Dearden welcomes...

Wendy Hull

Wendy Hull

Wendy has recently joined the Dearden team. She is a very senior and experienced Director of Finance, with a proven and strong track record in all aspects of effective financial management and budgetary control offering specific expertise in financial turnaround; service line reporting; progressing Foundation Trust application; Capital Planning and IFRS; governance and information technology.

Combined with effective interpersonal skills and extensive Board experience, Wendy makes a contribution beyond the finance role, providing effective and energetic leadership across organizations.

Wendy enjoys a challenge and has successfully undertaken five posts as Director of Finance; the last two specifically focused on sustainable turnaround; most recently at East and North Herts Trust improving a £22m deficit in 2006/7 to £2 surplus in both 2007/8 and 2008/9 and as Finance Director at South Tees Trust, recovering £30m savings in 2006/7. Prior to that Wendy was Finance Director with Greater Glasgow Health Board.

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DEARDEN

HARD TIMES

These are hard times. It would be easy to pretend that things are better than they are or to be overwhelmed by the challenges. Neither approach is to be recommended. We need to see the world as it is and well-founded optimism should be our mindset.

There is still evidence to justify well founded optimism. The resources made available since 2001 are still available. The investment that followed the Wanless Report was a historic turning point for the NHS. There have been real improvements in patient care including reductions in waiting times and the implementation of the National Service Frameworks. Foundation Trusts are a very promising model for the governance of provider units. The four home countries are free to develop their own distinctive policies and there will be much to learn from the differences – does commissioning deliver improvements or is integration the way forward? What are the relative merits of the two approaches? The Healthcare Commission has left a strong legacy including the valuable patient and staff surveys. NHS Employers is well established giving leadership to the NHS. Her Majesty's Opposition – and if the polls are right the next Government – has made an unprecedented commitment to the NHS describing it as "one of the most precious gifts we enjoy" and their "top priority".

Facing these challenging times

However the challenges are immense and must be faced openly and honestly. The deep recession will have a harsh impact on the resources available. The days of plenty are over. We should assume that there is unlikely to be significant growth until 2015/2016 at the earliest. The dreadful events in Stafford, and the reluctance to take responsibility, are clear evidence of systemic failure. It is possible for an NHS Trust to forget what it is there for – to fail the people it is there to serve – and to get away with it. The commendable efforts to focus on leadership may well be undermined by the continuing evidence of bullying and harassment and the reluctance to take on Chief Executive roles. The recent report from the NHS Confederation "Reforming leadership development... again" sets out the views of

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WE SHARE OUR THOUGHTS ABOUT NEGOTIATING THE IMMENSE CHALLENGES AHEAD...

Hard Times but Great Expe

What can clinicians expect over the next five years and how should they behave?

This Newsletter's editorial eloquently points out that the tighter financial position of the NHS in the next few years does not mean a return to the NHS of the 1980s and 1990s; the starting point is very different. As well as the factors discussed by Ken Jarrold there are two other important differences – the increased involvement of clinicians in leadership and the increased emphasis on clinical quality and patient safety. These have been talked about for many years but the way that Lord Darzi's NHS Next Stage Review has been received by all parties (political, professional and organisational) leads to some optimism that this time they have a chance of becoming a reality.

But what does this mean to individuals? What will be expected of clinicians, especially those in leadership roles and how should they react when asked to improve quality and safety at the same or less cost? There are pointers here in the way that Foundation Trusts have operated and, perhaps of even more relevance, in the challenges that have faced acute trusts undergoing 'Turnaround'. In both these situations experience shows that...

- There is no successful financial 'strategy' or 'recovery plan'; only a combined services and financial strategy/recovery plan has any meaning.
- There needs to be a detailed understanding of how services really operate and what professionals really do; only then can there be detailed service improvement, close alignment

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interviewees who thought that potentially excellent clinicians were put off CE roles because of "the very large risk" and several identified a problem of perceived or real toxicity in the wider system inhabited by CEs describing the environment as "brutal, arbitrary, prone to favouritism and intolerant of risk taking that is not successful". The political situation will be increasingly sensitive as a long serving government faces next year's election with very poor poll ratings.

In this edition of the Newsletter colleagues offer advice about the way through the challenge including the role of Non-Executive Directors and of Clinicians, turnaround, the push for quality and the future of community services.

In Hard Times it is important to have a firm grasp on what is important. The care and safety of patients must be the first concern of managers. Front line staff must be valued and supported. Behaviours need to be based on what we would hope for ourselves. The world must be seen as it is and the Emperor must be told that he is not wearing any clothes. Hard Times demand strong values in action, realism and honesty.

Nothing less will do.

Ken Jarrold CBE

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of consultant job plans with organisational objectives and the freeing of highly trained professionals to do what only they can do.

- There needs to be greater openness and discussion between clinicians and managers about the things that matter to both groups in order to get the best out of this detailed understanding.

- There needs to be significant investment in developing management and leadership skills in middle managers and clinicians to help them do this; preferably this should be done together, in-house, supported by senior leaders and focused on organisational objectives.

These four things sound simple but can be hard to implement in practice. The culture of the NHS with its increasingly discredited 'heroic' leadership style, blame culture and 'tribal' professional rivalries is still prevalent in some organisations. But it is possible to overcome this and well worth the effort.

For example, using the above approach clinicians will...

- Feel they are influencing the Trust strategy by improving quality and efficiency.

- Feel they are being freed to do the things they are trained to do rather than be frustrated by the system.

- Recognise they have responsibilities and accountabilities but be able to agree these with the organisation.

- Be able to make representations to the board and outside their organisations in a manner that middle managers or executive directors might not always be free to do.

While managers will...

- Be helped to identify where changes or investment can make a real difference thereby improving efficiency and productivity.

- Improve staff morale and working conditions (which are known directly to improve the quality of patient care).

And both managers and clinicians will be better placed to address issues that stretch across their professional or organisational boundaries.

The public's expectations of clinicians and managers alike have never been greater, but there are examples of where these expectations have been met. Organisational culture and leadership capacity are key.

If you would like to learn more about the ways in which Dearden can help your organisation develop its clinical leaders, please contact Dr David Dawson on 07940 438988 or at david.dawson@dearden.co.uk

Before joining Dearden, David was the Medical Director on a 'turnaround team' that helped remove a large acute hospital trust from 'special measures'.

Turning around turnaround

The economic forecast assumptions are well understood and the challenge is clear – the money must go further and quality cannot be compromised. The Commissioning for Quality and Innovation (CQUIN) will progressively link funding uplifts to improvements in targeted quality initiatives. The next spending review period from 2011/12 will be much tougher...

Current growth in health expenditure	Growth in public expenditure including benefits 2011/12		
	2011/12	2012/13	2013/14
4%	1.3%	1.2%	1.1%

In 2010/11 the public sector will need to find an additional £5bn through improving efficiency. As health represents 20% of expenditure, health's share is £1bn increases in efficiency.

To meet this challenge, NHS organisations, now well used to annual efficiencies, can no longer rely on savings found from the 'edges' of clinical and operational divisions. A real step-change in approach is needed, requiring real changes to work processes, the engagement of all staff and this commitment prioritised by Boards.

There must be a 'coming of age' of CIPs; no longer cost improvement programmes but, in the future, continuous improvement programmes. Otherwise the tougher planning assumptions will not be delivered; deficits and turnarounds will be back with no excuses for failure this time!

So what has been learnt from 'turnaround' and how might that understanding be used to deliver broader-based organisation-wide continuous improvement?

Engage the whole organisation in understanding the problem and contributing to the solution.

Service Line Management (SLM) potentially provides a powerful approach. Most organisations now can provide meaningful reports linking speciality income with costs; at the simplest level, identifying an allocation basis for distributing indirect and overhead costs to existing (direct cost) budgets. Resultant Service Line Reports (SLRs) provide a useful mechanism to review 'contribution' to the organisation's overall profit. Too easily such reports are used to identify the least profitable services in a way that does not necessarily reflect any understanding of the inter-dependencies between the different departments, particularly in hospitals.

The impact of the 2009/10 rebasing of national

MONITOR'S ASSUMPTIONS	2009/10	2010/11	2011/12	2012/13	2013/14
Assessor case Implied efficiency assumption	3.0%	3.5%	4.0%	4.0%	4.0%
Downside case Implied efficiency assumption	3.0%	4.0%	4.5%	4.5%	4.5%
Assessor case Clinical income	2.2%	1.7%	1.2%	1.2%	1.2%
Downside case Clinical income (excludes CQUIN uplift)	2.2%	1.2%	0.7%	0.7%	0.7%

tariff prices of HRGv4 has provided a salient lesson to such thinking. Local profitability profiles between specialities have been changed by national rebasing. This experience should now allow the more thoughtful development of SLM based on mature debate between clinicians focused on measuring how local costs benchmark against national average prices. Such systematic analysis, based on relevant and reliable data from patient-linked costing systems, could then provide focus for continuous improvement in every service, care pathway and speciality.

Understand the organisation's cost structure and improve efficiency by increasing income.

Not only is the economic landscape changing fast; but new policy initiatives provide opportunities to market and grow the business. Accepting patient choice and competition, contestability, plurality and the market testing language of the 'World Class' Commissioners should prompt a pro-active and not reactive response.

But providers need to do their homework as thoroughly as commissioners. Capacity and costs need to be understood in much more depth before an organisation rushes to offer service expansion or risks service reductions.

Business development and marketing opportunities need to be Board responsibilities with decisions informed by clinical leadership and reliable marginal cost analysis. The temptation is always to consider direct costs and income only, but it is the impact on the fixed overhead costs that will determine the profitability of each service development won or lost.

Work smarter and improve workflow processes by introducing technology to drive real business benefits.

As Connecting for Health rolls out (at great national cost), every organisation needs to be aggressively identifying organisation-wide opportunities to improve workflow processes and thereby deliver real business benefits from the investment.

Perhaps not glamorous, but technology can really improve the efficiency and effectiveness of background processes. Every new application upgrade is a major change opportunity and needs to be managed as such. Continuous improvement through the use of technology, engaging all staff in understanding the power of the application, training and process review would be money well spent and would deliver real cost reductions.

Huge economic challenges are ahead and the experience of turnaround needs to be put to good use to avoid returning to deficits. Organisations need to make a 'step change' in their approach to efficiency and pro-actively identify organisation-wide opportunities to 'do things differently'. Saving costs at the 'margins' is no longer enough. Every Board needs to holistically move to continuous improvement to remain financially viable. The lessons learned from 'turnaround' can be redefined in the new economic and policy landscape, but action is needed now!

If you would like to discuss the content of this article further please telephone Wendy Hull on 07710 120447 or email wendy.hull@dearden.co.uk.

Hard times never felt so good

How different it is today working in the NHS compared to the nineties. What a turnaround there has been in the last few years. Quality is the watchword and clinicians are beginning to believe the Department of Health really means it this time.

No more is it enough to manage the financial bottom line alone. There are standards to be measured, met and improved. There are staff surveys which generate action plans to be delivered, and what patients think about the services they have received in our hospitals and community services can make the difference between 'make or break' to commissioners and providers alike.

Over the last three months I have been working with the South East Coast SHA as the interim director for the development of their quality programme. I have never seen the issue of improvement to the quality of care being taken as seriously as it is there. Lord Darzi's report 'High Quality Care for All' followed by David Nicholson's letter about 'Measuring for Quality Improvement (MQI)' to all chief executives has given a clear message that only an improvement in the care commissioned and delivered will be acceptable. The establishment of Quality Observatories in every SHA which will collect, analyse and benchmark key indicators decided by commissioners and providers together will, for the first time, clearly allow clinicians to prove that they do, or do not, provide what is evidence-based best practice. The data will allow quality improvement targets to be set by commissioners and providers together. And when that improvement happens – then commissioners will have clear evidence that they are commissioning world-class care.

In the North West SHA's the 'Advancing Quality' programme, they have developed benchmarks for five groups of clinical indicators in five high volume conditions, delivered in every one of twenty four acute

hospitals in their area. There is real belief that this will greatly improve not only on the care delivered to patients, but the outcomes of that care will be improved also. The improvements will be in lower mortality rates, shorter lengths of stay, as well as savings to the bottom line of those organisations. Two other SHA's, South East Coast and South Central, are looking to work collaboratively with the North West to develop the methodology into other high volume conditions, and to spread the programme into primary care and mental health. South East Coast SHA, PCT chief executives are leading this is their areas to ensure they have the evidence to show the quality of their commissioning. This is the kind of support that should be welcomed by provider organisations to enable them to show they are delivering world class care. I believe this transparency in the system will lead to greater understanding and pride in attainment and continued delivery of proven best care with the resultant good outcomes for patients and improved satisfaction of the clinicians and staff working in these organisations. This is not an NHS about just targets and the need to balance the books; this is an NHS that believes that doing the right things will make all the difference.

Focus on improving quality of care even further

As the recent Chief Executive of the Queen Victoria Hospital NHS Foundation Trust (QVH), until December 2008, I was extremely proud of the quality of care delivered in that organisation. We achieved the Healthcare Commission rating of excellent/excellent two years in succession. We were voted top NHS acute hospital employer in the HSJ/Nursing Times survey and out-patients survey results were second best in the country. In the more austere times that we know we will face over the next couple of years, not only in the NHS, but in all public sector organisations, QVH, as other organisations, will have to focus on improving the quality of care even further. They will have to measure their results and plan how to improve them even more robustly, whilst still achieving all the targets they set in their business planning with Monitor. By using service line reporting and involving staff in leading the improvements they will be able to do more for less without undermining the quality of care. During 2007/8, through focusing on improved length of stay and more flexible skills of staff delivering care to the Community Services Directorate, a saving of £500,000 was made while still improving the care delivered. Another improvement that came about from rigorous clinical audit were shorter lengths of stay for patients waiting to come to QVH from other hospitals for tertiary care – this improved costs across the whole system.

It is sometimes difficult to prove that investments will deliver the benefits expected in acute hospital care. However if we follow the delivery of evidence-based practice, do the right thing, measure the outcomes and set our targets for improvements in care, I believe it will deliver any bottom line required in the future. The Department of Health support for this is paramount, and now we have it.

If you would like to discuss the content of this article further please telephone Sharon Colclough on 07766 688475 or email sharon.colclough@dearden.co.uk

Provision of Community Service

Community services have often been referred to as the 'cinderella services' of the NHS, less obvious than acute hospital based services that many are familiar with, but nevertheless providing vital services to many of the more vulnerable people in our communities, who, without the care of community-based services would struggle to manage, particularly in today's economic climate. Community services over the years have had many different homes and once more they face significant changes and challenges.

How community health services are organised and placed is firmly back on the agenda again. It is recognised that community health services have a crucial role to play in providing care to patients closer to home. The creation of internal separation of commissioning and provision to avoid any conflicts of interests are stated in both NHS operating frameworks 08/09 and 09/10 and reinforced in guidance issued by the Department of Health 'Transforming Community Services – Enabling Patterns of Provision', Department of Health, January 2009. In the NHS operating framework 08/09 (DOH 2007), it stated that 'all PCTs should create an internal separation of their operational provider services, and agree service level agreements for these, based on the same business and financial rules as applied to all other providers.'

Inevitably over the earlier years of PCTs, the management of significant provider services ranging from district nursing services, and in some cases mental health services, and a whole spectrum of smaller specialist services, has been significant, and has meant that many PCT Boards previously focused much of their attention on the management of these services, not least because service provision is often much more tangible than commissioning might appear to be. However, now the commissioning role of PCTs is very much in the spotlight, and following the outcome of the world class commissioning assessment process, PCTs are clear about the need to focus their energies on core commissioning.

In 'Transforming Community Services – Enabling Patterns of Provision' (DOH – Jan. 2009), a clear timetable is laid out for PCTs to follow. Many PCTs have already made significant progress with the separation process. All should have got to a position of internal separation by April 2009. As stated in the Operating Framework 2009/10, 'PCTs should ensure that their operational provider services are fit for purpose and able to perform effectively alongside all other providers. By April 2009, provider services should be in a contractual relationship with their PCT, providing sufficient separation from commissioning roles to avoid potential conflicts of interest.'

TIMETABLE FOR PCT PROVISION PROGRESSION

By April 2009...

All PCT direct provider organisations moved into contractual relationship with PCT commissioning function and be business ready.

By April 2009...

Development of commissioning strategies for community services by PCTs , shared with providers and informing organisational options.

By October 2009...

Development of detailed plan for transforming community services, including priorities for improvement and service development, proposals to enhance patient choice and introducing competition, drawn up by PCT commissioners and practice-based commissioners.

s, where next?

By October 2009...

PCT provided services review options for most appropriate organisational forms that best suit local need and circumstances and consider whether to declare an interest in establishing a Social Enterprise or Community Foundation Trust, based on the commissioning strategy.

From October 2009...

PCT commissioning arms complete service reviews and market analysis and establish and publish a procurement plan.

From October 2009...

PCTs will provide to, and agree with, their SHA their intentions for the future of provider services, timescales for potentially establishing Social Enterprises or Community Foundation Trusts, market testing and a plan for supply-side development or integration with other NHS organisations.

No later than April 2010...

PCTs will have agreed a clear and realistic strategy for the future of the community estate with their SHA.

During 2010...

PCTs should develop their implementation plan and progressing them, paying attention to the requirements of particular options.

From 'Transforming Community Services – Enabling New Patterns of Service Provision' DOH 2009

If a PCT decides to maintain direct provision, it is required to regularly review its service quality, viability and any financial risks or risk to sustainable services, the SHA ensuring that the process is robust.

At the heart of 'Transforming Community Services' is the need to ensure that patients are

receiving high quality care – safe, personalised and effective care. In the 'NHS Next Stage Review: Our vision for primary and community care' – DOH, July 2008, a public commitment was made to creating responsive community services of a consistently high standard. Quality and enabling transformational change in both clinical practice and services are crucial to the success of community provider services. The challenge is how to address this, maintaining a clear focus on quality and improving and modernising services, and not being distracted by organisational structures. There are many challenges for leaders and organisations, and there are many lessons from past experience that can be drawn on to help organisations ensure that they don't make the same mistakes, and learn from where things have worked well.

The Kings Fund have recently published an excellent document entitled 'Shaping PCT Provider Services –

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the future for community health' (2009), which highlights a number of lessons from previous experiences – highlighting the importance of effective leadership, team and collaborative working, clear understanding of goals, values-based approaches, significant investment in organisational development, focusing on process as much as structure, clinical engagement, understanding patient groups and needs, and paying attention to the human and cultural dimensions of change.

One of the other key challenges for PCTs will be the development of Provider Boards and associated governance arrangements. This will create different tensions and challenges and require Non Executive Directors within provider services to develop different skills.

Within Dearden we have a wealth of experience at working on a range of organisational development processes which would be beneficial to PCTs facing the challenging timetable outlined above. For example we offer board development, leadership development, clinical engagement and clinical leadership development, individual coaching for leadership/transition, service mapping and service development, strategy development, team building and staff development programmes, change management strategies, and many other tools and processes. We also have experience of international systems of health care and their application in the UK. We would be delighted to work with you.

In the first instance please contact Cathy Waters on 07500 013508 or cathy.waters@dearden.co.uk

Wanted... more ch

A Non-Executive Director recently talked to me about what had changed for him as a result of the Mid-Staffs and Maidstone and Tunbridge Wells scandals. He said "When there are major failures in patient care, such as in Mid Staffs; it is the Non-Executive Directors (NEDs) who live in the local community, and continue to do so after a new regime has been brought in to put matters right who suffer the outrage of the local community who ask – 'How could you allow this to happen on your watch? You were on the Board to ensure there was a local voice at the table holding the CEO and other Directors accountable'." Clearly a very uncomfortable position to be in, but how can the risk of a major failure in patient care happening again be reduced?

In their report '*Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance*' the Audit Commission identified recent failures of how Boards operate, and in particular the significant gaps between the processes on paper and the rigour with which they are applied.

The report identified three areas of concern:

- Where Board assurance processes were not always rigorously applied.
- Where Board members are not always challenging enough.
- That data received by Boards is not always relevant, timely or fit for purpose.

allenging Non-Executive Directors?

As part of the solution, the Audit Commission put emphasis on reviewing how to attract the best candidates to become NEDs, but say little about the wealth of experience that currently exists. Our conclusion from leading a large development programme for NEDs across one Strategic Health Authority, including PCTs, NHS Trusts and Foundation Trusts is that part of the solution may lie closer to home. There is a wealth of very able and experienced individuals serving as Non-Executive Directors. Thought needs to given to how their development needs are identified, and ensure they are given a tailored programme of support to operate at a higher level in the same way that the NHS supports individuals to grow to take on a board-level position e.g. Stretch to the Board Programme.

Addressing gaps in NED competencies

In an assignment Dearden have just completed we worked with over 75 Non-Executive Directors and generated significant evidence upon which to base a future training and development programme. Six areas were identified where specific interventions would address gaps in their competencies:

- Self-knowledge/behaviours and insight particularly supporting NEDs who had little previous personal development.

- Factual knowledge about the NHS outside their own organisation.

- Technical skills – chairing and facilitation of very high level discussions.

- Strategic thinking – managing the market, the changing health economy, governance and fitness for purpose, leadership & national policy.

- Mentorship – many NEDs aspire to Chair an NHS organisation. One way of facilitating this is to make sure talent is developed and not lost by putting in place suitable mentorship arrangements.

- Focusing on the patient experience - a clear desire to focus on patients and the local community.

NEDs are very clear that the typical training event where a series of speakers deliver presentations is not always an attractive way of addressing individuals' knowledge gaps. NEDs want a more interactive approach where they are actively engaged in 'listening and doing' with smaller groups and events locally provided.

There is considerable scope for the NHS to obtain better value from the wealth of talent it has within current NEDs, but it will not happen without their development moving up the agenda. The Appointments Commission transfer of responsibility for Chairs and NEDs development to SHAs is a starting point but it is clear that there is much work to do.

If you would like to discuss the content of this article further please telephone Derek Emm on 07974 574917 or email derek.emm@dearden.co.uk