questionnaires for many groups, including:

- Inpatients
- Outpatients
- Maternity
- Emergency care
- Mental health
- Paediatrics
- Primary care
- Sexual health
- Day case procedures
- Chronic care
- Oncology
- Diabetes
- Staff surveys

We offer the full range of feedback capture routes, from postal, online, telephone, face to face and SMS methods for remote collection to handheld devices and kiosks for use on wards and clinics.

We also undertake qualitative research (interviews, focus groups) and deliver quality improvement programmes.

For further information please visit:

www.pickereurope.org

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picker Institute Europe

Making patients' views count

Nick Richards Award 2010 for improvement in patient care

Picker Institute Europe has worked with healthcare organisations for over 10 years measuring patients' experience of their care and using this feedback to improve quality.

We have surveyed over 1.5 million patients and seen changes in both policy and practice as a result of what patients have said.

In memory of our dear colleague Nick Richards, who sadly passed away last year, we are inviting healthcare staff to apply for our 'Quality Improvement' award.

Nick was passionate about making a difference to the experience of every patient by using robust evidence to convince staff of the need for change. The successful team will be offered a six month improvement programme which will include a series of workshops on site.

We ask that healthcare staff are fully committed to working with us over this period, listening to the views of their patients and delivering real improvements in the quality of care.

We invite applications from all areas of healthcare; public, private and third sector.

Submission details

In order to be considered for this award healthcare teams will need to provide evidence of the following

- Culture of working with patients
- Commitment to improving quality
- Support at Executive level
- Nominated person to lead this work

Full details can be found on our website.
www.pickereurope.org

Deadline 30th July 2010, to start in Autumn 2010

picker Institute Europe

Making patients' views count

The Priory Group is Europe's leading independent provider of mental health services with more than 82% of funding coming from the public sector.

We work with individuals, their families and their care teams to create a personalised programme of treatment, care and education. Each programme is designed to maximise potential, increase self-esteem, promote independence and improve quality of life whether we're helping with a mental health condition, addiction, brain injury, old age or disability. Episode pricing is available.

Acute psychiatric services

Consultant-led primary and secondary care for a wide range of mental health conditions including:

- Addictions
- Depression, bi-polar disorder, anxiety and stress
- Eating disorders
- Child and adolescent mental health services

Care homes for older people

Nursing and care homes providing a dignified and individual service for residents who may:

- Be frail
- Be suffering with dementia
- Require general or specialist dementia nursing care
- Require respite accommodation

Education services

Education and care including respite care for young people aged four upwards with:

- Asperger's Syndrome (AS)
- Autistic spectrum disorders (ASD)
- Behavioural, emotional and social difficulties (BESD)
- Specific learning difficulties such as dyslexia

Specialist services

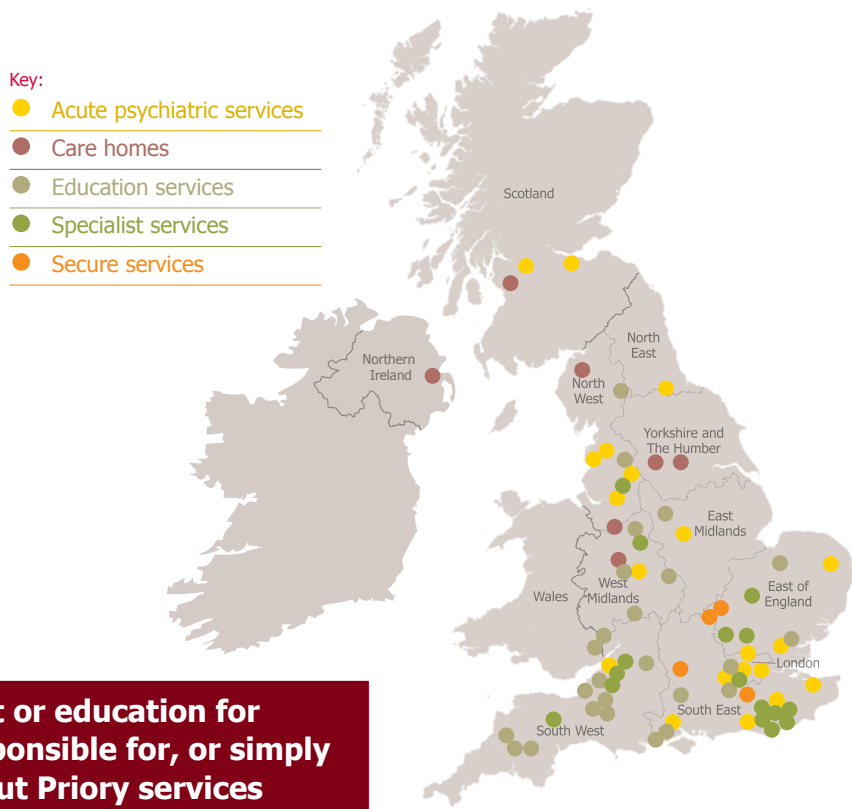
Individual care and treatment programmes including forensic services and respite care for:

- Adults and children with brain injuries (neuro-rehabilitation)
- Adults with complex and challenging behaviour
- Adults with learning disabilities
- Adults with physical disabilities
- Young adults with Asperger's Syndrome and autistic spectrum disorders

Secure services

Individual care and treatment programmes in a secure environment for informal or detained adults:

- Low secure
- Medium secure
- Psychiatric intensive care unit (PICU)
- Secure step-down facilities
- Specialist forensic programmes



To enquire about care, treatment or education for yourself or someone you are responsible for, or simply to request more information about Priory services please contact our central enquiry team on:

0845 2 PRIORY (0845 2 774679)

or send an email with your telephone number to info@priorygroup.com

www.priorygroup.com

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Individual care Innovative services Positive outcomes