A lot more for a lot less: Disruptive innovation in healthcare

Productivity and innovation
Turning hospital finances around
Disruptive innovation
Innovative delivery in the NHS
Policy levers for innovative delivery

With Rt Hon Stephen Dorrell MP, Lord Warner, Dr Peter Carter OBE, Dr Jane Collins, Professor Paul Corrigan CBE, Alastair Dick, Dr Jennifer Dixon, Peter Ellis, Dr Nicolaus Henke, Sue James, George Leahy, Lee Outhwaite, Ali Parsa, Joanne Shaw, Dr Devi Prasad Shetty, Sue Slipman, Dr Andrew Steeden, Nick Timmins, Dr Alfonso Bataller Vicent and Pedro Yrigoyen

Royal College of Nursing
20 Cavendish Square
London
W1G 0RN

Wednesday 8 June 2011
Reform is an independent, non-party think tank whose mission is to set out a better way to deliver public services and economic prosperity.

We believe that by reforming the public sector, increasing investment and extending choice, high quality services can be made available for everyone.

Our vision is of a Britain with 21st Century healthcare, high standards in schools, a modern and efficient transport system, safe streets, and a free, dynamic and competitive economy.

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## 08.30 – 09.00
Registration: tea and coffee

## 09.00 – 09.10
Welcome
Andrew Haldenby, Director, Reform

## 09.10 – 09.20
Introduction: Disruptive Innovation
Dr. Nicolaus Henke, Director, McKinsey & Company

## 09.30 – 10.00
Keynote speech: the productivity challenge
Rt Hon Stephen Dorrell MP, Chair, House of Commons Health Select Committee, will give a keynote speech on the scale of the productivity challenge and assess the Government’s approach to delivering value for money in the NHS. This will be followed by a question and answer session

## 10.00 – 10.50
Session 1: Turning hospital finances around
With over half of NHS expenditure spent in hospitals, trusts are on the front line to achieve value for money. Risings costs and tighter budgets will place many acute providers under severe financial pressure. Improving hospital productivity will be a major challenge for NHS leaders in the years ahead.

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<th>Name</th>
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<tr>
<td>Sue James</td>
<td>Chief Executive, Derby NHS Foundation Trust</td>
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<td>Finance Director, Derby NHS Foundation Trust</td>
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<td>Sue Slipman</td>
<td>Director, NHS Foundation Trust Network</td>
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<tr>
<td>John Drew</td>
<td>Partner, McKinsey &amp; Company, Head of the McKinsey Hospital Institute</td>
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## 10.50 – 11.20
Coffee

## 11.20 – 11.50
Session 2: Disruptive innovation: Integrated care
Health needs are changing and new health services are needed. With the rising costs of healthcare and a growing prevalence of chronic conditions there is new interest in transforming traditional health services to deliver integrated care.

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<tr>
<td>Dr Alfonso Bataller Vicent</td>
<td>Deputy Minister, Department of Health, Valencia, Spain</td>
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<td>Dr Andrew Steedan</td>
<td>Clinical Director, NHS North West London</td>
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<td>Dr Jennifer Dixon</td>
<td>Director, McKinsey Hospital Institute</td>
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## 11.50 – 12.20
Session 3: Disruptive innovation: New delivery models
Advances in medical science and modern technology have the potential to revolutionise healthcare. But more innovative and efficient services continue to be frozen in old, high cost business models. New business models to make healthcare more affordable, accessible and sustainable.

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<tr>
<td>Dr Devi Prasad Shetty</td>
<td>Chairman, Narayana Hrudayalaya Hospital, India</td>
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<tr>
<td>Professor Paul Corrigan CBE</td>
<td>Former Health Advisor to Tony Blair</td>
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<tr>
<td>Nick Seddon</td>
<td>Deputy Director, Reform</td>
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## 12.20 – 12.50
Session 4: Disruptive innovation: Technology based networks
The latest technology allows medicine to be brought closer to the patient. Improving access to information has the potential to empower patients to make better choices, while telehealth can allow patients to take greater control of their health. Realising the potential of technology based networks will revolutionise healthcare.

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<tr>
<td>Pedro Yrigoyen</td>
<td>co-founder of MedicaliHome, Mexico</td>
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<tr>
<td>Joanne Shaw</td>
<td>Chair, NHS Direct</td>
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<tr>
<td>Thomas Kibasi</td>
<td>Associate Principal, McKinsey &amp; Company</td>
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## 12.50 – 13.40
Lunch

## 13.40 – 14.30
Session 5: Innovative delivery in the NHS
Pioneers in the NHS are already changing how healthcare is delivered. The NHS has started to capture the potential of modern technology and modern medicine through innovation. Building on best practice and learning from international innovators will be vital to make the NHS more affordable, safer and better quality.

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## 14.30 – 15.20
Session 6: Policy levers for innovative delivery
The QIPP initiative to achieve £20 billion of savings by 2014 focuses on the role of innovation in finding productivity gains in healthcare. However the NHS has often been slow to adopt innovation, while weak competitive pressures and high barriers to entry discourage new entrants and more disruptive innovation.

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<tr>
<td>Lord Warner</td>
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<td>George Leachy</td>
<td>Deputy Director – Innovation, Department of Health</td>
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<td>Ali Parsa</td>
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<td>Public Policy Editor, Financial Times</td>
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## 15.20
Close
Nick Seddon and Dr Nicolaus Henke will sum up and close the conference.
Comment

We need to open up the NHS to a world of cheap innovation

Nick Seddon, Deputy Director

Those in need of heart surgery could do a lot worse than jump on a plane to India’s Narayana Hrudayalaya Hospital, one of the world’s leading cardiac centres, which is doing open-heart surgery for roughly $1,800. That’s much less than a typical Indian hospital, and a tenth of what it costs in the NHS. The doctors know this: they get their department’s profit and loss texted to them on a daily basis (most of our doctors never see theirs). It’s not just cheap, it’s good. In 2008, the 42 surgeons in the cardiac centre performed more than 8,000 surgeries – a volume unheard of in developed countries. As the number rises, so does quality: on clinical measures for heart bypasses, for instance, they do significantly better than other hospitals in India, as well as many overseas. What the owners have realised is that in medicine practice makes perfect, just as it does in other sectors.

This is the kind of innovation that can transform health care for patients. Many of the most exciting innovations are coming from emerging economies where, because money is tight, necessity has been the mother of invention. These new ways of doing things disrupt the old ways of doing things. Of course, the naysayers will holler about the risks, but what has happened in other service sectors needs to happen in health care: innovations are introduced by new entrants at the bottom of the chain and then, as they prove successful, they force others to keep up – or go out of business. Remember mainframe computers? It is rarely those who have dominated a mature market who deliver innovation, as their business model is based on traditional assumptions.

From the Far East to Africa, Latin America to Asia, patients are being given the tools to take charge of their own health care. In Mexico, $5 a month added to the phone bill allows patients to access Medicall Home’s doctors 24/7, and the company is expanding into the management of chronic diseases. Patients have their calls answered within three seconds, and nearly two thirds of callers have their health queries resolved over the phone. With English GPs facing increasing pressure from the worried well – and new responsibilities to manage NHS budgets – this is the kind of game-changing idea that could help them out. Almost all of us have mobile phones, after all.

Or take Singapore, which spends 4 per cent of its GDP on health care, yet has an average life expectancy of over 80 years. (The World Health Organisation ranks it sixth in the world.) That’s half as much as we spend, for better results. This has created its own problems: they have an ageing population and a heavy burden of chronic diseases such as diabetes, asthma or coronary heart disease. If Singapore, like the UK, tried to treat all of these people in hospitals, the system would soon go bust. So it introduced a national programme with regular screening and monitoring, encouraging patients to seek medical care regularly before things went wrong, and educating them to live more healthily. By the end of the second year, half of those targeted had got their disease under control and were using the best treatments. Hippocrates was right: the patient can be the best doctor.

With a tide of chronic diseases rising, another challenge is to make care joined-up – in the buzzword of the moment – seamlessly “integrated”. This means getting GPs, community clinics and hospitals to work together much more effectively. In the Spanish region of Valencia, where private companies are running joined-up, universal health services for large populations, one IT system links up the whole system. Patients can check the length of the queue in their GP surgery or hospital from their television at home – and take their pick. Hospitals and surgeries stay open for longer, reflecting a more patient-centred ethic. Not surprisingly, care quality is uncompromised, patient satisfaction has soared, and all at 25 per cent cheaper than the public sector.

Likewise, Kaiser Permanente, a not-for-profit company with almost nine million members across the United States, has spent years pioneering outbound medicine for patients with chronic conditions. It makes sure that if you have a condition like diabetes, your GP will be a specialist in that condition. At any time of the day or night, you can go into any pharmacy and have a test done. The computer will analyse the data against a statistical sample and if there’s a problem a red risk flag comes up. Your doctor will be sent an email and then give you a call to check whether, for instance, you’re still taking your drugs. This real-time tracking has made Kaiser a world leader in preventing unnecessary and expensive visits to hospital, consistently performing better than the NHS on value for money.

David Cameron recently declared that he wants the future NHS to look much like it is today. Actually, we should want it to look recognisably better. Across the globe, pharmaceuticals, medical technology and care services are changing at a bewildering pace. To keep up, to have a service that is truly world-class, to allow our patients to benefit from the best ideas, we need to open up the NHS. Narayana Hrudayalaya is rolling out a chain of hospitals across India. Why not here, too? The solutions are out there; we just need to open our eyes – and our doors to the innovators.

First appeared in The Daily Telegraph on 10 June 2011
Summary

The conference

On 8 June 2011, Reform brought together around 150 delegates, from policy, business, the NHS and the media, to listen to and debate presentations on disruptive innovation in healthcare. The speakers were:

- Rt Hon Stephen Dorrell MP, Chair, Health Select Committee
- Dr Nicolaus Henke, Director, McKinsey & Company
- Sue Slipman, Director, NHS Foundation Trust Network
- Sue James, Chief Executive, Derby NHS Foundation Trust
- Lee Outhwaite, Finance Director, Derby NHS Foundation Trust
- John Drew, Partner and Head of the McKinsey Hospital Institute, McKinsey & Company
- Dr Alfonso Bataller Vicent, Deputy Minister, Department of Health, Valencia, Spain
- Dr Andrew Steeden, Clinical Director, NHS North West London
- Dr Jennifer Dixon, Director, Nuffield Trust
- Professor Paul Corrigan OBE, Former Health Advisor to Tony Blair
- Pedro Yrigoyen, co-founder, MedicalHome, Mexico
- Joanna Shaw, Chair, NHS Direct
- Dr Peter Carter OBE, Chief Executive and General Secretary, Royal College of Nursing
- Dr Jane Collins, Chief Executive, Great Ormond Street Hospital for Children NHS Trust
- Alastair Dick, Managing Director, Serco Health
- Peter Ellis, Managing Director, EMEA, PharmaTrust UK
- Lord Warner, Former Health Minister 2003-2006
- George Leahy, Deputy Director – Innovation Policy, Department of Health
- Ali Parsa, Managing Partner, Circle
- Nick Timmins, Public Policy Editor, Financial Times

This conference provided the chance to hear the views of these figures and, in turn, provided them with the opportunity to receive questions from a range of delegates. A booklet containing short think pieces was published with the summit. Presentations and questions and answers during the day were recorded. This report contains a copy of the agenda of the event, the booklet that accompanied it and the transcript of the discussions.

The summit, and particularly the international case studies of disruptive innovation, received extensive press coverage. The Schumpeter column in The Economist reported that “NHS veterans repeated the old saw that the NHS is the closest thing Britain has to a national religion. But they also listened excitedly as Indians and Mexicans told stories of innovations back home.” Reviewing the examples of innovation in India, Mexico and Spain in The Times, Camilla Cavendish wrote “medicine is the product of human ingenuity... So why don’t we apply our ingenuity to managing healthcare?” Dr Devi Prasad Shetty appeared on the Today Programme and argued that “unless doctors take care of the financial management of the hospital, that hospital has no future”. In response Stephen Dorrell said of the question “whether we need to move in this direction, I think the answer to that is ‘yes’”.

Disruptive innovation

Introducing the themes of the conference, Dr Nicolaus Henke, Director at McKinsey & Company, set out the global challenge to make healthcare affordable, not only for today but for the next 100 years. With healthcare outgrowing the economy by 2 per cent each year across the developed world, by 2100 US health spending could reach 96.8 per cent. To meet the challenge of rising expectations, new technology, changing lifestyles and an ageing population, the delivery of healthcare has to be reformed. There are three opportunities for “disruptive innovation”: franchising, technology enabled delivery, and specialising healthcare in “focused factories”. These new models all understand the needs of patients, they use existing technology disruptively, maximise use of clinical teams, use standard operating procedures and use other people’s assets. To bring these disruptive innovations to the NHS, Nicolaus suggested five essential reforms: regulation needs to change in the face of new technologies, health results need to be measured and published, payment mechanisms need to incentivise outcomes, new delivery must replace old and clinical leadership must embrace innovation.

The productivity challenge

In his keynote speech, Rt Hon Stephen Dorrell MP, Chair of the Health Select Committee, responded by putting the global challenge to make healthcare affordable in an English context. He argued that as societies get richer, they spend more of their wealth on healthcare. If healthcare is going to be the largest single sector of the economy, making it productive is vital for both social and economic policy. But over the next four years 4 per cent increases in demand will be met by 0 per cent increases in spending. This is the “Nicholson challenge”, which has not been achieved in any health system ever before, and is the “genuinely radical unprecedented thing that Government is seeking to do.” However, “if you want to deliver something that no one has ever done before, it’s not a bad idea to keep your eye on a ball.” Key to meeting this challenge is ending the fragmentation of the system, creating a culture of improvement through releasing information on performance, empowering commissioners and capturing the competitive energy of clinicians.
Turning hospital finances around
Sue Slipman, Director of the NHS Foundation Trust Network, described the challenge facing hospitals, “the churches” in the national religion of the NHS. Acute hospitals need to achieve efficiency savings of 5.7 per cent while demand will grow faster due to cuts elsewhere. Service line reporting, improving patient pathways, benchmarking quality and sharing back office functions will improve efficiency of hospitals, but political leadership is needed to ensure vital reconfigurations of hospital services take place.

Sue James and Lee Outhwaite of Derby NHS Foundation Trust spoke of their experiences in managing hospital costs and the importance of working proactively in the wider health economy. Forming a partnership with local clinicians and the primary care trust to manage demand is essential to ensure both hospitals and commissioners remain financially sustainable. These strategic partnerships are particularly necessary to manage patients with long term conditions and focus on prevention. However there remains a lack of understanding, among the public and politicians, that healthcare has to change and this needs to be much better communicated. Sue James also argued that clinicians need to be engaged in the productivity challenge and NHS leaders need to be supported in delivering more efficient, high quality healthcare.

Disruptive innovation – integrated care
Integrated care in Valencia has been developed through dividing the region into 24 different concessions, each with a capitated budget to deliver all routine healthcare. Dr Alfonso Bataller Vicent of the Department of Health in Valencia described how outsourcing five of these departments to private companies on long term contracts has helped create strong incentives to integrate care and develop primary care services.

Dr Andrew Steeden presented the integrated care pilot in North West London that aims to reduce emergency admissions by 30 per cent and reinvest in primary care services. Multidisciplinary Groups of clinicians will develop and monitor care plans for patients with long term and complex conditions.

Disruptive innovation – New delivery models
Dr Devi Shetty of Narayana Hrudyalaya Hospital in Bangalore described how the delivery of high volume, highly specialist services can reduce costs and improve quality. Narayana Hrudyalaya does 8,000 heart surgeries a year or 60 each day. This scale has allowed the costs of surgery to be cut to £1,800, 60 per cent lower than other Indian hospitals, while quality has improved. Costs are also controlled by producing a daily profit and loss account for all senior doctors and managers.

According to Paul Corrigan, former Health Advisor to Tony Blair, disruptive innovations in healthcare will not work in existing NHS business models. Current business models are based on increasing inputs and new ones are needed to realise the value of co-production, with the patient becoming more active in healthcare.

Disruptive innovation – Technology based networks
Speaking about Medicall Home, Pedro Yrigoyen set out how over the phone consultations are handling 62 per cent of medical cases in Mexico. This engages patients in their care and reduces primary care and emergency admissions. Joanne Shaw of NHS Direct reflected that the NHS still needs to be more effective in using everyday technologies to transform the way in which people access healthcare. She cited the reluctance of health professionals and disincentives in the system to treat people outside the hospital. She also recalled the resistance NHS Direct encountered from the established health service.

Innovative delivery in the NHS
This session discussed how innovation in the NHS can be defused. Peter Carter of the Royal College of Nursing made the case for the redesign of services to improve safety and value for money and highlighted the need to reduce waste, particularly in prescriptions and procurement. He described examples of nurse led innovation and his concern that best practice was not adopted more widely across the service. Peter also stated that the RCN supports the intelligent redesign of hospital services.

Jane Collins of Great Ormond Street Hospital argued how important it was to engage clinicians in the quality and safety improvements of innovation and efficiency, and how the NHS can learn from other organisations on how to achieve quality and value for money. According to Alastair Dick from Serco Health, innovation in the NHS can be supported by new commercial structures such as joint ventures, clear lines of accountability and freeing up leadership within NHS structures to catalyse change. Describing a particular innovation in medicine management, Peter Ellis set out how remote pharmacies have made prescriptions and clinical advice more accessible to patients, while also reducing errors.

Policy levers for innovative delivery
The last panel explored how public policy can encourage innovation in the NHS. Lord Warner argued government policy has to be consistent, both in demanding efficiency savings from NHS providers and opening up the service to competition and new providers. George Leamy from the Department of Health suggested that commissioning for clinical outcomes and effectively managing failure in the NHS would incentivise greater innovation. Ali Parsa from Circle claimed the key priority for policy makers will be to find out how to encourage international innovators to deliver NHS services, and stressed the need to open up both the private and public health markets to new providers. Concluding the session, Nick Timmins from the Financial Times spoke in favour of competition to improve NHS services and suggested that structural reforms often have little impact on NHS services and local variation in organisation should be accepted.
Embracing innovation in the NHS

The NHS is at a crossroads: if it is to secure higher quality care and shorter waiting times, it must dramatically raise productivity. If the NHS stands still, it will fall back. One route to better value is to embrace innovations in how care is delivered. Our global search with the World Economic Forum found many innovative solutions to long established healthcare problems.

Emerging markets are where the greatest innovations in healthcare delivery are to be found. From the Far East to Africa, Latin America to Asia, necessity has bred innovation. In the face of enormous health challenges and poor health system performance, innovators have stepped up to the challenge. So here are three ways in which the NHS could embrace innovation and rethink its approach to delivery.

First, the NHS should empower patients to undertake more of their own care themselves. Whether in online check-in for airlines or self-service tills at supermarkets, customers in other sectors are taking on greater roles leading to both more efficient businesses and higher satisfaction. A move to so-called ‘self-care’ would see chronic diseases such as diabetes managed by patients themselves in partnership with professionals – working together over the phone rather than through in-person visits.

In Mexico, for example, $5 a month added to the phone bill allows patients to access Medcall Home’s doctors 24/7, and the company is presently expanding into the management of chronic diseases. Medcall’s patients have their calls answered within three seconds, and nearly two-thirds of callers have their health queries resolved over the phone. With GPs facing increasing pressure from the worried well – and new responsibilities to manage the NHS budgets – a successful telephone-based chronic disease management and triage service could free up huge amounts of time and resources.

Second, the NHS should enable and encourage highly focused units that seek to serve specific patient groups, rather than relying on one-size-fits-all delivery models. LifeSpring Hospitals in India offer high quality maternity care for one-sixth of the cost of their competitors. How? They looked at manufacturing plants, low-cost aviation, and successful service industries and applied the lessons to their business. Streamlining processes and eliminating waste has enabled them to improve quality, lower cost, and improve access and patient satisfaction. Existing NHS providers and new entrants should pursue this route to higher quality and productivity.

Finally, with the rising tide of chronic diseases such as diabetes or coronary heart disease, the big challenge is to achieve seamlessly integrated care across the health system. This means integrating and personalising the management of chronic disease through greater collaboration between primary care and acute providers. The Valencia region of Spain has achieved this through powerful incentives and timely information, with one IT system serving both sub-sectors. Kaiser Permanente’s MyHealth initiative enables patients to access their medical records and to enjoy e-consultations. The NHS needs to raise its game in information technology, with quality and productivity as the guiding stars of its IT strategy.

The NHS has been quick to innovate but slow to adopt. Many of medical science’s greatest innovations have originated in this country, but for too long the NHS has lagged behind in their adoption. As resources tighten, now is the time for the health service to open its eyes to the accomplishments of others, to think radically, and to allow innovation to succeed and to flourish.

Dr Nicolaus Henke, Director, McKinsey & Company and Tom Kibasi, Associate Principal, McKinsey & Company
Disruptive innovation: 
Integrated care

Jennifer Dixon
The ingredients of integrated care

The NHS is entering a period of severe financial restraint unprecedented in its history. This particular challenge is set because of the need to reduce the fiscal deficit across the wider economy. But there is a more fundamental reason: how to put the NHS on a more sustainable financial footing. In the UK we don’t yet have the US problem of per cent GDP spend on healthcare touching 18 per cent. But if effective reform is not made, the NHS will reach this figure at some point.

There is huge scope for efficiencies in hospitals, the largest source of costs. But given that much ill health in future will be in older frail people and those with multiple long term conditions, there is huge promise that better care for this group might prevent costly hospital care. For these individuals, there is greater scope for self management, more proactive tailored care and better coordination/integration of care among multiple providers. The question is how best to achieve that.

Several researchers have documented the ingredients of healthcare organisations that make integrated care a reality, such as US high performers Geisinger, Kaiser Permanente and Intermountain Health Care. They include: an enrolled population, emphasis on primary care, developed IT, clinical leadership, time to develop (years) and aligned financial and non-financial incentives across collaborating organisations. Examples of incentives include: capitated payment with gainsharing; regular peer review of clinical performance; and pay for performance incentives based on quality.

These ingredients for success have spurred innovation but are likely to vary by site. Success is also likely to be heavily linked to the degree that these organisations can attract in clinicians with the right motivations and mission. What is not clear is the extent to which competition between integrated organisations (for patients and resources) is beneficial. Yet the evidence on savings made by integrated care initiatives in the peer reviewed literature is disappointingly mixed.

In creating a high quality lower cost healthcare for those with multiple chronic needs for care, it is hard to see what better supply side route there is. Integrated care may not be the whole answer to the sustainability question, but a good part of it.

Dr Jennifer Dixon, Director, The Nuffield Trust

Dr Alfonso Bataller Vicent
Integrated care, Valencia Region, Spain

The Valencia region of Spain leads the world in providing high quality, low cost, integrated care. A decade ago, prompted by troubled finances and operational inefficiency, the regional government took the bold decision to decentralise healthcare, promote patient choice – and to engage the private sector in healthcare delivery. Today, Valencia has per-capita costs for healthcare that are up to 25 per cent lower than comparable regions of Spain.

Healthcare became the responsibility of 21 sub-regions, financed on a per-capita basis for all primary, community and routine secondary care (tertiary care is financed separately). Patients are empowered to choose where to receive their care – but if they leave the sub-region in which they live, they take their money with them. Furthermore, five sub-regions were handed over to the private sector to run as a concession – responsible for building and operating health infrastructure.

As a consequence, there are strong incentives to simultaneously maintain access and reduce costs. If access is not maintained, then patients will simply switch to an alternative sub-region, taking their money with them as they vote with their feet. At the same time, with a fixed annual budget, the operators have a strong incentive to contain costs – they carry all the financial risk in the system.

Given this framework, there are strong incentives for more integrated care. The sub-regions in Valencia offer proactive, convenient primary care precisely because prevention is both better and cheaper than cure. The operators have a strong incentive to keep people out of hospital, where the cost of care is, of course, much higher. At the same time, access must be maintained – or patients will end up being admitted with more advanced disease and consequently higher costs.

With low costs and high patient satisfaction, Valencia is leading the way in the provision of high quality integrated care.

Dr Alfonso Bataller Vicent, Deputy Minister, Department of Health, Valencia, Spain
**Disruptive innovation: New delivery models**

**Dr Andrew Steeden**
Integrated care pilot, North West London, England

Inspired by the achievements of integrated care internationally, and learning from their successes, later this month, the NHS’ largest integrated care pilot will launch in North West London (NWL). Initially covering a population of 200,000 – and extending to 750,000 lives covered during the year – the pilot will focus on improving care for the elderly (all those over 75 years of age) and adults with diabetes. These populations account for 9 per cent of the population in NWL but 28 per cent of the healthcare spend.

If the pilot succeeds in meeting its goals, it will mean better quality care for patients, a richer, more rewarding and less frustrating professional experience for staff, and lower costs for the health system. Through better coordinated and more proactive care out of hospital, the pilot aims to reduce unnecessary attendances at A&E and emergency admissions. The pilot will be subject to a full and comprehensive evaluation.

At the heart of the NWL model is the creation of Multi-Disciplinary Groups, comprising of professionals from primary care, community care, social care, mental health, and acute care. Each group covers a minimum of 30,000 lives, and will work to an agreed framework – a single patient registry, stratification of patients by risk, agreed clinical protocols and care packages, the provision of integrated care plans, better coordinated care delivery, multi-disciplinary conferences to discuss the most complex cases, and performance review to ensure continuous improvement.

The model has been developed by clinicians themselves, with providers coming together in an Integrated Management Board to oversee the pilot. They will work to both agreed clinical protocols as well as an agreed financial framework. The pilot has developed an innovative IT tool that will enable professionals to see an integrated view of a patient’s data from across settings, to create a care plan and ensure that it is followed. And through the multi-disciplinary group, the pilot will bring about a new accountability – to the population and the patient pathway, with representatives from all providers holding one another to account for fulfilling their mutual obligations.

There is now enormous momentum behind integrated care in NWL. Professionals speak with passion and conviction to see the changes successfully implemented so that patient care improves and resources are better deployed. For many, this has been a journey from fear, scepticism and resistance to change to passion, excitement and enthusiasm for what they can achieve and accomplish together.

*Dr Andrew Steeden, Clinical Director, NHS North West London*

**Dr Devi Prasad Shetty**
Narayana Hrudayalaya Hospital, India

Narayana Hrudayalaya Hospital is one of the world’s leading cardiac centres. Its innovative model – operating at a scale not seen anywhere else in the world – means they are able to offer open-heart surgery for $2,000 on average. This is 60 per cent lower than a typical Indian hospital, and significantly lower cost than any advanced health systems.

How do they do it? At the heart of the model is process innovation: Narayana Hrudayalaya is a form of production specialisation – a “focused factory” that dramatically increases utilisation and so lowers costs.

It is founded on the observation that scale economies can be achieved in healthcare, just as they are in other sectors of the economy. Not only are Narayana Hrudayalaya’s surgeons busier, the capital assets are used more productively too.

The Narayana Hrudayalaya Hospital has 1,000 beds; adjacent to it is a 1,400 bed cancer centre; and a 300 bed eye hospital. All three facilities share common services, such as a blood bank and laboratories. In 2008, the 42 surgeons in the cardiac centre performed over 3,000 surgeries – a volume unheard of in healthcare providers in developed countries.

As volume rises, so does quality. The huge volumes at Narayana Hrudayalaya Hospital mean that surgeons can become highly sub-specialised, repeating rarer procedures more commonly than their counterparts would in smaller facilities. The 30-day mortality rate stands at just 1.4 per cent for coronary artery bypass graft - significantly better than that of peer hospitals in India, and of many overseas.

Dr Devi Shetty, the founder of Narayana Hrudayalaya, has ambitions to expand the scale of his facilities over the next decade – rising to some 30,000 beds by 2020. Last year, his hospitals accounted for 12 per cent of heart surgeries in India – with such significant ambitions for the future, that figure is only set to rise.

*Dr Devi Prasad Shetty, Chairman, Narayana Hrudayalaya Hospital, India*
Disruptive innovation: Technology based networks

Pedro Yrigoyen
Medicall Home, Mexico

In the past twelve years, Medicall Home has answered some seven million calls from patients in need of triage and advice in Mexico. Today, over one million households subscribe to its service – all for $5 a month, paid over the phone bill, giving immediate access to those in need, 24 hours-a-day, 365 days-a-year. The service receives 100,000 calls a month – indeed, its founders are experienced telemarketers and entrepreneurs, rather than healthcare professionals.

On average, calls to Medicall are answered within just three seconds. After running through a triage protocol, patients’ health issues are either resolved there and then over the phone, referred to a care provider for further investigation, or are emergencies which are swiftly handed over to the appropriate authorities. Some 62 per cent of cases are resolved over the phone, meaning patients don’t have to pay to see a doctor or take time off work.

For patients that do need to see a physician, they are able to access Medicall’s network of 6,000 accredited doctors and 3,000 healthcare providers operating in 233 cities across Mexico, enjoying discounts ranging from 5-50 per cent (Mexico has one of the highest rates of out-of-pocket spending on healthcare in the OECD, with a significant proportion of the population without health insurance). In short, Medicall saves money for its patients.

Medical takes quality seriously: its call centre is always medically-supervised, and its triage protocols were developed by the world-famous Cleveland Clinic in the United States. All Medicall patients have an electronic medical record, meaning that continuity of care is assured. And, as their founders proudly state, in over ten years of operations and millions of calls, they have never faced any litigation.

Now, Medicall is expanding north into the U.S., and introducing new services for chronic disease management, as well as enhancing the provider services through a new network of clinics.

Pedro Yrigoyen, co-founder of Medicall Home, Mexico

Joanne Shaw
NHS Direct, England

In the current economic climate, the challenge for the NHS is clear: to find innovative and cost-effective ways of providing healthcare, which respond to the specific needs and choices of patients and the public, whilst maintaining safety and improving health outcomes.

Remotely delivered services help manage the pressures on already stretched primary and secondary healthcare by reducing avoidable demand on face-to-face services and by steering demand to the right setting at the right time. They support patients to take greater control and exercise greater choice over their health and healthcare, and how they access services. They do so in ways which promote patient safety and support the achievement of high quality health outcomes.

Since its launch NHS Direct in 1998, NHS Direct has begun to demonstrate the value of remotely delivered healthcare to patients and the public, to the NHS and the wider social care system. Our expertise in providing clinical care and services across a range of channels, through our virtual national network of call centres and home-workers, continues to attract worldwide interest.

NHS Direct uses telephone-based care management, online services and telehealth technology to assess patients’ symptoms, provide self-care advice and help them to access appropriate urgent care. We help people with long term conditions to manage their health better and we support patients to make choices about their care.

The fact that over eight million people a year use NHS Direct’s mobile and online health and symptom checkers compared to 4.5 million calls to NHS Direct’s 0845 4647 telephone service demonstrates the increasing importance of the internet to our patients.

NHS Direct will continue to play a leading role in supporting the wider NHS to exploit the full potential of multi-channel, remotely delivered clinical care, for the mutual benefit of local and national health economies and patients.

Joanne Shaw, Chair, NHS Direct
Innovative delivery in the NHS

Dr Peter Carter OBE
Clinically-led and patient focused innovations

The NHS has been set a monumental challenge. In England alone, health managers must find savings of 4 per cent of the total budget each year for four years. No organisation as large as the NHS has ever been set such a task and the reality is that the NHS may be inefficient, but it is not that inefficient. So, after root out wasteful spending and inefficient practice there will still be more to do.

It is at this point that we are presented with two obvious choices. The first is that cuts are made to front line care and patient services, things that are already being seen across the UK. But with a population that is ageing and an explosion of people living with long term conditions, this hardly appears like the sensible, sustainable and, it must be said, moral way forward.

The second option, which the RCN favours, is that the NHS needs to adopt clinically-led and patient focused innovations; to realise that staff can be the solution - not the problem. Providing nursing staff, and all health workers, with the freedom and trust to change the way they provide care is crucial now and will be essential in the NHS that emerges from this financial crisis.

It is important to note that innovations need not be significant changes to practice. An innovation can be the smallest alteration to the way things are done which makes them easier, quicker, and more efficient for staff and patients. These are not just warm words – we know it works.

Marina Lupari, winner of the RCN Frontline First Innovations Award, worked on a redesign of community care for older people in their homes. Her changes saved £400,000 in nine months. It is examples like this that need to be championed, understood, and rolled out across the UK.

Improving the way we do things, and investing in good ideas, will ensure that the NHS becomes a more efficient organisation in the years to come.

Dr Peter Carter OBE, Chief Executive and General Secretary, Royal College of Nursing

Dr Jane Collins
Hearts and minds and innovation in the NHS

Despite the efforts of organisations such as the NHS Institute for Innovation and Improvement, the Health Foundation and the Institute for Healthcare Improvement, there are still problems of spreading innovative practice across the NHS. Sustaining the changes from innovation is also a challenge because it has often been led by a single champion and/or in a single organisation. Either practice slips back to the “old way” or it survives in the single organisation where it started.

A combination of transparency with league tables and the economic environment is changing this attitude. But they are not enough. To create an innovative environment and deliver innovation each organisation needs to create a story to encourage, drive and maintain the change. Since early 2007 Great Ormond Street Hospital has used improvement methodology and learning from non-healthcare industries to deliver progress against our objectives Zero Harm, No Waits and No Waste. These objectives have gained traction because staff understand them in the context of working at Great Ormond Street Hospital as they come from children, their families and staff themselves.

Dr Jane Collins, Chief Executive, Great Ormond Street Hospital for Children NHS Trust

Alastair Dick
Turning Innovation into Reality

If modernisation could be achieved by brilliant and innovative thinking alone, it would happen everywhere in the NHS, routinely. There is no shortage of creativity among policy makers, clinicians and managers, but the double challenge has always been how to harness this to produce sustainable improvement across the complex structures and networks that deliver public healthcare in this country – and how to do so in a service which can never compromise on quality, or take time out to implement change gradually.

For these reasons, although innovation within the NHS has never been more vital to its future success, delivering it remains difficult.

Health is an activity like no other, and the NHS has a unique ethos and culture which is central to its effectiveness. However, its leaders increasingly recognise that there may be lessons to be learned from other sectors. From

Significant change, both cultural and operational, has been made. Hearts and minds are as important as methodologies in delivering innovation in the NHS.

Dr Jane Collins, Chief Executive, Great Ormond Street Hospital for Children NHS Trust
more than four decades providing a very wide range of critical public services, including healthcare, Serco has derived three hard-won insights in the management of disruptive change in frontline organisations.

The first is to understand, before you start, the existing incentives and barriers to the specific reform in prospect. Grasp the underlying cultural and organisational realities, and you are in a good position to redesign structures that dismantle obstacles and encourage the right behaviours. A good example is mutualisation, which may help to engage key staff, while innovative joint venture arrangements can unlock the potential of vertical integration.

Secondly, organisations often struggle to manage change because of their internal dynamics – so governance and accountabilities need to be re-examined, re-aligned, sometimes simplified, to reflect new priorities.

Finally, there is often a need for a catalyst. Change requires focused leaders who can step away from day-to-day delivery and make the driving of innovation their fulltime job. Innovation carries risk. So an external partner can facilitate change, by bearing the risk, while also bringing the bandwidth for implementation and acting as an honest broker when change brings tough choices.

It is in this role that Serco looks forward to supporting agents of change across the NHS – bringing a depth of experience and capability to help innovation to happen.

Alastair Dick, Managing Director, Serco Health

Peter Ellis
Effective medicines management

Admissions and readmissions rates in the NHS have been exacerbated by medicine errors, non-adherence and other failures. Effective medicines management could save patients and save the NHS time and money.

PharmaTrust UK Ltd improves pharmacy services through its MedCentre and MedHome technology that has the potential to make pharmacists and medicines available wherever and whenever patients require them. By enhancing the availability and reach of pharmacists, they can truly be the most accessible frontline healthcare professional.

The MedCentre is a complete, pharmacist controlled, point-of-care medicines dispensing system. It can stock and dispense over 2,000 different medications. They are under the direct supervision of a pharmacist who can intervene at any point in the process. It ensures 24-hour access to medicines and pharmaceutical advice anywhere without the costs of traditional “bricks and mortar” pharmacies.

The PharmaTrust system has been operating in Ontario, Canada, since 2008. The Canadian example has shown that there are many potential benefits to UK patients and the NHS. Pharmacists would focus on patient counselling and clinical tasks instead of dispensing, while specialty or foreign language pharmaceutical advice would always be available. Patients would be guaranteed full counselling by a pharmacist, including as a routine follow-up. A reduction of errors such as through contraindications would reduce emergency hospital admissions. Finally, new models for reimbursement for dispensing could be developed, which would get away from facility and script-based reimbursement.

Peter Ellis, Managing Director, PharmaTrust UK

Ali Parsa
Transforming the value equation

The imperative for healthcare reform is inescapable. In any professional service, value is defined as quality relative to price. In healthcare, quality is defined as clinical outcome plus patient experience. This simple equation provides a tool to assess the value of UK healthcare. The conclusion is stark. In little over ten years, the denominator of the equation—the cost of healthcare—has tripled, whilst the numerator—patient experience and clinical outcomes—is undoubtedly improved, but by nowhere near the same three times. As such, the dispassionate economic truth is that we have seen a massive destruction of value in the largest sector of our economy. Few dispute that this trajectory is unsustainable.

Much academic effort has been spent researching the drivers behind innovation that re-engineers unsustainable industries. The conclusions are encouragingly simple. Study after study has shown that the vast majority of innovation comes from new entrants to a sector rather than incumbents, be they public or private. Think about the transformations that have taken place in the IT sector through a stream of new entrants. Yahoo did not do what Google did. Google did not do what Facebook did. Facebook could not achieve what Twitter achieved. Each new entrant has innovated to advance open source technology in a way that has revolutionised human interaction.

I will make a prediction: none of these established names will create the next big thing in IT. I’m confident making this prediction because history has shown one unaltering truth about innovation: it does not happen because you ask incumbent organisations to become more innovative. Innovation happens because barriers to entry are removed. It happens when all sorts of people are encouraged to provide a whole variety of solutions, and where the best solutions can be adopted by unprejudiced recipients.

The Coalition is at a crossroads with the current “pause” in their NHS reform programme. They can choose to protect inefficient practices and providers, presuming that it is they and the investment already put into them that matter most. Or they can seize their moment, and empower many new entrants to deliver innovation that transforms the value equation in UK healthcare. Our hope is that they choose the latter. The country that pioneered the first blood transfusion, the first antibiotic and the first universal health service should still be a place where it is irresistible for the best talents to offer the boldest solutions.

Ali Parsa, Managing Partner, Circle
Introduction – Disruptive Innovation

Fiona Johnson: Good morning everyone. My name is Fiona Johnson. I’m Director of Communications for the Royal College of Nursing. It’s my very pleasant duty to welcome you here to Cavendish Square to the home of UK nursing for this important international conference.

It falls to me to do the usual housekeeping announcements. So first of all may I enter the usual plea to turn your mobile phones and pagers off or on to silent. If you haven’t already found them and need to know where they are, the ladies’ and gentlemen’s facilities are through that door to the left or through those doors and downstairs. There are no fire tests planned for today so if you do hear the fire alarm please do respond and exit through the fire exits there, there, or probably best of all straight back through the doors where you’ve been having coffee where RCN staff will assist you into Cavendish Square.

So without further ado I would like to hand to Andrew Haldenby, Director of Reform, and I hope you have a very enjoyable and productive day.

Andrew Haldenby: Well, good morning everyone. Thank you so much for coming. I mean just let me really begin by saying what we’re trying to do at Reform. We’re trying to advance the debate on public service reform and economic prosperity in the UK. We try and do it through publishing solid research – solid, timely research – and having excellent events which put the right evidence before policy makers and move the debate forward.

I think it would be difficult to imagine having a better cast list today, not just the speakers but also the attendees. I mean I think this is really a spectacular group of people to come together, and it will enable us to talk together and to generate ideas of real value at what is obviously a very, very lively and important moment in the debate in the UK. So I just want to really begin by giving my great thanks to you all for coming. We’re going to transcribe today so do please speak openly and freely and enthusiastically and controversially, because we will capture the ideas and we will feed them straight back in to the Westminster policy debate.

I’m not going to say anything. I’m going to let the title of the event speak for itself. We will hear throughout the day what disruptive innovation is, why it’s needed, how it works and what the policy triggers are that will enable it to happen more quickly in the UK. So I’m just going to sort of leave it at that.

And really I just want to end these remarks by giving two further thanks, firstly to Fiona and Dr Peter Carter at the Royal College of Nursing for enabling us to have these wonderful rooms in this fantastic location, which means everything for an event like this. So thank you very much indeed. And also perhaps particularly to Nico Henke and Martin Markus and all of those at McKinsey who have helped us do today, not just in the various contributions that Nico and his colleagues will make but in actually the very substantial financial commitment helping us identify the international case studies, flying them over, looking after them. It’s really actually a remarkable commitment. So Nico, thank you very much indeed. And can I ask you to give your introductory remarks.

Nicolaus Henke: Thank you, Andrew. It’s a pleasure to be here, and I look forward, together with my colleagues, to what should be a very interesting day. The topic of innovation in healthcare delivery is really a global topic of global importance. I think it’s not particularly different in any country. And I think we wanted to bring this topic into the debate not so much because it’s a comment on any particular reform idea of the current day. I think today is much more about foundational thoughts for the next 100 years, so to speak, than any particular comment on any particular reform proposal for the next four years. So I think we should take a little bit of a step back and think a little longer term in what we are trying to do. And that’s really the intention of this day and of this research, and that’s the intention of my comments – which are strikingly similar to an almost similar speech in Cape Town where there was yesterday a global summit on the same topic. It is incredible how many countries are pursuing this now.

Why do they do that? Well we spent quite some time over the last years to research this topic, and the observation we would make is very simple. There is almost – and some of you have seen this – there is almost a natural law going on. Healthcare outgrows the economy by 2 percentage points. It’s a natural law. And this has happened for 60 years. 60 years. Not a single developed country has deviated from this trend. It’s amazing. There is only one little outlier which is the United States for the last 20 years but that is probably a short term effect. Nobody really has systematically deviated from this trend. So it’s 2 per cent.

Now you then think well, if this has happened for 60 years it could happen for another 90 or so. So what will happen by 2100? You will be pleased to know that by 2100 96.8 per cent of the US economy is going to be for healthcare. And, you know, most of the other countries are likely in the 50s and 60s. Now what can you conclude from this? The first thing is you all have chosen the right industry. This is the only industry which grows forever. [laughter]
A lot more for a lot less: Disruptive innovation in healthcare

Nicolaus Henke: The second implication you can draw from this: this is absolutely not going to happen. Most countries – including the United States – fund most of their healthcare out of tax, and nobody can pay this basically. And there are all sorts of things which will happen before this happens. So this chart is not saying McKinsey predicts everybody – you know, the entire economy will be for healthcare. No. This chart – this means this is not going to happen.

There are four factors why this has happened in the past. One is rising expectations. One is technology. One is lifestyles. And only the fourth, by the way, is ageing. Ageing is not the biggest driver of this. These four factors have driven this, and these four factors have caused a lot of countries a lot of problems. You all recall this little banking bailout which we had to go through over the last years. The cost in the US for that was $1 trillion. What do you think is the cost of Medicare? If you discount the future cost of Medicare down to today, which is not yet budgeted for, what do you think is that number? Is it $1 trillion? Is it 2? The answer is 37. The unfunded commitment of the US government for Medicare is $37 trillion – a very, very unpleasant number – which causes a lot of people to say that the US government, from an economic point of view, is a healthcare business with a sideshow in defence.

[laughter]

Nicolaus Henke: So the reason why I’m mentioning these few statistics is something has got to change. And while we sometimes look at the next three to four years and say oh, this is all very difficult and, you know, this is the worst time and hopefully this will be over, the first point is what is going to happen in the next three or four years in France, because the social security is bankrupt, and in Germany because the sickness funds are basically at the end of their limits, in Japan because the sickness funds are at the end of their limits, and the $20 billion a year – it’s all the same numbers roughly in most countries – the next few years are actually quite exciting because to some extent we have got to find ways, in the long term anyway, to do this all in a different way. And that brings us to the reason for this research because if you really look at the last 50 years, not so much in terms of the technology and what happened in the hospitals, but how the whole thing was run, it hasn’t really changed that much. And there are many ways to demonstrate that.

So what we did for the last two years is not so much poking further into this problem, although it’s enticing to analyse all these trends, but to look at what are potential solutions, and there are multiple areas of solutions. A lot of people think about funding and incentives and all of these things. We focused our research mostly on delivery. There will always need to be delivery so while there are payer side or commissioning side initiatives that need to happen, there will always need to be delivery. And what is the story behind those players in the world who deliver healthcare fundamentally more productively than anyone else? And here are 30 examples. I will, you will be pleased to know, not go through them, but it’s written down so if you would like this material we can make that available.

Fundamentally what we find is that there are fundamentally three types of innovation. The first one is what we call franchising. Franchising, the basic idea is to say here is – I develop a relatively standardised business model and I license the way to run this model out to people and I train – I skill up people by using a franchise model. Half of Pakistan’s primary care system is done like that without a lot of doctors. Very much nurse driven. Many countries’ healthcare systems have used franchising ideas to add scale, bring healthcare to people who didn’t have it before. Very, very interesting innovation. I will not dwell on that. There are some developed country examples as well: MinuteClinic in the US and so on where – I don’t think it has fundamentally arrived in high quality top-end healthcare, but it’s a very interesting idea.

The second big idea, I think, is a technology-enabled healthcare delivery. Mobile health, lots of remote health monitoring – there is a lot of innovation here, and players fundamentally pushing the needle a lot. Yesterday there was a joint meeting between the South African and the Philippine delegations to think about how they organise their e-health structure. And what these two countries are currently doing is quite amazing, remarkable. And we have an example here today: MediCall of Mexico which is a private-run call centre which I will not cover much because we will get the original data later.

The third one is product specialists. Much closer to home and very well known. Everybody has heard about the hernia clinic in Canada where people basically focus on one thing. There are similar examples. Aravind Eye Care of India provides about 60 per cent of the NHS eye care volumes. It’s a very big player. In every single quality metric they are slightly ahead of the UK NHS results in infection rates, complication rates etc – at one per cent of costs. One per cent of costs! So focused factories can be an interesting question. The question is what does it mean for a place like this? And then there are integrated delivery...
systems. We will see Valencia and for time reasons I will not cover more of that because Alfonso will do that later.

The interesting thing is when you look into these players – and we have done deep cases on all these players and keep doing that – they all do six factors. They all deeply understand the patient – and unfortunately I could talk for hours about this but you will be pleased to know I won’t. I just name these factors. The first thing is they’ve all incredibly deeply understood the patient process. For example, the maternity player in India, they do live births, safe births for $30 a case. $30 a case. They have cut the whole birth process into six clinical stages, and the way how they understand what is happening in each of these is remarkable – I think ahead of many developed countries’ hospitals.

The second one is they all use existing technology disruptively. None of these players is innovating new technology. They all use existing technology disruptively. The third thing is they all really think through how to use doctor and nurse time best. They leverage doctors and nurses by giving them the tasks only doctors and nurses can do, and they try to give more and more tasks to people who don’t necessarily need medical training. They confront, essentially, professional assumptions. This is quite tricky to do in a lot of developed countries because of safety regulations etc which are kind of made for yesterday’s medicine. It’s a quite difficult area.

Fourth one is they have all standard operating procedures. Fifth one is they’re built very much on other people’s assets. They look at how can I use the internet? How can I use mobile health platforms? How can I use existing real estate rather than building more real estate? They are trying to take assets out of the equation of healthcare. And the final one is they try to link it to other revenue streams, which we can talk about in the coffee time.

Because this is so powerful, and a lot of people on earth got so excited about it, we actually started a partnership which does nothing else but promote this idea. And this partnership – think of it as an industry association of entrepreneurs who have a great innovative model and who do something in one country and want to do it in another. And we’ll try to help them out to scale up. We are pleased to note that the founding members of the World Economic Forum – Duke Medicine and McKinsey – there are a lot of very, very strong healthcare companies very excited about this. And they are now signing up entrepreneurs and further companies. So if you know of any company which likes this idea, let us know. There are more opportunities to shine and to contribute.

Final point: what does it all mean for England? What does it all mean for any country? Let’s assume for a minute you wanted to have more of this innovation happening in England, or you wanted more of this innovation happening in Germany. I’m not sure whether you want to, but if you want to. Five things. First one is regulation. We need to develop rules and standards for all things remote. I think one of the fundamental shifts going on here is we have 6 billion of these devices on earth. These devices will be our bank account, they will be so many other things. We are not yet using them in healthcare smartly enough at all. And a lot of healthcare interaction could be done in a very different way. However, in order to do this safely we need to develop an entire set of regulations and standards how to actually do this.

The second one is Tim Kelsey’s favourite point: measure and publish results. The counterintuitive thing is that well, 20 killers, and in either and each of the 20 killers there is a big debate how to measure results. But counterintuitively you would relatively quickly agree to a big one. For example, in diabetes you can relatively quickly agree that Hb A1c control of a population is a pretty good measure of overall results. So why don’t we just focus on that? Take the big 20 killers and really measure these 20 metrics linked to the 20 killers on the population level rather than get stuck with a zillion standards etc, etc. The more we measure and publish that, the more change will happen.

Third is payment. We need payments reform. Medicine right now is kind of “bums on seats” medicine, like management consulting 20 years ago. You know, somebody turns up for a day and charges for a day or something. Somebody goes to a doctor for a visit. You can’t get a referral without a visit, otherwise the doctor can’t get paid. It’s absolutely ludicrous. So we need to change that.

The fourth thing is enable substitution. That’s particularly important in developed countries, not so much in developing. Why is that? Well, if you want to do something new, adding something new doesn’t save anything. You need to also take something out. And on the commissioning side and on the provision side things need to happen in order to make that work. We’ll not go into detail here.

And the final one is clinical leadership and education. Often underappreciated; probably the most important point. We are spending right now £36 billion or so in England on hospitals. We are spending £4.1 billion on medical education and clinical education – roughly 10 per cent of what we spend for hospitals. Implication is we have to assume 10 per cent of clinical activity is roughly for education and training. How do we actually spend that? How smart are we leveraging new technology in that process? How smart are we getting all these new things which will fundamentally transform medicine to get firsthand experience? How much do we teach population medicine, integrated care, looking after a population for glycemic control
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rather than just seeing the next patient? Fundamentally I don’t think the curricula of medical and clinical education are fit for purpose. And in particular if you want to do any of these innovations which we are seeing today, we need a clinical workforce which is not only skilled in it but also excited about it. And the best way to do that is to really leverage technology also on the education side.

So these are five things a country can do, and I hope sooner or later in whatever stage of whatever reform process, some of these will be embraces. Thank you very much.

[applause]

Keynote speech – The productivity challenge

Andrew Haldenby: Nico, well thank you so much. You’ve absolutely got us all thinking and perfectly set the frame for the day. What we are going to do now is we are going to have two sessions to look at the question of productivity, and perhaps we will move from the international to thinking a bit more in the UK. But Nico is absolutely right that the idea is to think big, to think ahead, and to think of the fundamental questions rather than the ins and outs of the moment.

So at 10.00 we will have a session to discuss the hospital, productivity in hospitals, which is so important as Nico has already said. But now I’m really thrilled to be able to ask Stephen Dorrell to give the keynote speech of this conference on the whole of the productivity challenge in the English NHS. I don’t think – I’m sure, to say this actually – I don’t think any politician has thought harder about this question in this Parliament. So Stephen, we’re very lucky to have you indeed. I won’t introduce you. I mean everybody here knows that you are the Chair of the Health Select Committee and are a former Secretary of State for Health of course. Not everyone, perhaps, will know that in the time in between your period of Secretary of State for Health of course. Not everyone, perhaps, will know that in the time in between your period of Secretary of State and now you didn’t stop thinking about public services, and indeed for the Conservative Party in Opposition did a heck of a lot of thinking at times not just on health but in other public services. So Stephen, do please come and give us the keynote speech. We are hanging on your words.

Stephen Dorrell: Andrew, thank you very much. That’s the kind of build-up everybody dreads because then it’s completely impossible to live up to it. But thank you very much for your generosity anyway. And it’s a great pleasure, actually, to be able to follow what Nico has said because what I want to do is pick up some of the global points he was making and seek to apply them to a UK context. And as he was speaking the words that were going through my mind were those of Nigel Lawson saying that the National Health Service is the closest thing we have in Britain to an established church. So what we’re actually seeing here is a culture clash. This is religion meets venture capital. And it’s not entirely surprising, therefore, that at the point at which religion meets venture capital there is quite a lot of scope for disruption. And I want to explore that concept a little bit.

The first point – the first serious point I want to make, picking up what Nico was saying, is to emphasise that in the modern world – and this will be increasingly true as we go forward – health policy is a matter of economic policy as well as being a matter of social policy. That’s, if you like, a jargonised version of “religion meets venture capital”. There is a great tendency in this country to think that because overwhelmingly we pay for healthcare through the tax system that means that health is somehow a form of wealth consumption. It’s a form of wealth destruction. It’s a burden on the wealth-creating sector.

That’s economic nonsense. Any economist understands that the delivery of healthcare is a form of wealth creation. In fact in many ways it is the purest form of wealth creation. By what definition of wealth does it make sense to say that we create wealth when we make locks to keep out the burglars but somehow we consume wealth when we enable people to live longer, healthier lives? That’s complete nonsense.

So the efficient delivery of healthcare is not just a matter of social policy, though it’s vitally important as a matter of social policy. It’s also a matter of economic policy to achieve more, to achieve the kind of economic growth we want to achieve.

Of course it’s true that the delivery of healthcare is a form – a vitally important form – of wealth creation. Indeed vitally important not just because it goes to the heart of our ability to enjoy our lives, but vitally important because in most developed countries it’s already the largest single sector in our economies, and as Nico’s graph shows it’s going to take a growing share of our economy. So the efficient delivery of healthcare is not just a matter of social policy, though it’s vitally important as a matter of social policy. It’s also a matter of economic policy to achieve more, to achieve the kind of economic growth we want to achieve.

And we shouldn’t either be surprised by the proposition that as societies get richer they spend a rising proportion of their wealth, of their income on health. Health education actually falls into the same box. Rising share of GDP being devoted to these services, it’s Maslow’s hierarchy of need. The simple principle is that if you’re struggling to survive, then food is your most important priority. Then comes cover, and then comes comfort. And health, as societies get richer, takes a rising share of their income. We shouldn’t be surprised or think that that’s a problem. It’s something we should celebrate – that as we get richer we can afford to devote more resource to making our life longer, more comfortable, more
The genuinely radical, unprecedented thing that the Government is seeking to do is to deliver an efficiency gain out of our National Health Service during the lifetime of this Parliament that has never been done before anywhere.

healthcare. And just to put it in context the NHS throughout its history since 1948 has never delivered four per cent efficiency gain in a single year of its history, never mind four years running. And I challenge McKinsey – and it’s a good opportunity to do so on a public and open platform – to find any healthcare system anywhere in the world that has delivered four per cent efficiency gains system-wide for four years running. I’ve challenged – since I’ve been Chair of the Health Select Committee it’s been a favourite theme of mine. I’ve never yet had a response so I’m doing the politician’s thing which is to assume – draw a natural conclusion from the facts available to me, which is that since nobody has offered me an example of anyone who has delivered four per cent efficiency gains four years running, I don’t think anyone has done it before.

So politicians love to think of themselves as radicals. I think the radicalism of this Government in healthcare is nothing whatever to do with legislation in the House of Commons. The idea that anything that the House of Commons does in healthcare is unprecedented doesn’t stand up to very much historical analysis. The genuinely radical, unprecedented thing that the Government is seeking to do is to deliver an efficiency gain out of our National Health Service during the lifetime of this Parliament that has never been done before anywhere. As simple as that.

Now, if that’s the objective that we’ve set ourselves, am I – as I’m often asked – is that just a coded way of saying it’s impossible? Well I actually don’t think it is impossible. I think if you embrace the need for change on an unprecedented scale, see it as an opportunity to do something of real and fundamental importance, it is possible. By looking at the kind of examples that Nico was talking about, it is possible to see how we can deliver healthcare in this country on a radically different basis that is not merely more efficient but is actually better quality care than the care we deliver now. So I embrace the challenge, but the one thing I do say is that if you want to deliver something that no one has ever done before, it’s not a bad idea to keep your eye on the ball.

The Nicholson challenge is extremely simple. It is that demand for healthcare rises by, roughly speaking, four per cent per annum. Has done certainly since 1948 and on my own test probably since the building of the Great Pyramid. But certainly since 1948 demand for healthcare has risen by four per cent per annum. Through the history of the health service, between 1948 and 1997 that four per cent rise in demand for healthcare was met by, in round numbers, a three per cent increase in its budget and a one per cent increase in productivity. Three plus one equals four.

Between 1997 and 2010 the four per cent increase in demand for healthcare was met by a four and a half per cent increase in the budget, and roughly speaking a half percent decline in productivity. Four and a half minus half equals four. During the lifetime of this government demand for healthcare is going to continue to rise by four per cent per annum but the budget to meet that demand is going to grow in round numbers by nought per cent per annum. There is therefore a demand – if the system is going to meet demand for healthcare there is a requirement to deliver four per cent efficiency gain four years running out of the National Health Service.

It’s very simple. Searily simply. Four per cent efficiency gain, four years running required out of the system. Otherwise we don’t meet demand for...
delivering fundamental change in the way care is delivered by our health and social care system, by disruptive change. That’s why this conference is so timely. The theme of the moment, the theme the Prime Minister was talking about yesterday which I think is an absolutely key part of the response to the Nicholson challenge, is to reengineer, to reshape a system that is excessively fragmented. If you look at our system we run three different structures of care delivery, all of which are community-based care – their core business is delivery of community-based care to people with long term requirements, long term conditions.

The three pillars: the primary healthcare system, the community healthcare system, the social care system, each of whom typically, right around the country, employ a nurse working from the same building. So you can have three offices, one next door to another – a social care nurse, a community nurse, and a practice nurse all in the same building, all with different computer screens in front of them, none of which talk to each other. It’s no wonder we deliver expensive, poor quality care. And it’s no wonder that the patients that those three nurses are charged with trying to look after – but the nurses don’t know where they are – it’s no wonder that patients where the nurses don’t know where they are end up in hospital costing us ten times as much as they need to. Bad care from the point of view of the patient. Inefficient care from the point of view of the taxpayer.

My favourite anecdote from my own family is of my 98 year-old father-in-law who sadly passed away quite recently. My sister-in-law went to report his death to his GP to get his death certificate signed. The comment from his GP was: “That’s a surprise, isn’t it.” 98 year-old passes away. That’s a surprise.”

Stephen Dorrell: That’s where we are. We have a community-based healthcare system that isn’t focused on the need for early, timely intervention. Staying close to the patient need in order to meet and sustain the patient need in the community where they live, where they want to live. And we have hospitals that are picking up the pieces at excessive cost and delivering poor, disintegrated care as a result.

patient need in order to meet and sustain the patient need in the community where they live, where they want to live. And we have hospitals that are picking up the pieces at excessive cost and delivering poor, disintegrated care as a result. So reengineering that system in order to deliver timely, high quality care, in order to do the care where it’s required, that’s one of the big opportunities. I’m not going to go through the implications of all the others Nico mentioned.

I’d just like to make three very quick points in conclusion. The first is – well, there are three slogans almost that I want to mention – how do you achieve, how do you set out down this road to achieve in an institution that is our national religion, to achieve the kind of disruptive change that’s necessary to deliver unprecedented efficiency gain? Well, there is one guy in history that has tried to do this. And maybe the suggestion of the day to McKinsey is that you should recruit Mikhail Gorbachev. You remember he had two slogans on the way that he was going to drive change through the system he was responsible for.

The first was “glasnost”. The first thing you have to do is to throw the spotlight on the reality, on the facts.

Go to a clinical community. Go and meet a few doctors. They’re among the most competitive people I know. The secret of success in the commissioning process is to harness that competitive energy, the impatience with poor results, and the anger that is generated on the part of clinicians by poor results. Harness that energy to drive the process of disruptive change that we all want to see.

It’s where Dr Foster has been so important. It isn’t that we don’t know where all these things are going wrong. The doctors all know. It’s that the patients don’t know. They’re not trusted with the information. So if you want to drive change into this system, start by telling the truth about what goes on inside it. Throw the spotlight on to the reality of the system and you will create some allies for change, people who will become angry because they will understand how poor the system is in reality in too many parts of it. So number one: glasnost. Tell the truth.

The second slogan Gorbachev had was “perestroika” – reform. Now that doesn’t have a precise parallel in this country. The key demand that I think comes out of this demand for disruptive change is to empower the commissioners. We’ve been talking about commissioning in our healthcare system now for 21 years. And it still has the feel about it, doesn’t it, of being an idea we should try sometime. Well now is the moment. Who is going to do the heavy lifting? Who is going to drive the change through this system?

The answer, in my view, has to be the commissioners: the people who hold the budgets on behalf of the taxpayers, on behalf of the patients who call the providers to account. Empower commissioners to drive this process of change through.

And I’m going to end on exactly the same spot that Nico ended on which is that you can’t do this if it’s management consultants and politicians on a platform saying we know what’s good for you. The reason commissioning hasn’t worked – hasn’t lived up to expectations over 21 years – is that it’s been
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experienced by the clinical community as something done to them by managers. Engaging the clinical community is the key, I think, to driving this process of disruptive change. People ask me: are you in favour of competition in healthcare? I think that’s a bit like asking whether you’re in favour of the sea with or without waves. Go to a clinical community. Go and meet a few doctors. They’re among the most competitive people I know. The secret of success in the commissioning process is to harness that competitive energy, the impatience with poor results, and the anger that is generated on the part of clinicians by poor results. Harness that energy to drive the process of disruptive change that we all want to see.

[applause]

Andrew Haldenby: I shall call Stephen – Stephen, did you want to just stay at the lectern but I’m going to take the opportunity of, please, taking questions now for the next 12 minutes or so. We’ve got the great opportunity of being able to ask both Stephen and Nico to give thoughts. So can I ask –

Stephen Dorrell: Can I sit down.

Andrew Haldenby: Yes, you can sit down. Very good.

Stephen Dorrell: It gives me an unfair advantage over Nico.

Andrew Haldenby: So I think Sue Slipman would like to ask a question, the gentleman in the aisle here, and then to my left. So Sue Slipman first, please.

Sue Slipman: Well to both of you really. I agree with much of what you’ve said. I mean one of the problems for those of us who are responsible for running organisations who are trying to embrace the challenge of that change is the political framework that we live within and its inability to deal with failure and allow reconfiguration. So how do we solve that one, because if we don’t solve that one, no matter how good the managers, how engaged the clinicians – although they might start to win the public debate if the clinicians are involved – are we really saying the politicians won’t move on this kind of thing until we, the practitioners, have made the public debate and got the change? Do we have to lead it, or do politicians have a role?

Stephen Dorrell: Shall I go first? I completely agree with Sue that the politicians have a key role in this. The politicians’ role is not, in my view, to go and say “we have to lead it, or do politicians have a role?” but equally if you want disruptive change it’s not a bad idea not to announce it four weeks before a key local election. A little prudence about how you take people with you and engage the critical mass of support in the local community to win local arguments. But provided that there is intelligence about how change is driven through, the proper challenge to the politicians is that they must create the space to allow it to happen.

The only other point I’d make is that it’s no good – or at least you minimise your chances of achieving what you need to achieve – if it’s seen purely as “this service is being withdrawn”. It’s why I think the Prime Minister’s message yesterday is so important. What we’re in favour of is better care. More integrated. More focused care. Better able to intervene early. Make the case for what you’re trying to create. That helps you make the space to disengage from that which is not what you want because you don’t need it because it doesn’t fit the vision of what you’re trying to create. Make the positive case as well as facing the difficult questions about what you need to withdraw from.

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Andrew Haldenby: Thank you. Did you want to say anything?

Nicolaus Henke: Those places around the world that have managed to fundamentally change organisations or hospitals had conditions in place where management teams and the clinical leadership of the organisation saw the case that unless they make big changes they will not be there. There was no more money and there was a credible challenge and therefore we need to move. That’s why the Veterans Health Administration has become so good. That’s why Kaiser Permanente has sorted itself out despite almost going under. That’s why seven hospitals in Berlin got merged into one and it’s a wonderful new hospital. And I think we’ll hear later from Valencia how they have dealt over many decades with a low resource situation and dealt with it quite well. So I think the credible case for “there will not be other money coming from somewhere”, and politicians, managers and clinicians sticking to that and making change happen is critical. And then you can ask yourself why hasn’t that happened so much and I think Stephen has answered that very eloquently.
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Andrew Haldenby: Thank you. I’m going to take three questions together so we can get the ideas in. So in the middle row, could you introduce yourself as well please?

Ben Geoghegan: Ben Geoghegan, BBC News. Mr Dorrell, the Prime Minister announced some changes that we’re all aware of yesterday. Do you think there is a danger that the government is now taking its eye off the ball and the Nicholson challenge won’t be met in this parliament?

Andrew Haldenby: Thank you. Can we rush a microphone down to my left at the front here please? That’s it. And then the next question will be at the back – Nick Bosanquet.

Rowenna Davis: Hi there. Rowenna Davis from The Guardian. Three tiny short questions. One – [laughter]

Rowenna Davis: Tiny, tiny, tiny ones. First one is you talk about evolution – you talk about “disruption” in healthcare. The Prime Minister is really emphasising “evolution”. Is there a tension there? Second one is that four per cent efficiency challenge, can you do it in the next four years when it’s so disruptive to services to make that change? I mean maybe you can five years down the line after these reforms ten years, but what about now? And the third is, given how this process has been handled, do you think it’s better if Lansley steps aside?

Stephen Dorrell: My plan is to turn to Nico on that one. [laughter]

Andrew Haldenby: Thank you! We have to meet the Nicholson challenge. We have to achieve the productivity gain that’s required in order to be able to ensure that we’re going to meet demand placed upon the system by patients. And as I said in my remarks, that seems to me to be the key change that’s needed to deliver both improved care and more efficient care. So what we’re now talking about is greater integration of services in order to avoid the effects of fragmentation, in order to improve care and improve efficiency. And if that is our objective then we’re starting out, in my view, down the right road. And the quicker we move the better.

That also, I think, addresses the key questions really from the lady from The Guardian: how quickly can we do this, can we achieve the scale of challenge that’s required in this parliament. The answer is that if we’re going to meet demand for healthcare, unless George Osborne is going to go back to the IMF and say: my spending totals actually have to increase. Could you please now re-sign my audit certificate? The reality is we have to meet the Nicholson challenge.

I think the credible case for “there will not be other money coming from somewhere”, and politicians, managers and clinicians sticking to that and making change happen is critical.

comes the solvency challenge with many hospitals sliding towards cash reductions. How does the panel think we should cope with the sort of pragmatic financial situation of trusts in the next few months and weeks and beyond into 2012?

Andrew Haldenby: Thank you, and because I think we’ll probably just have time for this one round of questions, at the front please.

Devi Prasad Shetty: Hi. My name is Dr Shetty from Bangalore. I would like to know whether NHS hospitals today have a balance sheet. At least at the end of the month do you have a profit and loss account?

Andrew Haldenby: Well can I see if I can divide those questions with the most political first set to Stephen – including on Andrew Lansley – and the question on solvency and the nature of financial accounting to Nico.

Stephen Dorrell: First of all on the question of is the government’s eye on the ball of the Nicholson challenge. The answer is, as a result of what the Prime Minister said yesterday, I think it’s much more clearly on the ball than it has been up until now because there is a clear commitment in what the Prime Minister was saying yesterday to achieve greater integration in the delivery of healthcare. And as I said in my remarks,
Now if I was concerned that that was in some sense undeliverable or in some sense incompatible with good care for patients, then that would be a real dilemma. But as I’ve sought to explain I think this is partly about efficiency, but its efficiency driving the requirement to deliver better care for patients. It’s both about better quality and greater efficiency. And so, as I sought to articulate at the very end of what I had to say, I think there is real professional impatience verging on anger at the way in which resources are not being used currently to deliver those objectives, and therefore an impatience to drive this process of change through. If we can harness that, I actually don’t think the pace of change issue is particularly difficult to meet.

As regards the personalities, since you asked me the question and if I don’t answer it I shall be accused of dodging it, the truth is that I was elected at the beginning of the Parliament by my peers for a term of a full Parliament as Chair of the Select Committee. That’s what I’m proposing to do and the Prime Minister has made it crystal clear that he is intending to continue with his cabinet without changes. And he has my full support in that.

Andrew Haldenby: Thank you. And Nico, the questions on hospital solvency and accounting.

Nicolaus Henke: The intention of this workshop today was to look 100 years out. If we score ourselves, you know, ten is good and zero is not so good, we’re probably scoring two with all the questions around anyway. So think harder about long term questions, dear audience.

[laughter]

Nicolaus Henke: I think your profit and loss (P&L) question is core. In a very simple way you have asked, I think, a core question which is that at the end of the day does the P&L of a hospital mean that that’s it, or if there is a big loss, is money kind of coming from somewhere else. And right now – what’s implied in Sue’s question was right now there is a habit of whenever there is a big loss there will be some kind of solution with money from some other institution coming. Now that probably is a way to deal with hospital financial problems which this country has gotten used to, but given the financial situation the country will now need to learn in a different way. When people in this country ask for a failure regime, what they mean is could we make the hospital finances actually work in a sense of stick within the rules and if somebody has a loss they actually need to do something about that and there is nobody writing a cheque.

And that is also the answer to Nick’s point. You asked solvency before efficiency. In those situations – and I would never possibly comment on any particular situation in England – but I think in effect those situations in Europe where we have seen the biggest productivity change happening in hospitals – for example in east Germany and parts of northern Italy – were situations where the solvency got tight.

A big hospital in Berlin had seven days’ cash left and they had already not paid the doctors for a month, and that’s when they agreed it may be a good idea to do a turnaround programme – [laughter]

Nicolaus Henke: And that turnaround programme actually was relatively robust. And by the way, it wasn’t fun. Nobody likes to enjoy these things, but it has been saved. It has now saved a lot of money in all the ways. And I think the solvency challenge signalled in no uncertain terms to the staff that something has to happen. And it’s not just getting rid of this manager and the doctors sitting there saying let’s see how the next manager will deal for that because this one will probably get fired. I think that’s an attitude which, in these kind of situations when solvency gets tight, is probably not happening. And I think there are situations – I won’t comment on names – in this country where we are in the middle of this right now and see some successful change caused by it. So I hope we can create an opportunity for change out of all this.

And that’s also the final question – comment on disruptive change. I just want to be crystal clear, particularly to journalists in the room. The point about disruptive change is not that anyone in this room particularly likes disruption as a change model, right? We’re not saying this isn’t working. Let’s disrupt everything and then maybe it’s better. That’s exactly what we’re not saying. What we are saying is there are innovative health delivery models around the world which surprisingly produce fantastic health results at a fraction of the cost of traditional healthcare players.

And there are three or four models which sustainably have done this in many, many countries. And shouldn’t we have a look at them, and shouldn’t we think how MediCall lessons can be learned by NHS Direct and really making NHS Direct a fantastic medical remote service? Can we not learn from Bangalore, from the heart hospital there, for London’s heart hospitals? And how many of those do we need and what can we learn? We’re not suggesting we need to just copy everything, but what can we learn from all these models which have said we don’t do healthcare in the way which it has always been done. We do it in a fundamentally different way and we can show with clinical evidence that we give greater care for lower costs. Shouldn’t that make us think in the time we are now in?
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That’s, I think, the whole point of this conference. And we are not saying that necessarily the venture capital or free market is going to solve all of these things. We are just saying there are better models, tested and proven in multiple places. And given that we have to save so much money and deliver great care at the same time, we need to take a look at what can we learn from them. And then think about how we can embed that into the change story of the NHS. And that’s the comment on your question of disruptive change.

Andrew Haldenby: Thank you. That’s just it. So in a moment our next panel will come up and I will ask John Drew, the head of the McKinsey Hospital Institute to introduce that panel in a moment, but I don’t think we could have got off to a better start and so thought provoking. So can we please thank Nico and Stephen.

[applause]

Session 1 – Turning hospital finances around

John Drew: Good morning everyone. We’ve got a panel today who I think can give some great and complementary perspectives on the topic of turning hospital finances around. I’m just going to say a few words to start off and then introduce the panel. Sue Slipman will speak first, who is the Director of the NHS Foundation Trust Network, with perhaps some perspectives on the system and also the nature of what’s happening in the pipeline at the moment, the FT pipeline. And then Lee Outhwaite, who is the Finance Director looking at the balance sheet, will give some comments from the perspective of Derby Hospital.

And then Sue James will be the third speaker, who is the Chief Executive at the same hospital.

Just a couple of thoughts to start with. I was thinking in my mind this morning about a U2 song called “Running to Stand Still”. And I think there is something about the 15 to 20 per cent Nicholson challenge which feels like that. It feels as if, even if you’re starting from a good position, there is an element of needing to just keep running in order to stand still. To deliver 4 per cent a year for each of the next four years is a big ask. And I think one of the things I would expect to come out of this session is you can’t actually strip out hospital finances as a topic to focus on because a hospital is a multi-layered thing. I think we all know that. We’ve been reminded that it’s a very political thing bordering on perhaps being the nearest thing we’ve got to an established religion. It’s an organisational/operational thing, like a sort of healthcare factory. And obviously, at its heart, it’s a clinical thing, which is delivering patient care.

So I think this topic of hospital finances has to be considered in that perspective of how does it relate to the rest of the hospital’s agenda. And increasingly, as we’ve just heard, it’s going to need to be solved in a way that recognises the interdependency of the hospital and other elements of the healthcare system.

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Sue Slipman: When Stephen Dorrell was talking about the NHS being the religion of our country what he should have said as well is that hospitals are the churches in that religion, as they have traditionally been. So we’re not just talking about an economic evolution/revolution here. We’re talking about a cultural revolution as well, which is going to have to be part of this.

The quick challenge – the Nicholson challenge – 4 per cent, is actually rather more than that. We were all told 4 per cent but the figures that we have in the survey work that we’ve done with our members shows that actually this year it’s 5.7 per cent, that is the mean average of the financial challenge that organisations are facing, with a downside of 6.9 per cent. And that’s really scary. If we’ve never delivered 4 per cent in a single year, delivering 5.7 per cent is really extremely worrying for people, and that’s not just because we are facing the tariff challenges which make it four per cent, but also there are other policies that Ministers are pursuing at this stage which vastly increase the risk. There are things like the readmission policy – and I’m not going to talk about the rights or wrongs of the policy. I’m just saying it’s massively increasing the risk. And because demand schemes haven’t delivered so far, hospitals are still working on a demand volume which was the outturn of ‘08-’09 and have been paid 30 per cent marginal pricing above that rate. So those two things together are massively increasing the risk that organisations are facing.
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The other element of this is that the increase in demand is partly being caused by cuts elsewhere, particularly in social services, and cuts to voluntary sector organisations as well. So all that demand is likely to change into demand on hospitals. And so what I would say is that there is a huge amount that hospitals themselves have to do to meet their own challenges, and I’m going to talk a bit about what they are doing. But the ultimate conclusion is that this is not a scale of a problem that can be solved by individual organisations themselves, no matter how good their leadership, no matter how efficient their systems. Now that’s not an excuse for them not being as good as they can be, and there are clearly a lot of challenges that organisations are facing.

So how are they responding? Well operational improvements. There is clearly Monitor as the regulatory system really driving efficiency, and that’s been an extremely good exercise in discipline for NHS organisations. And Monitor has looked at service line reporting, i.e. do you know your business organisation? Do you understand where you are making surpluses and losses? Can you actually manage the organisation? We’ve done a lot of work with McKinsey in partnership on benchmarking where we’ve looked at specialisations such as cardiology, ophthalmology, orthopaedics, maternity services. We’ve then gone in to do cross-organisational themes such as A&E and operating theatres. And next, we’re trying to do a whole patient pathway, which is promising – we’ve got the methodology and we’re very excited about it. But all of these things are focusing people’s minds on the costs, how they can do things at high quality standards for less, and those have been very positive. Clearly, there is a lot more and better quality information and data than there used to be and that is absolutely key to engaging clinicians. If clinicians don’t believe the data you’re giving them, they will never be involved in making things better. They won’t take ownership of it.

So clinical engagement and incentives are on everybody’s agenda. Quality indicators are now captured and reported to staff so that they can know how they’re doing and begin to take ownership of their own performance. We’re also doing a lot more with a lot less, and Nico talked about some of this stuff. In terms of the staff, it is about having the right sizing of staff and the right skilling of staff so that the more senior people do what only they can do and others take over some of those more routine tasks, so that you’re really using your staff in effective ways and deploying them well.

In terms of resources, we had some very interesting results from our operating theatres benchmarking, and what we discovered was that operating theatres are often not used for more than 35 hours per week because of the throughput. And we’ve also had cases of organisations which have already put their throughput up to 50 hours per week and therefore saved themselves a million pounds. So there are huge savings that can be made in terms of greater efficiency within organisations using resourcing and staffing properly to make sure the organisation is responding well.

There is then the issue of reconfiguration of services. We’ve gone through what was called the Transforming Community Services project. Actually, so far it’s been “transferring” community services rather than transforming, and we’ve got a huge transformational process to undergo. We’re already seeing pockets of excellence emerge in that process with people really taking command of this, working well with partners in terms of transforming those services. Organisations are looking at mergers in terms of a transactional strategy to become more efficient. But as we all know, mergers are very difficult to pull off, they’re very difficult to realise value around, and it takes a lot of time. And actually, just getting bigger doesn’t solve your problems. It might actually compound your problems unless you’ve got an incredibly good integration strategy and all of your clinicians have bought in to that and so have your communities. So those are some of the things that people are doing, but as I say the challenge is too big to resolve in individual organisations alone and needs a whole system process in order to do it.

So structural change. Well a lot of organisations are now integrating their back office functions and we are benchmarking this nationally with the Department of Health. In a sense that’s an easy win and something you can do reasonably quickly. There are strategic partnerships developing between organisations to look at a more rational way of providing different services in different locations so that you can get the patient to where they need to be and therefore you can begin to cut the cost of trying to do everything in every place. And those, I think, are quite exciting in terms of what they can deliver.

Perhaps more exciting are the federated organisations, and we’ve got one or two examples of these where different organisations are coming together. They’re not merging, but they’re forming a single governance structure in which they yield some of their sovereignty in order to provide services in different settings and to begin to rationalise what they can do. So those I think are looking very interesting. But in all of these changes we’ve got the potentially very big problem of stranded assets, and that’s something that needs to be dealt with in organisations.

So is all this doable? Can hospital organisations survive and thrive? And I guess my answer to that is: not all of them. Certainly many can and will. And my question to Stephen Dorrell earlier on whether the
There is much you can do to revolutionise your own organisation, to work with others across the patient divides and pathways to revolutionise the way in which services get delivered. But if you are blocked in terms of that reconfiguration by the politicians, then the whole thing falls apart. And I think we will get to a stage where if we can’t see those rationalisations and reconfigurations, healthy organisations will start to fail because the resources are being swallowed up by those who really aren’t runners in the long term. And so that’s, I think, one of the key issues that we’ve got to face.

And key to all of this is the demand management, and the demand management is ultimately only really going to happen through integrated pathways. And that seems to me to be the key to enabling hospitals to change their shape. They won’t change their shape unless that demand is being catered for elsewhere. And although we’re concentrating through the FT pipeline on things like the quality of boards and leadership, their vision, how they are able to form partnerships for all of this, we have to remember that foundation trusts themselves are hybrid organisations. Their fate is not entirely in their own hands. And it will be the regulatory and political systems within which they operate which will ultimately determine how successful they can be in this.

John Drew: Thank you Sue. Over to Lee, and Sue James after that.

Lee Outhwaite: Well good morning everyone. I’ve got five minutes to get through the 29 spreadsheets I’ve prepared that are even denser and smaller text than Nico’s. So I’ve got to go at some pace. Thankfully I’m not doing that.

Four themes I want to discuss. I’m going to do a bit of a caricature on what has been happening over the last seven years in terms of hospital efficiency, and I want to talk about what hospital and wider health economy efficiency needs to look like over the next five years. Then I want to talk a bit about Derby Hospitals Foundation Trust because I should know something about that. And I want to talk specifically about what future financial management success looks like. And there is a big role for the finance function here – just to plug it – because if we get this wrong and we get the clinical engagement wrong, we’re in a big mess.

We’ve lived through a period where what finance directors have been doing in a period of unfettered PBR is getting full cost reimbursement for clinical work based on 1948 definitions of treatment and care. And then they’ve been recycling the marginal cost benefit of that back to quality of improvement in care in their hospitals. That’s what we’ve been doing. Be under no misapprehension. That’s what we’ve been doing. That’s what we’ve all been doing.

Then we’ve got into a fettered system of PBR where we only give 30 per cent marginal rates from schedule care because you’d want less of those patients to arrive at the trust and you want to do outreach from the hospital. And now we’re in a period where we want to do something about readmissions because we’re trying to keep patients out of a secondary care context because it’s expensive. This is what is happening. So now the paradigm has shifted somewhat. And I think it’s very interesting that we’re moving into an area where increasingly hospitals are playing into PCT affordability, the QIPP and Nicholson challenge, and the question is: how do we do better align incentives? And the future will be defined not by hospital efficiency but by whole health economy efficiency, and it has got to be.

So what does hospital efficiency look like in a period of no growth? We’ve got to have a health community strategy which is developed across primary and secondary care which clearly defines the hospital role. We’ve got to have the right strategic alliances, and we’ve got to have a sensible leadership role for hospitals in the vertical integration debate.
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out or do one in ten hospitals close? And in some way we’ve got to be able to articulate that debate in a way that the public understands.

Just in terms of our development as a Foundation Trust – this is sort of my three/four year period of tenure – in 2009-10 we were a little bit myopically focused on rationalising two DGHs on to one site. That was a big endeavour. But whilst we were doing that, we observed we probably needed a bit of a plan to deliver all this money-saving stuff so we developed something called a programme management office (PMO). Consultants will sell you this at great cost. It means nothing more than having a series of plans that you manage in an office in terms of developing and delivering improvements in your care.

[laughter]

Lee Outhwaite: While this was going on we observed that PCTs were running out of money. And eventually they turned around to us and said “we can’t afford to pay you our contractual obligation.” That’s what happened.

In 2010-11 we started improving our PMO approach and we thought perhaps we need to get the clinicians a bit more involved and that’s a devilish job because the financial paradigm in which we operate sometimes is not as clinically engaging as it needs to be, and we also agreed, much to the chagrin of Monitor, that we would take some volume risk by looking at whether we could play into a demand management space, which all hospitals are going to have to do in my view.

In 2011-12, we’ve got a growing out approach with primary care and increasing dialogue about system alignment and incentives. And unless we go there we’re going to finish up in a big mess. We can either get into some sort of mutually assured destruction race between primary and secondary care about who is going to fail first, or we can have an open narrative about what we need to do collectively. We’ve now got a £420 million turnover, £20 million PFI mortgage, £29 million spent on solving hard and soft FM and that puts us on the Monitor radar for “problem organisation”. I’m not sure I’m entirely sympathetic to that description. We can influence that £29 million but there is a whole raft of work we need to do for the £12 million savings in our walls this year, and with the £9 million cost reduction we are complicit in dampening down demand in the system. If we do not do this, our PCT will run out of money.

What do we need? I put “basics” here in inverted commas. Have we got the right people making the decisions, not just in the hospital but across the health economy in terms of the delegated financial management? Do we really understand what we’re spending our money on? Can we compare and benchmark different clinical performance levels inside and outside the hospital? What’s our approach to business change? How the devil do we go about strategic reporting right so that we’re not just focusing on finance? And how do we get the incentives lined up to do away with traditional functional budgeting, which makes everybody a very acquisitive resource. These are not basics that are easy to deliver, but that’s where we need to be.

Then we need to get into the complicated stuff, which is the more sort of “Jedi arts” end of financial management. How the devil do we provide decision support for whole health economy process change? How do we innovate outward the confines of the PBR system, which is blunt and foolish? How do we develop collaborative relationships across multiple agencies? All the directors of finance who come into the NHS from the private sector say – a number of them say – probably a little strong – it is the least collaborative sector they have ever worked in. What does that say about the system in which we operate and the relationships we have? Out with our organisational boundaries. We need to address some of that, and I think the key thing for me is not around plurality of provision but perhaps plurality of management models. The extent to which we can get empowered clinicians running joint ventures across primary and secondary care, where they feel empowered to embrace and innovate and change.

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And that’s it from me and I’ll hand over to Sue.

Thank you.

[applause]

Sue James: Thanks very much Lee. It’s amazing what you learn about your finance director when you’re sitting on a stage, isn’t it?

[laughter]

Sue James: I want to move the discussion on from within the walls of our own organisation to Derbyshire as a whole. And I want to talk about the challenge in Derbyshire, responding to that challenge, some of the new solutions we’re beginning to implement for old problems, and the lessons we’re learning along the way. And I think you’ll find there’s an awful lot of resonance with what I want to say with what we’ve already been talking about this morning.

Derbyshire health economy faces our own part of the Nicholson challenge which is a gap of £260 million by 2015. That’s 16 per cent of the current budget. But we know we’ve got major ageing, obesity, and lifestyle challenges which are going to continue to increase the level of demand on health services. We already know that our emergency admissions have been growing across Derbyshire at twice the national average. At the moment, the NHS Derbyshire spends
We know that 8 per cent of our patients in Derbyshire account for 25 per cent of emergency acute spend. And again, the examples that Stephen was giving around failures of community services to link together to support patients, mean that the hospital is the service of last resort, the place of safety where people come in and are then taken into the system and treated at vast expense but with very little impact, is exactly what’s happening to our system day in day out. Over half our high users – those 8 per cent – have at least one long-term condition. And we have a significant variation in emergency admissions by GP practice that doesn’t seem to correspond to the levels of population they’ve got with long-term conditions or issues.

So what are we doing about these issues? Well, as I say, the first port of call was let’s reduce the cost of acute services. Let’s say for example, one of our PCTs came to us and said we can’t afford the £200 million a year we spend on you. What can we have for £170m? Well actually, the answer was not as much as you got for £200m. And that didn’t take us much further forward.

So we’re now looking at managing long term conditions, at optimising the settings of care, trying to deliver services in the community so that people haven’t got to suspend the rest of their lives while they come to the cathedral of care, which is the hospital.

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around 51 per cent of its total budget on acute services. And that’s where we started looking first for a lot of these changes. It’s generated lots and lots of debates about how we need to reduce demand management. And I think in the earlier times when there was a sense of we are the foundation trust, you’re the commissioners, you do demand management, we do delivery of care. There was a real standoff at that stage. The commissioners cannot do it by themselves. I think Stephen Dorrell’s comments about the fact that we really need to do is get a whole clinical engagement across the primary and secondary care divide to actually address some of these problems is absolutely crucial.

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We’re also looking at a whole range of new technology. I was at a clinic recently where we were helping a group of young teenagers learn how to use insulin pumps. These pumps actually, they wear them every day. They’re a bit like an external pacemaker for a heart condition. They wear them every day and the pump picks up when they need insulin and provides insulin, meaning that their overall health condition is much improved, their quality of life is dramatically improved, and their long term prognosis in terms of the impact that this horrible disease will have on them is also much improved. These pumps cost £3,000 each. They’re very expensive. But actually if you think about the impact that that sort of investment is going to have on the long term costs for these people in their teens who are going to have diabetes for the rest of their lives, I think it’s probably a very, very good investment.

We’re also making sure that patients who do come into hospital with diabetes are seen and treated effectively. We know that 20 per cent of all our patients who are smoking have worse outcomes than patients who aren’t, as a result of the anaesthetics related to surgery.

We also need to prioritise spending and make sure that we’re spending money in the areas that are most likely to achieve benefits. All of these things need a whole health economy approach. It’s no use us retreating into our castle and the PCT retreating into theirs and then us slingling mud at each other. And we’ve also got to make sure that we’ve got strong clinical ownership.

So I want to give you an example of the sorts of things we’re doing. And this is a new solution to an old problem relating to diabetes. We set up, last year, a joint venture with GPs – a small number of GPs at this stage. The joint venture is funded via a capitation contract with a profit share agreement. All patients who are on the GPs’ registers for diabetes in this group who are working with us have a proactive personalised care plan, with the majority of the service delivered in the community. So if they need a regular eye check-up, that’s proactively organised for them. If they need a regular foot check-up, that’s proactively organised. We’re not waiting for people to start getting gangrenous toes before we start managing their circulation. So we’re working very closely with our GP colleagues to provide that service. And our hospital staff are actually moving away from picking up the pieces when GPs can’t cope to helping them cope more effectively so that we’re not actually seeing the sort of continuous cycle through the hospital service.

We also need to focus on prevention much more effectively. We, as a hospital, tend to sort of yank people out of the river, patch them up, and then leave them to fall back in again. What we’ve got to do is to use our enormous leverage when we’re dealing with people at acute crisis moments of their lives to actually really push health promotion and improve the healthy lifestyles of people. So, for example, we ought to be able to insist that people who want elective surgery maybe need to attend a stop smoking clinic. Not that they stop smoking, but at least that they think about it as part of their preparation for this sort of surgery because we know
inpatients have diabetes, but only a tiny proportion of those actually stay on a diabetic ward. And many of them are being managed by staff who have no knowledge and even less interest in the management of diabetes. So we’ve now developed a register in the hospital and every patient who comes in with diabetes is seen by one of the specialist team who advises the team who are looking after them on the management of their insulin, on their diet, on a whole range of other issues that may be associated with their disease. And we’ve already found – we’ve been doing this now for about six months – and we’ve found that where it’s working we’ve reduced length of stay for these diabetic patients by half a day on average.

So the results generally, are that we know that patients are healthier in the GP practices that are involved in this joint venture. We’ve looked at their QOF data and the blood sugar levels are much more stable across the piece and are actually down. And it picks up the point that Nico was making about how we actually manage health and measure health rather than health input. We know our length of stays are down, as I say, in terms of patients with diabetes in the hospital. New referrals to hospitals are down. Follow-up outpatients are down. GPs are much more confident about managing complex cases, and interestingly the high priests of diabetes – the hospital specialists – are finding as much satisfaction from dealing with supporting, training and developing their GP colleagues and working in partnership with their colleagues as they have done from dealing with the straightforward sort of one-to-one interaction with patients. So the role of the hospital specialist is moving. Yes, of course they will still have a major role in delivering healthcare for individual patients, but it’s actually moving into delivering the population care that we were talking about one-to-one interaction with patients. So the role of patients, but it’s actually moving into delivering the population care that we were talking about and also supporting and training their GP colleagues.

So what lessons have we learnt from this? Well first of all we couldn’t do this while we were in an adversarial relationship with our commissioner. So we have to create the right relationships at the top of the health economy so that we can both take risks with each other, we both trust each other, we’ve got away from the sense that each of us has this sort of stash of cash somewhere that if only we can access it then the rest of the world will be fine. We know that both of us are broke if we don’t actually work this together.

We need to frame issues in a way that engages clinicians. We’ve talked a lot this morning about clinical engagement, but when you talk about the financial situation and that there is a £20 billion problem in the NHS, the clinical response is: blimey, haven’t the managers got a challenge. We’ve got to talk about these issues in a way that clinicians understand and can relate to, and can see their role in helping us to resolve them.

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We’ve got to talk about these issues in a way that clinicians understand and can relate to, and can see their role in helping us to resolve them.

And finally, and again it’s the point that Lee was making, we’ve got to align incentives to reward the delivery of right care. The reason that this joint venture has been successful is that it’s paid on a capitation basis not on payment by results. And I think we need to actually take that lesson and learn it in terms of the way we implement the new arrangements. Thank you very much.

[applause]

John Drew: Thanks Sue. I think it’s great to get some kind of concrete practical examples of what’s
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going on. One of the things that does strike me though is that all of that needs to happen very fast and kind of for every specialty. And one of the things that we want to talk about is this point about the pace of change that’s required and the scale of it. Let’s do what we did before which is take two or three questions and then we can put those to the panel. So yes, one at the back there.

Peter Ellis: Yes, I’ll probably be touching on some of these issues myself later in the session that I’m involved in where medicines management is seen as a potential cause of unnecessary admissions and unplanned admissions. But interestingly some of your comments were about the use of insulin pumps and the cost occurring in one pocket but the benefit popping up somewhere else, and the hostility that exists, that Lee mentioned, between the primary and secondary care services. There are obviously things you can do on a product-specific basis, on an anecdotal basis. But we seem to be avoiding discussing a lot of basic, fundamental structural alignment issues within the system as a whole that get us into this mess.

John Drew: So the question is really about how to align the incentives to make this easier. Is that right?

Peter Ellis: Exactly.

John Drew: Thank you. Yes.

Nigel Holder: Nigel Holder, management consultant. It seems as though, taking Lee’s two slides – one of simple challenges and one of complex challenges – that if you had a free market, most of those challenges would be resolved. And I’d just like to make the point that there’s a policy that dare not speak its name called privatisation which, if we are to address the issue of institutional failure being accepted as a mechanism for driving change, and if we’re going to get the kind of pressure to improve patient pathways, we are going to need significant competitive elements within the NHS where the privatisation leads to competition that is mediated by the patient, not the bureaucrat.

John Drew: Okay, thank you. I’m going to – is your question also about this area of incentives and competition? I thought it would be. So let’s take that one and then we’ll take that group of questions.

Nick Bosanquet: Thanks. Nick Bosanquet from Imperial College. Congratulations to Derby which is unusual in having a very good reputation for having an unusually thriving private sector with a number of very successful firms. What scope is there for the Trust to engage in joint ventures, collaboration, buying in various kinds of service from these local firms?

John Drew: So I suppose we’ve got a set of questions really about if we do think about how to scale and spread some of this, can it be done in a planned way in terms of creating the incentives. Is it, you know, letting the forces of competition drive this? And some questions about collaborating with local private partners. Do you want to start us off, Sue?

Sue James: Yes, okay. I think in terms of the financial incentives and aligning those incentives, the approach we’ve done on the joint venture is actually providing a capitation based allocation which is designed to enable the whole of the healthcare needs of that group of patients to be met within the costs of that allocation. But then there is no more money. So actually we take the morbidity risk. The joint venture takes the morbidity risk, not the commissioner. That really reinforces and incentivises our ability to minimise costs. It also, I think, may well help us to begin to invest in some of the areas like insulin pumps as long as we can see the return on investment in the timescale of the contract. And that’s maybe where there is a problem. But I think that we’ve got to move away from a single approach on financial incentives. Payment by results works for planned care. It works for one-off episodic care. It doesn’t work for long term conditions.

Lee Outhwaite: To answer the medicines management question, I think there is a big gap, and this is about some of the “Jedi arts” of financial management about how do you get the money in the right place to deliver a whole health economy benefit if it happens to be a pharmaceutical spend in primary care which releases money from the secondary care environment. Why can’t we do that? So this is something about whole health economy working to have a sensible joint plan to deliver patient benefit across a continuum of care. And if we’re not delivering that, it’s a failing of financial management in the local health economy, be that the finance director in the acute sector or the primary care sector, in my view.

The market. The market for what? The market for what? So governed how? Is it a market delivering curative disease interventions at the last gasp of a patient under a 1948 definition? Is it an integrated care system that’s measured in some way in terms of some sort of One Wales coalition of local health board? What are we describing? And I think part of the ambiguity about the collaboration/competition debate gets into that “market for what”. I think there needs to be a healthy tension in the system about is this organisation delivering what it should be doing. And if it isn’t, a new entrant should be able to arrive and say your diabetic care is woeful. We’ve got an alternate model of care for
But I think that we’ve got to move away from a single approach on financial incentives. Payment by results works for planned care. It works for one-off episodic care. It doesn’t work for long term conditions.

In terms of innovation, I think we’re in the foothills of innovation. I see huge opportunities for joint ventures with the private sector and with entrepreneurs. But when we are operating as we are at the moment with total limitation because of the private patient income cap, it’s extremely difficult to get organisations thinking in an innovative way. And the private patient cap isn’t about doing more private patient services directly. It’s about innovation within the system and bringing money into the NHS. So the conditions aren’t quite right for it, although some organisations are having limited success to date.

Sue Slipman: No, but I think we don’t roll things out on a one by one basis. We try things out with the innovators then roll them out to the early adopters and then everybody at once. So I think we are in the foothills but we’ve got now some really good experience which we can use to inspire and to educate others.

Malcolm Durham: Thank you. Malcolm Durham. I’m also a finance director. There are a lot of people here talking about what can happen. Who is listening? Who is not listening? Why is innovation so slow in the National Health Service? Where are the blockers? Is absenteeism improving? Is the Department of Health listening? Are they here today? Why are people not listening and making these good things happen quicker?

Richard Edwards: Good morning. I’m Richard Edwards. I’m from Federation of Ophthalmic and Dispensing Opticians. It’s interesting, as an optometrist our profession has had some disruptive innovation over the last 20 years and I think I’d like to encourage people in the room to look at our sector as perhaps a blueprint for how things could be.
Sunday Times survey when we were going through some quite significant merger with a competitor. So mergers can be done.

I think the other real silver bullet in our industry is as a profession we’ve embraced the franchise model, and I just think this is as close to a silver bullet as we’re ever going to get, guys. Our big competitor is Specsavers that has gone from a low starting point to complete domination of a market on the back of a franchise model. We at Boots, to be honest, were slow to take up on this, but we have now started to franchise some of our practices. And it plays to Sue’s point around clinical leadership. I absolutely endorse that. When you get clinicians managing their own affairs, they love it. And in Boots Opticians we’ve got practices that are now managed by professionals where their performance has shot up.

And I can tell you, where we’ve really gone for it in franchising existing business we’ve measured three things: the productivity of the business could go up 30 per cent in one year. So actually we can do it quickly, and clinicians can do it quickly. But at the same time our customer satisfaction went up and our staff satisfaction went up. The staff satisfaction went up at a point where they were all being taken out of a final salary pension scheme. It can be done and it can be done quickly, but you’re absolutely right. It’s got to be against the backdrop of the need for change. I hate to say this, because it’s a competitor, but you do wonder if maybe the answer to this may be that Mr Lansley may need to go to Specsavers.

[laughter]

John Drew: So I think one of the questions in there could be what the role of a franchise model could be or what that look could like to drive change faster. So let’s take one more question. I think this chap on the end in the white shirt has been waiting the longest.

Nick Holie: I’m Nick Holie. I’m a healthcare public affairs consultant with Advocate Consulting. My question really was about the concept of demand that we’ve been talking about, and we’ve talked about the economic and the management challenges of increasing productivity. Is there also a political challenge – I suppose both with a big “P” and a small “p” – in addressing the concept of patient demand both in terms of the services that patients expect from the NHS and the way that they access those services.

Sue James: Can I just pick that – are you ready to answer questions?

John Drew: Yes.

Sue James: I’ll just pick that question up first because I think you’re absolutely right, and it goes back to Lee’s point about the fact we’re still talking about the health service in the terms that were defined in 1948. And people see their health service and the main currency is beds. And when beds go down, then people see their service being lost. And we’ve got to get much, much better at explaining to people, in language that they understand and that really means something to them, what the service is going to do. And if you start from the position of saying we are going to provide local services for people so they don’t have to come to hospital, they all say three cheers for that. And it is about, as Stephen Dorrell was saying earlier, explaining what we’re going to do and what we’re going to give people before we actually talk about what we’re going to take away from them. And I think that’s a really important point.

The franchise issue is a really interesting one and I think it ties into the federation stuff that Sue was talking about earlier.

Sue Slipman: I was just going to say that part of the cultural revolution here is also about individuals taking responsibility for their own health. And there is still this concept that we’re a system that fixes them. Whereas actually with long term conditions you have to fix yourself using the resources that there are within this system. And that’s a huge re-education. And we’ve got to play a partnership role in getting people to that stage and actually empowering patients. And that’s a completely different model of care.

Lee Outhwaite: The first question was about why we’re not going fast enough, I think, and I do think there is a problem about system alignment, incentives, and the extent to which people are prepared to innovate based on the consequences of failure. And I think we’ve got to be desperately honest about that. My EBITDAR (Earnings Before Interest Taxes Depreciation Amortisation and Rent) margin starts to fall. I’m hauled in to see the beak with my chief executive. We’re told off. We’re doing daft and silly things measured on a financial construct which probably isn’t good enough. And I think we’ve got to be honest about that. So when I’m called in before the beak to say my EBITDAR margin isn’t high enough on a range of my service lines, if I’m doing lots of innovative things in that diabetic model of care, which in actual fact has lost me income and has contributed to the Trust position being worse, am I a bad finance director or a good finance director? And I’d like somebody to answer that question for me and quickly.

[laughter]

Lee Outhwaite: The franchise model I think would be criminally insane – criminally insane to assume we could be good at everything. Boots are, on our outpatient pharmacy service, a damn sight better than we ever were, and we need to be a damn sight more
honest about where we innovate and adopt from external agencies better support, and do that in a way that isn’t threatening for staff, which doesn’t create the sort of subtext of backdoor privatisation because I don’t think it’s about that. It’s about delivering better patient care. And I think we’ve got to take our staff with us on this journey and not sort of assume we’re giving them out to some sort of red in tooth and claw marketplace that’s going to beat them with a stick. I don’t quite see private and public sector management in those stark terms.

The demand concept I think is quite key really about what we are describing. And I do think at some point we’ve got to answer some of this sort of QIPP challenge with a little bit of a reality check about what’s possible and what isn’t for our public. And at the moment we’re running along in a very hubristic way assuming it’s all deliverable by changing things and quickly. Now I’m getting a bit more middle-aged I think there has been something about, since 1948, the culture of entitlement and what we expect from our patients and public in addition to what they can expect from the NHS which needs to be addressed in a more credible debate.

Sue James: Sorry, can I just add, I think we need to ensure as part of this narrative with patients that we were talking about earlier that they understand the value of the services that they receive. Because it’s free at the point of delivery there is a real sense that they don’t value it, they don’t understand it. One of the things I’m trying to work with Lee on is for every discharge letter we give patients we actually say to them at the bottom “this has cost the NHS X” just so that they understand that popping in to A&E is going to cost the NHS £50-£60 a time. And I think beginning to discharge letter we give patients we actually say to them at the bottom “this has cost the NHS X” just so that they understand that popping in to A&E is going to cost the NHS £50-£60 a time. And I think beginning to educate patients in that way is really important.

Sue Slipman: And it was a really interesting question you asked, Malcolm, about is anyone listening. We’ve just been through a pause in which everybody is meant to be listening so I find it quite interesting that you don’t think anyone is. We will see, won’t we, next week.

In terms of the questions about integration and promoting integration now as a regulatory duty, that is going to be very interesting for the new Monitor, I think. And I think a lot will depend upon where the competition function now sits within the regulator. Does it sit within the regulator? Will it be separate? Will we see a continuing CCP being separate from the regulator? And I think the regulatory judgements are now going to have to be very careful about what is in the patient interest as to whether they are promoting integration or enabling competition in a given set of circumstances. And so it’s going to be a very interesting question about whether the regulator will now be competitive judge and jury over its own strategies in the patient interest. So I suspect we’ll have some conflict of interest issues to deal with in the new regulatory environment as a result of this.

John Drew: Thank you. I’m going to get us to coffee. Just a couple of thoughts to sum up. I think the franchise model is an interesting one to raise, partly because presumably when you take on a Specsavers franchise there are all sorts of things that you don’t have to work out because the model is defined for you. It doesn’t mean it’s straightforward to run it well – so there is still an implementation challenge – but it’s made easier by somebody else having defined the model. And you know one big opportunity I think in the NHS as a national system is that management and sharing of knowledge of what works and packaging that up, and potentially this franchise analogy which at the moment is not done as well as it could be for sure.

The final thought really is that there is lots of religious language and analogies being drawn and I’m sort of looking up here at the stained glass window up here with the word “faith” on it. And so I think that we’ve got another song: “We’ve Got to Have Faith”. And I thought faith in a few things, really. One is the incredible commitment of managers, and I think that you saw it from Lee and Sue, that this is not a straightforward challenge. And I do agree that a bit more support for the people that are trying to make this happen wouldn’t go amiss. I think the second thing is that we’ve heard about faith in the incredible drive, pride, and competitive instincts, if you like, of clinicians. I think on the whole they came into this profession for a reason, and recapturing some of that fire, now is a good moment to do it. And I think that is happening certainly in some cases quite quickly.

The last thing I would say is I think in just the work that we do and the conversations that we’re having, I would have faith that the sort of unfreezing process is happening very fast actually. So I think the kind of conversations that people are having, the kind...
of options that they are considering, has changed extremely fast to being relatively radical. So I think that at least suggests that the beginning of this process is gaining momentum rapidly. Whether that means it’s possible to do the four plus four plus four plus four, we’ll wait and see. But I think that those are some causes for faith. And now coffee.

[applause]

Session 2 – Disruptive innovation: Integrated care

Jennifer Dixon: I’m going to introduce our speakers in a second. You can gather there is a thread running through this morning which is a little bit about integrated care nirvana it seems and this is something that has been talked about for some time, it’s quite interesting, at least ten years in the NHS. And it takes a financial crisis for us to really push the accelerator pedal down.

The nirvana seems to consist of Kaiser-style integrated care capitated with integrated IT, aligned incentives, strong mission, strong governance leadership, quality focused, competing with other integrated organisations to achieve low cost, high quality. That seems to be the kind of dream that we want. And we’ve got two speakers here today who are going to talk about their experience in kind of groping towards that kind of nirvana, if I can put it that way. It strikes me we know roughly what to do, don’t we. It’s a question of how to get there from here and it’s all in the “how”.

And so there are two aspects of the “how”, it strikes me. One is inter-organisational “how”: how to develop these networks and so on. And there’s the extra-organisational national policy context “how”: how do you facilitate this stuff and remove the barriers that are existing to achieving it.

That’s enough from me. Let’s hear from our two speakers. So we’re going to start off with ten minutes from Dr Alfonso Bataller who is the Deputy Minister, Department of Health in Valencia, who is going to talk to us about the interesting developments there. Thank you. The promise of “the four per cent” is going to hang over him.

[applause]

Alfonso Bataller Vicent: Thank you very much. Good morning. First of all I would like to express my regards to the Reform think tank and to Nicolas and his organisation, McKinsey, for the kind invitation given to me, the opportunity to try and explain in ten minutes what we have done in our perestroika since ten years ago.

If I have my first slide, I always like to start with this because I think it concentrates all the real problems that the health administrations in all the developed countries have. I think that they are all well-known: the ageing population, more competitive environment, passing information, growing health expenditure – this is a big problem for all of us – organisation and management changes, and advanced new technologies.

Spain has one of the lowest cost health systems in Western Europe. We have an average in 2007 of $2,671, and the percentage of the GDP spent in public and private is 8.5. It’s very close to the UK, and with, I think, very good average outcomes. In life expectancy we are in the top. In deaths we are also doing very well, as well as tobacco consumption and obesity.

We are in the east part of Spain. We have about 58,000 medical professionals, 11,000 physicians. And our budget for this year is 4.6 billion euros. This has decreased 3 per cent from the last year. So you can imagine how many problems we are having. And these are some of the issues that you are dealing with here in the UK: putting patients and the public first, improving health outcomes, empowering clinicians, increasing local democratic legitimacy and improving public health.

In 2005 we focused the same objectives. And we made a strategic plan that, as you can see here, was centred to promote health, to enhance the value perception on our administration, to integrate primary and specialist care, to improve the perception of the service quality, to strengthen the degree of quality initiatives and to transform care provisions. For example, we have the same number of acute beds since ten years. We haven’t increased the number. We have more hospitals but the number of acute beds is the same.

And also, as you can see, we are worried about the financing. And so one of our objectives is to be aware and rationalise growth in costs. Fundamentally to develop alternatives to direct management – I will talk about our public-private partnership alliances and concessions – and also to be efficient in the pharmaceutical expenditure. Our pharmaceutical expenditure is 30 per cent of the total budget. It is more than 1,700,000,000 euros so we are making very important efforts to control this
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because any percentage of savings in this part is very, very important and I think also here for England and for the UK.

So ten years ago we tried a new model. These are the main features: comprehensive health management, freedom of choice, financing per capita, invoicing for the patients going out of the catchment area – that’s to say as they have freedom of choice they also take the money with them when they are going out of the 24 health departments that we have. And also we started in 2006 with management agreements with the responsible managers of every health department. That is to say there is one director of the health area and he is responsible for the primary healthcare services and the specialist care services.

And we also have five departments attended by concessions – private concessions – that have the same objectives and targets in these management agreements. And we also have a strong information system. This has been one of our keystone elements in this management model.

So we started with one hospital – it’s La Ribera in Valencia – at the beginning it just had specialised services but this is not efficient. We also have to put in the contract the primary care services. The private health insurance companies that won the tender told us “let me manage completely all the health services because then we will be able to be more efficient.”

So we started with this model. We have now five concessions in different parts of the territory. That is about one million citizens who are being covered by these private concessions. And since 2005 this is how it works. The thing is that we actually paid 619 euros per capita to the private concessions, while we are paying about 900 euros per capita to our public departments. So we are paying 20 per cent less of the real cost to these private concessions. And they have to build the hospital and in 15 years to return all the money they have invested.

So what is capitative financing, because this is very important. It consists of assigning to the group of care suppliers of a geographic area an economic amount for each person of the area included inside the protected population. One thing that we have is that we know all the citizens very well when they come to our health network because they have a health card and this is the gate for the entrance to the system. So we know how these people are distributed in the different territories and when they move to another territory we know that they are going out of the catchment area.

This is very important also because we have an electronic clinical record for the 5.2 million people living in our community. This clinical record can be viewed by the nurse in the hospital and the nurse in primary care. So if you translate this to the territory you will see the population, the premium that we are giving them per capita, as you can see in red – this is in 2009 – 597 euros, but the rest of the departments in black are the public departments and the total amount per year. So for example La Plana was 214

million euros for the year and this is what we pay to the primary care, hospitals, and it’s not included the public health nurses – for example vaccinations or screening of colorectal cancer and other cancers – and emergency – emergency services are centralised and the pharmacy of primary care. That’s a very important amount of money, but it’s not included in the capital.

Well besides this we have also developed since 2005 a target management model because we want to finish this free ride for all because everybody was earning the same amount of money in our health centres. We tried to put incentives, to put a ranking list of the best hospitals, and to start measuring. We started with 75 objectives and now we have 100 objectives – 70 per cent of them are quality, 25 per cent are on rationalising costs. This is our strategic plan, how we started with the management agreements, how we started with the pay differentiation and how this is correlated to the professional career of each worker in our health system.

We have even tried more things to be more efficient. We have our central purchasing body. We tried to buy many of the things for the entire network of hospitals, and this is giving us some important savings. We also keep an index of the performance of different departments. In 2005 some departments with very low scores but in the following two years all the departments move to the top of the ranking because they want to be the best ones.

The model of the public private partnership relations and concessions is very important. Why? This is why – it’s more complex and would cause me more time to explain it but we are very, very proud of this model. It’s just public financing, capitative payment, usually at 15 years, with public control through the commissioner and the committee. Public property reverts to the state and a private provider builds a new hospital.

These are the five public-private concessions – 20 per cent of Valencia. The premium has been increased in the past few years to 619 euros for this year to the five concessions.

So integrated care and capitation financing are two mutually dependent management concepts in our model. And it only makes sense with an integrated healthcare mechanism. So care integration, capitation financing, intercentre invoicing, compensation, information systems – because if you don’t have it you don’t have the information to invoice and to make the final balance. And the money follows the patient. These are some of the key success factors: price

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review, on expiry of the concession all the investments revert to the regional control bodies and decentralisation. And as you can see here, our health card. Very important. Our database of all the citizens and we know very well all the contacts they are doing with the health network. This is the difference between the capitas that we are paying to our public hospitals and to the private hospitals.

Another important issue is that we have learned a lot from private performance, because as we report monthly or bimonthly all the outcomes in the entire network, as you can see here in Alzira – this is the number of surgeries per operating and these are some of our hospitals and the average length of a stay. So what we say to them is let’s learn about this performance, what you are doing that we are not doing. So this, in the last five, six years, we have learned a lot of this, and this is one advantage that I would like to highlight.

This is the ranking of 2009. As you can see the Torrevieja hospital was the number one. This is a public/private concession. Number two was a public hospital, number three is La Ribera, a public/partnership, and number four is a public hospital. So every year you have our ranking and the people – we can’t pay as much as we would like to pay for the productivity because we don’t have enough money, but at least when they look at the ranking, it’s enough to incentivise and to try to change the things. But if you have money, it’s better.

These are some of the advantages for the citizens because they have better accessibility, lower response time, an individualised approach, and the same information is shared between the specialist and the primary healthcare attention. Advantages for the staff: obviously health professionals that work in these concessions, private concessions, earn more money, but they work more. And advantages for us because we have fixed budgets that for these departments that don’t change during the year. And we try to solve the funding problem also.

Okay, these are some of the key pitfalls to avoid: lack of dialogue between public authorities and private insurance companies. We have a very fluent dialogue with them. They are not our friends – because then they would say these private companies are your friends, no? But we have a very close dialogue with them. If you have not prepared your information systems, it is difficult to implement this model. And mistrust of trade unions. We had problems at the beginning with the trade unions. Now nobody says anything wrong about this model, okay, in our community.

And just for conclusion, the investment capacity and management expertise of the private sector are able to improve the efficiency of the public healthcare sector mainly if we are at the core of the delivery. And a high perceptive quality is achieved. Citizens are interested more in accessibility and quality than in who provides the healthcare in our community. Infrastructure – we have an electronic health record. Clinical and management information – information visible to all organisations. And a business model. Integrated primary and secondary care. Public/private partnership in some of the areas – so we have a competitive environment and it makes economy of provision. And thank you very much. This is Valencia.

Jennifer Dixon: Thank you very much. We’ll move straight on to Dr Andrew Steeden who is Clinical Director of NHS North West London.

Andrew Steeden: First of all thank you very much for the opportunity of coming along and speaking to you today. My name is Dr Steeden, as Jennifer says. I’m a GP working in Kensington which is in the northwest part of London. And what I wanted to talk to you about this morning is something that we’re getting quite excited about in northwest London which is an integrated care pilot (ICP) which actually launches today. About half a mile away there is a launch going on on the integrated care pilot, which I’m going to explain to you now. A lot of what I’m going to say has already played a part in other people’s presentations so there is nothing new I think I’m going to say and it’s very simplistic. Being a GP it has to be fairly simplistic for me to understand.

Jennifer explained that we’d been groping towards integrated care all over the NHS but we’ve been doing it in North West London for the last year and we have decided that the pilot, which as I say starts today, and is going to be concentrating on diabetes and care of the elderly. This is an illustration of the area that the integrated care pilot is going to cover. We’re quite excited about this because we think we’ve got something quite unique in the NHS in that we’ve got a very complex system with many partners and we’re covering quite a large area. We are hoping that once the pilot gets underway with both our acute trusts that we’ll cover a population of about 750,000. The first wave, which is launched this morning, is going to cover about half of that, and that’s a population area that serves the Imperial, our first academic health and science centre here in London.

The partners involved are one of the things that both enable this to be very exciting and have made it quite a complex process to get us this far. We have two acute trusts: the Imperial Academic and Science Centre and the Chelsea and Westminster. We have five PCTs which are feeding into this as well as five local authorities, two mental health trusts and two community trusts, who are also delivering our community services. And what we’re hoping to achieve – and we’re quite confident that we probably
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And just for conclusion, the investment capacity and management expertise of the private sector are able to improve the efficiency of the public healthcare sector mainly if we are at the core of the delivery. And a high perceptive quality is achieved. Citizens are interested more in accessibility and quality than in who provides the healthcare in our community.

...we’re going to become a beacon for delivering integrated care to the people of northwest London, and that’s integrating all the care delivered by health and social care, so that’s primary, secondary, community, mental health, and our local authorities as well.

And basically the process has seven steps. We know who these patients are because they are on disease registers or they are on practices’ lists at the moment. So we have a list of who these patients are that are going to play part of the ICP. We’re going to use a combined predictive tool which will take information from the primary care systems that we have as well as hospital information so that we can risk stratify those patients that fall into the two groups. And once we’ve done that there is a piece of work that we’ve already done over the last year where we’ve been working with clinicians, patient groups, community therapists, as well as GPs to set up clinical protocols and care pathways. And these have been agreed. There is nothing new or terribly exciting about these. These are fairly standard care pathways for diabetes and care of the elderly. But what has happened is they have been agreed by all the partners, and these care pathways now will feed in to the care plans that each of the patients who have been risk stratified will have.

So the MDGs will be responsible for monitoring that these care plans have been delivered. And what the MDGs then do is they spend the resource that they have been allocated to decide how that care is delivered to that population. And that might vary from borough to borough depending on what resources are already available or whether there are particular services that things need to be invested in.

The setting up of these MDGs do give us the opportunity now to get physicians and specialists in the same room so we can case conference patients that are complex. So rather than waiting for consultants to have any interest in a patient only when they are in an outpatient setting or in a hospital, we can sit down around the desk and come up with a care plan to keep that patient healthy before they end up at an A&E service. And that’s very important, particularly for the pilot year, is that each of the MDGs will be performance managed against each other, and each of the partners inside the MDGs will be performance managed against their expectations and the work that they’ve signed up to do. And Jennifer has helped us with that as we’ve been developing that over the last year.

What’s listed below are some of the enablers that we recognised that we had to get in place before we could even start. And that’s about putting patients and users right at the very centre of this. And what that’s been useful to do is that we’ve been able to move away from just talking about finance and savings to delivering improved care. And we’ve also been able to get patients and users to talk to clinicians about the benefits of how they can change their behaviour as well. So that’s brought all kinds of healthcare professionals out of their silos and talking to patients around the table.
We’ve developed a joint governance arrangement so that each of the partners in the ICP know how they can talk to each other and their responsibilities up through the structure, and they all have membership on the board as well. We’ve aligned incentives, as I say, so that people don’t just get rewarded for when people get sick but they also get rewarded for keeping people out of hospital and for staying healthy. Information sharing, people have already said, is a problem that we have in the NHS already, and the last 12 month period has been a time of very intense work when we have developed an IT tool which is allowing us to share the care plans that we’ve developed with all the partners involved – something we haven’t been able to do so that hospitals can see GPs care plans as can the community services as can the social care and hopefully – we haven’t quite got this right yet – but as can the patients and carers as well. That’s something we’re particularly proud of, and the organisational development and culture is something that’s an ongoing process, moving people and groups out of their silos and into a new type organisation.

This is just an illustration of the scale of the change that we have to deliver to make the ICP sustainable. We have to create savings to make it attractive to the commissioners, whoever they’re going to be next year. And we figured for a GP with a practice of this size – about 2,000 patients – he or she has to save one admission a month for this to be sustainable. That delivers the finances that make the ICP, as I say, sustainable. But more importantly it means that patients and physicians get excited about the improved quality that they are delivering, and that keeps them engaged as well. Thank you very much.

[applause]

Jennifer Dixon: Two really interesting case examples, I think you’ll agree, both depending on very expert management to deliver these implementations, these interventions. We’ve got a few minutes for questions. Yes, thank you. One there.

Peter Ellis: I probably should say I’m coming at this with – Peter Ellis, sorry, from PharmaTrust – coming at this with an agenda, who has always believed in the independent state of Yorkshire. The comments in terms of Valencia, I just wondered, all our discussion today has been about England and the NHS if you think about the issues we’ve talked about. To what extent, the fact you have an autonomous region of Valencia and a health economy of 5 million people to develop these innovative approaches to it, would that have worked if you were working through Madrid all the time and trying to do that on the basis of the whole of Spain?

Alfonso Bataller Vicent: Good question. Okay, Madrid has the same political party that we have had for a lot of years. This is one of our advantages. We have been in government for the last 16 years and we just have won again the elections two weeks ago for four years more. But Madrid has tried other models – for example in the public/private partnership they are going through the PFI model which is closer to the English model. The health services are not included. And also they pay differently in the different contracts that they have developed. And I don’t understand how you can pay differently because the health services cost the same. So one of our strategies is that the premium is always the same. And for our hospitals it’s a pity because they can’t accomplish these fixed payments because they are different territories.

Jennifer Dixon: Okay, we have time for one more question. And seeing as it’s Nico I’ll allow that even though we’re slightly over time.

Nicolaus Henke: I just wanted to add there are 24 regions, 19 public, 5 private. How have the 19 public management teams reacted to the 5 private ones? The structures are the same but the performance is different. What has been the impact of this diversity and these competitive pressures?

Alfonso Bataller Vicent: That’s a very important question because when the first private consortium started working in our community – that’s in 2001 – they started with the epidural anaesthesia, for example. And many of the pregnant women went there to have their children. So they only get paid 80 per cent of the real cost for this because this is one of the parts of the contract. If your citizens go out of your catchment area, you pay 100 per cent. And if you receive patients from the public system, you will only get paid 80 per cent. But the reaction is that in two or three years they start giving epidural anaesthesia in the public hospitals. So this has been very important for this competition controlled by the government. I think it’s very positive.

And here in the United Kingdom I think it would be important to have some kind of competition, while always keeping a measure of government control. All the objectives and targets are the same for the same 24 departments. They compete in the ranking, as you could see before, in the annual ranking. But the only thing is that they pay differently in the contracts. We can’t compete with them to work on Saturdays, for example, as they do in the same areas.
And here in the United Kingdom I think it would be important to have some kind of competition, while always keeping a measure of government control. All the objectives and targets are the same for the same 24 departments. They compete in the ranking, as you could see before, in the annual ranking. But the only thing is that they pay differently in the contracts. We can’t compete with them to work on Saturdays, for example, as they do in the same areas.

Dr Shetty asked a question from the audience earlier about whether or not our hospitals have a monthly P&L. I don’t need to tell you too much about his hospital, but I will tell you that the doctors at the hospital get a P&L texted to them every single day. Dr Shetty is chair – I think he’s, using Lee Outhwaite’s words earlier, he’s kind of – he’s a Jedi knight in terms of the hospital that he is chair of in India. He trained at Guy’s and also in India. He’s a pioneering cardiologist working on very complex operations. It’s sort of mind boggling the complex stuff; I’m sure he’ll tell you about that too. And the hospital that he is the Chair of Narayana Hrudayalaya Hospital in Bangalore. What’s interesting about this is it’s what, in the sort of technical argot people are calling a “focused factory”. They are doing high volume, highly specialist surgeries. And to give you a sense of what that means, they’ve got 42 surgeons in their cardiac centre. And they’re delivering an unheard of 3,000 cardiac surgeries a year. Volume is enabling them to make quality completely outstanding, and they are doing it a tenth of the price that we are doing open-heart surgery here.

So I’m going to hand over to Dr Shetty to speak in just a second, and then I will ask Paul Corrigan to follow. Paul is probably known to most people here. He was a special adviser to Alan Milburn and then to John Reid and then to Tony Blair as Prime Minister. He works as a consultant. He’s writing something for Reform at the moment. He has a history as an academic and he also writes an extremely good blog called Health Matters which I can recommend to you. So, Dr Shetty, over to you.

Deviation is all about numbers. When we do 60 major heart surgeries in a day your results will always get better. If you have to choose a surgeon who does one operation very well in a day or a surgeon who does five operations in a day, go to the surgeon who does five operations. You are very safe with him. As we do their operation. That’s the main reason why we never refused a single patient. With or without money policy by the management and the family we have in a day. We get patients from 76 countries, and as a hospital which has 24 operating rooms. We currently do about 35 major heart surgeries a day but we have the infrastructure to perform 60 major heart surgeries in a day. We get patients from 76 countries, and as a policy by the management and the family we have never refused a single patient. With or without money we do their operation. That’s the main reason why we get so many patients.

Healthcare is all about numbers. When we do 60 major heart surgeries in a day your results will always get better. If you have to choose a surgeon who does one operation very well in a day or a surgeon who does five operations in a day, go to the surgeon who does five operations. You are very safe with him. As we buy more, we pay less. Last year we implanted the largest number of heart valves in the world so we naturally get materials at a much lesser price. Because of the numbers competent, talented doctors will always want to work with us and we have a zero per cent attrition among the doctors.

Because we are an academic institution, because of the numbers we train – we have 78 training programmes in our hospital and these residents will...
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reduce our salary burden significantly. And research activity, because of the numbers, adds to the revenue. And because of the numbers most governments in India give us land virtually free. In India the value of the land is much more than the value of land in Manhattan.

Now how does the number and the quality coincide? First of all our hospital has a very high standard of quality. Our hospital is accredited by the Joint Commission of the US. It is the same organisation which accredits American hospitals has accredited us. And the next – on the other side, how we control the costs. At 12.00pm every doctor – every senior doctor, every administrator gets the SMS with the profit and loss account of the previous day. We keep an eye on the profit and loss account (P&L) on a daily basis. If you get the P&L account at the end of the month, it is a post mortem. The patient is dead. If you get the P&L account on a daily basis, it’s a diagnosis and you can treat.

Because of the numbers we were chosen by Harvard business school as one of their case studies five years ago. Last year we were on the cover page of the Wall Street Journal. We are the only hospital in the history of the Wall Street Journal to be profiled on the cover page. When I was a young man all the policy makers in our country told us that healthcare is expensive, it will remain expensive, but one day India will become a rich country and everyone can have healthcare. And we believed them. Then we looked at some of the richest nations in the world which are struggling to offer healthcare.

Wealth of a nation has no relationship with the quality of healthcare. We have to look at a different model. We have to dissociate healthcare from affluence, from your bank balance, and we have to dissociate healthcare from taxpayers’ money.

Taxpayers’ money cannot pay for healthcare. It was paying all right at a time when people retired at the age of 60 and they died at the age of 65. Today people retire at the age of 60 and they celebrate their 95th birthday, and added to that they don’t produce babies. So if the younger generation is not there to earn and the old people don’t die, you have a serious problem.

Devi Prasad Shetty: We decided to have a different concept. We ran a health insurance eight years ago with the state government for the milk vendors. We are a very strong cooperative society where people sell milk. We started with 1.7 million farmers with the

premium of 11 cents per month. So they pay 11 cents per month and we offer them any surgical treatment. There are 350 hospitals across the state we network. They can go to any of the hospitals. There are 1,650 varieties of surgeries done on the human body. These operations are covered by their insurance.

After three years we revise the premium to 22 cents, and that became a major success and we helped many of the state governments to launch a similar insurance. We believe that the government will gradually become a health insurance provider in our country because that is the best gift they can give to the World Bank, and politicians all across the world do the right things for the wrong reasons.

laughter

Devi Prasad Shetty: There are five countries in the world which can put the satellite into space, and we are one of those countries. We get the satellite connection free of cost. We have got hundreds of tele-medicine centres across remote locations, and we have treated 53,000 heart patients who had heart attack in remote locations entirely free. And we get hundreds of ECGs through the telephone line, and our doctors diagnose heart attack and give their advice.

All across the world outstanding doctors came from deprived backgrounds. They have the fire in their belly and they changed the rules. But in a developing country children from poor families cannot become doctors. So we launched a programme five years ago in rural West Bengal where children who are 13 years old should commit to us that they will become doctors. Then we give them a scholarship, we fund their education with the idea that they will change the rules of the game.

We have 100 towns in India with a population of half a million to one million without a heart hospital. A 300-bed heart hospital traditionally costs about $25m where you can never reduce a heart operation to $800. This is a model we have developed with India’s largest construction company where this hospital would cost us $6m including equipment from GE. Traditionally a heart hospital takes two and a half years to build, and this hospital can be built within six months because it is prefabricated.

We have changed several assumptions in healthcare. Why do you need an air-conditioned hospital in a tropical country? When our house is not air-conditioned, why should the hospital be air-

"Healthcare is all about numbers. When we do 60 major heart surgeries in a day your results will always get better. If you have to choose a surgeon who does one operation very well in a day or a surgeon who does five operations in a day, go to the surgeon who does five operations."

At 12.00pm every doctor – every senior doctor, every administrator gets the SMS with the profit and loss account of the previous day. We keep an eye on the profit and loss account (P&L) on a daily basis. If you get the P&L account at the end of the month, it is a post mortem. The patient is dead. If you get the P&L account on a daily basis, it’s a diagnosis and you can treat.

laughter
conditioned? Why should a nurse look after a patient in the ward? A spouse can be trained to look after. Nobody can be as good a nurse as a spouse.

We believe that healthcare is not a burden to the society. The 21st century economy will be driven by the healthcare industry. Global healthcare and wellness industry is the second largest industry in the world. So do not look at it as a burden. We need to look at creating jobs all over the world. Today the buzzword is inclusive growth. God did not create everyone intelligent. He gave intelligence to very few people and the rest of the people are average intelligent or less intelligent people. We need to create jobs for them. Which industry in the world can create millions and millions of jobs for average people?

There is only one industry. That is the healthcare industry.

In my country the IT industry gets phenomenal benefits. For a quarter of a million dollar turnover in the IT industry they hire just five to seven people who are engineers, who are smart people. In the healthcare industry in my country, for a quarter of a million dollar turnover we need to hire 250 people. And the bulk of the people are the ones who are driving ambulances or cleaning the toilets.

Everyone criticises the NHS. For the time being just assume the NHS is not functioning for one month. What are the implications? It is not the implication of millions of people dying. Nothing will happen. People will survive even without the doctors and the hospital. But the entire economy of England will come to a grinding halt. The NHS distributes £5 billion of salary every month to 17m households where the families can buy their food, they can educate their children, pay the mortgage. This is the one which keeps the economic engine of England going. So never think about trying to reduce the cost or trying to – you have to address the efficiency.

In a developing country like ours creating jobs for women is very, very important. In the whole of India there are not more than 20 lady ambulance drivers. Our job is to create employment opportunities for women. As an organisation we have 12,000 employees across the country and 94.8 per cent of our employees are women. Why women?

Because if I give the job of cleaning the floor to a man and give him 4,000 rupees salary, he spends 2,000 rupees on himself and 2,000 rupees goes to the family’s welfare. Instead I give the job to his wife and give her 4,000 rupees salary, she spends the entire 4,000 rupees on the family’s welfare. When a woman from a lower socio-economic strata becomes employed she becomes an empowered woman who will bring up confident children, disciplined children who will build a great nation.

My purpose of coming here is one, to attend this conference and the other one is to have a meeting with the Royal College of Surgeons. Today you think that there is poor healthcare in Africa and India because they have no money. Money is not the problem. The problem is shortage of skilled manpower. In Malaysia they produce 5,000 babies and they have two surgeons who can operate on them. We have hundreds of surgeons in India but these surgeons cannot go to Malaysia and operate. None of these countries in developing countries recognise each other’s degree, but there is one thing: they all recognise a degree from the Royal College. If the United Kingdom has the option of giving $1 trillion to developing countries or help the medical education, they do the second one.

I just want to end my talk saying that we have a lot of rules and regulations about what is a quality of every person involved in the healthcare. When somebody does an appendix operation the person who hands over the instrument has to be a BSc in Nursing. Is it required for that qualified person to do this? Look at this great painting. It is a lovely painting in my office. You will be wondering whether Michelangelo or somebody else has done it. This painting is done by an elephant in Thailand.

[laughter]

Devi Prasad Shetty: If you can train an elephant to do this masterpiece, can’t we train people with average skills to give a surgical instrument?

This is the data from the Bureau of Labour Statistics on the US. Out of the 20 fastest growing occupations in the US, 15 are in healthcare. And none of those training programmes exist in most of the developing countries. The message I just want to let you know, that unless US and Europe spends money on developing our resources to develop robust healthcare in Asia and Africa, the cost of healthcare in your country will never go down. Today you are buying a mobile phone for a few cents primarily because 75 million Indians are buying the mobile phone. We give the volume, the price of the product will go down. We give the volume for healthcare, your price will go down.

I just want to let you know that we will become the first country in the world to dissociate healthcare from affluence. It’s because we produce the largest number of doctors, nurses and medical technicians in the world. Outside the US we have the largest number of USDA approved drug manufacturing units. We have everything going for a fantastic healthcare delivery provided the Royal College takes pity on us and tries to help us. Thank you very much.

[applause]

Nick Seddon: Fantastic. Thank you very much. Just to let us have time for questions, Paul, do you want to...
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Paul Corrigan: I think I want to say two very different things in my five minutes. First of all some general words about disruptive innovation because what we've heard in the last ten minutes is a story of disruption. Actually what we've heard is several stories about disruption. Almost each theme was put in such a way as to be disruptive. So you don't just pick people, you pick women, because that's the Keynesian multiplier effect. And so everything is discussed in such a way as, as you go through a chain of activity, what can be the most disruptive? I know, let's do that.

My point about saying that is if we are about disruptive innovation, not all innovations have to be disruptive. In fact nearly all of them aren't because we don't like disruption. The truth is we really hate disruption because do you know what it does? It disrupts.

[laughter]

Paul Corrigan: And what we really want is disruptive innovation without the disruption. And actually what you see in the National Health Service and in most large industries is entire successful industries circling around a piece of disruptive innovation and crushing it relentlessly. If we want to see disruptive innovation, we have to be in favour of disruptive innovation winning conflict against the people that stop that. Otherwise let's not bother. Let's just get involved with innovation and leave the disruption bit out.

So the purpose of disruptive innovation is disrupting the way in which we do things. The problem is the NHS hates disruption. Public services hate disruption because they sort of see it as a dangerous thing. And you know, they're right. But who is it dangerous to? It's dangerous to the people that are protecting against disruption. And the problem we've got – and there is a very interesting book by an American called Clayton Christensen which has got in the title “the problem” is – it's called The Innovator's Dilemma. And the dilemma for an innovator is if they go into one of the best examples of the current business model and try and innovate there, they get crushed. Why? Because actually that organisation is doing very well in the existing business model. Why on earth should we change? So the dilemma is how do you find disruptive innovation locations that can have an impact outside of the existing business model.

Now just to talk then the last two or three minutes on what I think is an example of that. The business model for healthcare across the world, and on the edges of what Dr Shetty was saying – he was challenging that business model – but the business model for healthcare across the world is that if you want to increase healthcare you need more medical staff, more kit and more drugs. Those are the things that add value to healthcare. And therefore if we need more – oh, we've got a rising demand of healthcare coming up, therefore we need more of those things. And that is a business model.

However it's a business model which is now running out of money. And so what do you do? Now you can do an enormous number of things within that business model – and these are very, very important things – to reduce the cost within that business model. But you can also look for different – locate and realise different places where value resides, which is what a new business model does. And in other industries they have located and realised value through the customer doing a lot of work.

My experience and Mr Tesco's is I now make most of his money. I do most of the work. I now do most of the bar-coding. I go in and you know, I really like it. Because I'm in charge of this process. There isn't someone between me and my cheese. I do it. And I gain from that and he makes a lot of money. And I like it. I now do all my banking – I've personally sacked a whole bunch of tellers because I now do all my banking, because I'm in charge of that. So the disruptive innovation in those industries is people doing things themselves.

Now you won't be a million miles away from where I'm going with this. We have a healthcare system which believes that value can only be constructed by medical staff, kit and drugs, and we have health which needs people to look after themselves. We have healthcare that needs people – if you have a long term condition and you are awake 16 hours a day, in a year you'll have 5,800 waking hours where you're looking after yourself for that long term condition. If you're very lucky you see a doctor for 20 minutes in that year and a nurse for two or three hours. So if you increase the productivity of those statistics, if you increase the productivity of the 5,800 hours by one per cent, you'd do very well. If you double the productivity of the doctor, it doesn't really matter. So where do we put our emphasis and our

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...what we really want is disruptive innovation without the disruption. And actually what you see in the National Health Service and in most large industries is entire successful industries circling around a piece of disruptive innovation and crushing it relentlessly. If we want to see disruptive innovation, we have to be in favour of disruptive innovation winning conflict against the people that stop that. Otherwise let’s not bother.

on the third sector in constructing products to sell into the National Health Service that will transform the value of those 5,800 hours and therefore transform the value of the one hour and the three hours. The two things will multiply each other rather than actually be done separately. And what has the third sector got to bring to this? It has a set of trust relationships with a set of people that want to give time and can bring to this? It has a set of trust relationships with a set of people that want to give time. And those organisations can sell that giving of time and can be constructed by medical professionals, or for that matter the private sector, cannot because of that trust relationship.

So to conclude, what I’m doing with this is taking – getting together a group of very large third sector patient organisations, constructing products, going to talk to commissioners, and trying to construct a new form of value chain which potentially transforms all of the value chains given that 70 per cent of the money we spend in the NHS goes on long term conditions, and given that about 97 per cent of that is spent with patients looking after themselves. Thanks a lot.

Now you won’t be a million miles away from where I’m going with this. We have a healthcare system which believes that value can only be constructed by medical staff, kit and drugs, and we have health which needs people to look after themselves.

...one more about allocative efficiency – doing the right things and doing the right things in the right ways. I’m sure you’ll have questions from both of them. I’ll probably take in clutches but let’s see. One here and one right at the back. Yes, Lee. Maybe just wait for the microphone.

Devi Prasad Shetty: No. I have no plans. As I said, I haven’t come here to advise the NHS. I’m a very, very great admirer of the NHS. I used to work at the Guy’s Hospital many years ago. I think it requires a little bit of a tinkering here and there but it’s a great system.

Devi Prasad Shetty: See, in any hospital if the doctors are not aware of the money coming and money going that hospital cannot have viability. It is – doctors have an illusion that money comes from heaven, so it is very important that they have to understand that that’s all we have. And within that money how best we can treat patients. See, if everyone
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Nick Seddon: Brilliant, thank you. And Paul –

Paul Corrigan: I think just to continue that point, I think exactly in my experience of reframing the challenge – take your – is that there is sort of a war that goes on in most medic’s heads between habit and science. And science moves people forward and habit holds them still. And that seems to be – it’s not unusual for doctors. It’s true of all of us. But what you have with doctors is the possibility of talking about science. And in a sense your message about economics is teaching a piece of a science and people can pick that up. But it needs to be framed properly, not just in terms of the scientific method, but an argument about what is to be gained. That’s the first thing.

The second thing is that the doctors are very, very different. And actually the notion there is a bloc – if there was a bloc we would have been a very bad position. But actually what you’ve got is an enormous variation. So all of the patient organisations – UK Diabetes, Asthma UK, all of these – have a number of doctors that are passionately in favour of self management and will argue from a position of great strength with others about it. So it seems to me what you have to do is to really take the arguments to the profession and really argue it through rather than stand back from it and think: oh my God, they’re conservative, what do we do? So – and I think there are specific arguments and there is a lot of economic education that has to go on for anything to happen.

On the second point – and whenever I’m asked a political question I give an answer as a politician, which means in the first year of a government oppositions don’t make policy. And in fact if I was in charge of the Opposition looking at this government’s health policy I’d be brought to mind Wellington’s great feeling about – he always said when opposition generals are making a mistake, I make it as a rule never to interrupt them.

Paul Corrigan: And if I was the opposition I’d keep very quiet about it.

Nick Seddon: There we go. We’ve run out of time. I shall take that particular anecdote and also the elephant painting with me from today. That was completely outstanding. Thank you very much indeed. Malcolm asked earlier whether or not anybody is out there listening. Whether or not they’re listening they’ll soon be able to read because we’re transcribing this. So once again, thank you both very much indeed.

[applause]

Session 4 – Disruptive innovation: Technology based networks

Andrew Haldenby: Can I ask our third and final panel for this part of the day to come forward. And Tom Kibasi, Associate Principal at McKinsey, will introduce the panel.

Thomas Kibasi: Well, good afternoon everyone and I’m delighted to be able to welcome Pedro Yrigoyen and Joanne Shaw who are joining us for this panel discussion now. Pedro co-founded MediCall Home in Mexico which provides unlimited phone consultations with doctors for $5 a month paid on a phone bill. And they resolve something like 62 per cent of the cases over the phone, but he’ll tell you more details about what they’re doing. They’re currently the largest Spanish-speaking provider of telecare operating in Mexico, the US and Latin America. And I’m particularly grateful to Pedro because he’s travelled here for the conference all the way over from Mexico. And we’re also joined today by Joanne Shaw who is the chair of NHS Direct, which many of you will know provides remote health advice via phone, web and mobile. And I think Joanne is also chair of Datapharm Communications which provides digital medicine information to the NHS, to the pharmaceutical industry and to the public at large. She was formerly on the board of the Audit Commission. But since we’re pressed for time I’m going to hand it straight over to Pedro to talk about his experiences setting up MediCall Home in Mexico.

[applause]

Pedro Yrigoyen: Thank you. Hi there. First I would like to thank our hosts, Reform and McKinsey. This is very exciting and we’ve gone to a few of these conferences presenting a very simple business case, but one that usually works. So hopefully today I will be able to explain my business case to you quickly.

The concerns I hear when I go to these conferences is always the same: the public sector’s natural resistance, even terror, to the word disruption or innovation. You know, it’s like they either imagine a 100 per cent privatised health sector run by external management consultant companies or, even worse,
technology so complex that only Steve Jobs can create it and implementation is doomed to fail. So we just heard this morning, evolution vs revolution. Can we settle, on a word – let’s say “creative”, for efficient implementation of proven tools. “Proven” is the word, I think, that we should choose here.

I’m going to talk about a very simple phone usage. Is it disruptive? Phone usage – we all carry a phone every day; we use it all the day; by itself it’s not disruptive, but it can generate huge amounts of savings. That’s tremendously disruptive. About 70 per cent savings on primary care. So let’s just be creative here. The reality is that telecommunications and computers are integrated into our daily lives. The web, Twitter, Facebook – it’s here to stay and everything has converged. So will medicine come and converge with it? It is just a matter of if, not of when. So are we going to resist it or are we going to promote it as a way to lower costs?

Yesterday I asked a question at dinner: how many phones are there in the UK? It’s like 70 million, 80 million – I don’t know. How many doctors, general practitioners? 30,000 somebody said. So that’s a big ratio. Can we change the paradigm? Can we take medicine to the phones, to the people, instead of forcing people to make unnecessary visits to their doctor’s office? I think we can. Our model in Mexico has been running for 12 years. And it’s just this very disruptive use of very low-tech technology. Shouldn’t we make people call us, government or not, before they visit a doctor? A single stat stands out and there are several companies like ours – very successful ones – one in Canada, India, the US – and our figures are all the same. We’ve all found 62 to 68-70 per cent of first call visits – primary care visits – can be avoided on the phone. That’s a huge number if you do the math.

So should we make that compulsory? Probably yes. Are we going to treat major ailments – cancers, etc? No, no. We encounter this resistance from doctors who feel you can’t really treat a patient if you don’t feel the patient and see them etc. But yes, you can for the two-thirds of things that are can be treated. So the model is very simple. I know the NHS Direct example here has had some successes and some failures, but over the years you have to become huge. It all depends on volume. Thank God I’m not a politician or a doctor. I’m a telemarketer. I’ve been a telemarketer all my life. And all telemarketing operations are businesses and you control all the variables to the dime, to the pence. So if you have the volume and you have uniform medical protocols – you always stick to them.

And then you engage the patient. You treat the patient not as an industry but as an electronic record somewhere out there if you do things right. Our average response call time is less than three seconds for ten years consecutive.

So if you deliver quality you will convince people to call you, to engage in this new form of medicine. They may not be used to it, but they will become used to it. They will participate in their own
it uses very sophisticated technologies. But what the NHS has been less good at is the application of everyday technologies in transforming the way in which people access the system, interact with the system and interact with healthcare professionals. And in the last ten or twelve years most consumer-facing businesses have radically transformed the way that they interact with their customers, and they have provided a much better experience for a much lower cost, primarily through the internet and telecommunications IT – big corporate clout – can be brought in because they are eventually going to be players here anyway, so how can entice these big corporations using the right economic incentives to make money out of helping our national health systems and getting into development themselves?"

"But I do know that telecommunications IT – big corporate clout – can be brought in because they are eventually going to be players here anyway, so how can entice these big corporations using the right economic incentives to make money out of helping our national health systems and getting into development themselves?"

If we hadn’t been around, a third of them say they would have gone to A&E, and 42 per cent of them would have gone to their GP. And they’re very satisfied with our service on the whole, 93 per cent of people say they’re very satisfied, 90 per cent of them follow our advice and 76 per cent of them say they would very definitely recommend us to other people.

And the way that we work is that we have – I mean this is a historical legacy and it will make your hair stand on end – 32 contact centres around the country. But we network them into a single virtual contact centre. So we aim to capitalise as far as we possibly can on economies of scale by routing calls around the country to the next available person. And we employ about 3,000 people, of whom 1,200 are nurses.

So I’ll just finish by telling you about some of the other things that we’re doing. We have 12,000 patients in the Midlands whom we support remotely to manage their long-term conditions, empowering them to look after themselves better, to set and meet their own health goals. And we have about 100 – which is a pitifully small number, to be honest – but about 100 people supported with technology in the home through tele-health. And I don’t know if you are interested in talking about what some of those barriers are but that’s a disruptive innovation which is very difficult to sell at the moment in the NHS.

We have developed four decision aids. These are computer-supported tools embedding the latest clinical evidence to help people make decisions about the intervention that works best for them in situations where the clinical evidence is quite finely balanced and where, if well-supported they might well, and often do, choose a less expensive, less interventionist option. And we found that our technology works particularly well for public health goals. So, for example, in the flu pandemic of 2009, we enabled 2 million people to assess their symptoms. Around 40 per cent of those assessments were self-assessments online and we enabled a million people to have access to antivirals in that way.

There are some other things as well. There is pre- and post-operative care. We can give people assessments on the phone to reduce the number of patients who have to go to face-to-face outpatient appointments. And we can use these everyday technologies to reach into people’s lives to provide advice – confidential, anonymous web chats to young women about emergency hormonal contraception, about the HPV vaccination – and we create entry points to those services in social networks where young girls spend their time. My children, of course,
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are much the same as everybody else’s so that’s how we know these things work.

It’s difficult to be a disruptive innovator within the NHS, partly because as an inside player we play by the NHS rules. So we adhere to Agenda for Change. The expectations of our staff are the expectations of staff working with the NHS and within the NHS, and that’s a real challenge. But we’re working on it and we’re very happy to talk to you a bit more about our experiences. Thank you.

[applause]

**Thomas Kibasi**: Thank you very much. That was great. Before I open it out to questions from the floor I’m just going to quickly respond to something that Joanne said and pass it on to Pedro. So you mentioned that you thought that NHS Direct would be more risk averse. Does that imply that Pedro is taking risks? So I’m going to ask Pedro where do your clinical protocols come from? And the staff in your call centres, what kind of training and experience do they have?

**Pedro Yrigoyen**: We have actual MDs answering the phones. In developing countries you can afford them, at least part time. I mean yes, it wouldn’t be realistic to do this in Europe or in the US but we have actual MDs. It’s not just a doctor with a white coat on the phone. We have very sophisticated protocols, based on medical algorithms developed by the Cleveland Clinic in the US and approved by the FDA. So I mean we’ve never had a litigation or a civil suit in 11 years and 7 million calls. I mean we’re so strict. We are already working in the US, and you all know what a lawsuit in the US can do to you so we did two years preparation just to establish a call centre in the US. But as long as you really stick to procedures – then again, we come from the world of productivity and industry and call centres, which is cutthroat. Otherwise the jobs are sent to India, unfortunately, or to places where labour is more accessible. So we’re very strict and our protocols are uniform. We share a single electronic record for every patient with a history of every call: who called, what was the diagnosis, etc, etc. And I can pull it up 10 years later. So we’re very technology-oriented. But it’s not high tech. It’s just proven procedures.

**Thomas Kibasi**: Fantastic. Thank you. And now to see if there are any questions in the room. Nick.

**Nick Seddon**: The question is, Pedro, same as Rowenna’s question in the last session, for £5 a month will you come over to England and open up business here?

**Pedro Yrigoyen**: Well that question popped up last night as well. I don’t feel the British would be – or the English – very pleased to have, your medicine outsourced to Mexicans. So the issue is who is doing it. Can it be done here locally? It can certainly be done here. And the numbers would be fantastic. I mean on different economies of scale, but you’ll be saving lots of money and – to get into another very important point which is the next enterprise we’re launching in Mexico and Latin America – is anyone measuring the cost of productivity, of a day’s labour lost by a single person unnecessarily having to go to a hospital or to an emergency room? That’s a lot of money involved there. And it’s hard to come up with precise stats but we’re not only talking about a doctor’s visit. We’re talking about a day lost – paid in transportation, gas, etc., etc. There are many costs when we lose a day from a person.

**Thomas Kibasi**: Andrew.

**Andrew Haldenby**: Thanks. Reform are monopolising the questions. Joanne, you gave a sort of fascinating glimpse there where you said that you were a disruptive innovator who had sort of felt the heat of that. Could you just tell us a little bit more? Because I remember when NHS Direct was set up. I’m pretty sure it was presented by Tony Blair – he might not have used the word – as a disruptive innovation, but I’m sure that was the feel of it. So if you were able to sort of say a bit about that and you mentioned something about tele-health and why you felt that was a particular challenge at the moment.

**Joanne Shaw**: Yes, I think that we are disruptive. What we’re trying to do is disruptive in various different ways and at different levels. So at one level what we’re trying to do is to enable people to look after themselves more, take control, make decisions about their health. And I think some sections of the UK health establishment find that quite difficult. And we are seen – and I think this is reasonable and I have great sympathy with this – as somebody who gets in between, potentially, the GP and “their” patient. And, you know, so far the technologies haven’t allowed us to share records in the way that we would like to. So we can tell a doctor that somebody has contacted us to sort of say a bit about that and you mentioned something about tele-health and why you felt that was a particular challenge at the moment.

**Sue James**: Thanks. A theme is emerging from Pedro’s presentation and Dr Shetty’s presentation earlier which seems to be that disruptive change is more straightforward in a less developed environment where you haven’t got the high priests of the religion, as we’ve been developing the analogy, with a lot to lose from any change that might develop. And I suppose a question for all of you is how can we – particularly for Joanna – how can we...
actually innovate and disrupt in a way that keeps those high priests with us. We've talked about talking about the financial situation and all those other issues, but that still actually requires them to join with the sort of vanguard on change. How do we get them to appreciate their role and become advocates for change?

Joanne Shaw: Well it's very interesting because I think if you ask Paul Corrigan that question I think he'd take quite a reductive line and he would say it is not possible, that it's a fight and you have to win it. And you have to demonstrate that the economics are strong enough and the improvement of patient experiences is strong enough that you win a battle. Now I don't actually believe that. I mean I'm more with you, I think, in that what we have to do is enlist advocates and do everything we can to help the people who have a stake in the current system see what they have to gain from working with us.

And we don’t think that what we do in any way diminishes the importance of doctors or nurses, that it diminishes the importance of face-to-face care. In fact, quite the reverse. What we believe is that by creating a system which could be web first, supported by the telephone, we preserve resources so that face-to-face treatment is used where it’s really needed for the people who only want to do things face-to-face — and there are lots of them — and for the situations that require face-to-face interaction.

So I think what we are trying to encourage people to see is that by investing in and developing systems like ours you provide the environment in which these very scarce resources can be used for face-to-face treatment as well.

And if you say to a doctor: “wouldn’t it be great if the people who had self-limiting, self-limiting trivial illnesses could look after themselves better and you could spend more of your time creating deeper relationships and better consultations with the people who really need you, wouldn’t that be good?” And that’s the message which we try to convey with more or less success.

Thomas Kibasi: Great. Thank you very much. A question just over here, I think.

Adrian Wooldridge: In some ways what we’re talking about is quite old, established technology in talking about the telephone and I wonder if we could look forward a little bit to the “internet of things” and look at the way people and their homes can be connected to the internet. You can have remote diagnosis. You can monitor people remotely. You can use their medicine bottles to send messages about when they should or shouldn’t be taking medicine. The “internet of things” is coming very, very quickly and I wonder what the implications of that are for the NHS and how the NHS will cope with this very, very disruptive new technology.

Joanne Shaw: I mean I may not be the best person to talk about the further horizon of technological change. What we are really interested in at NHS Direct is using everyday technology to improve health and healthcare. So we’re interested in —

So I think what we are trying to encourage people to see is that by investing in and developing systems like ours you provide the environment in which these very scarce resources can be used for face-to-face treatment as well.

Adrian Wooldridge: It will be about technology.

Joanne Shaw: It will be. So we’re interested in what today and what the next generation of devices will be able to do. For example, we’d like the people on the phone to be able to look at pictures people take of their rashes and their lumps and bumps and we’d like to back-up telephone advice with emails that contain the details. We’d like to use devices in people’s homes so they can send us their readings, they can send us data. I mean that is all quite imaginable and the technology is all there today. I don’t think we have to look further than that to see things which can transform the system enormously, transform it almost unrecognisably from where it is today. The technology is there. That’s not the barrier.

Thomas Kibasi: So I think that the only thing between you and your lunch is the number of questions you want to ask. And so I think maybe just two final questions. Nicolaus, and the lady in green.

Nicolaus Henke: A question really to both of you which is let’s assume you had a magic wand and there was a region coming to you — say the southwest or Yorkshire or some substantial region of one million to three million people. As usual, they have 9 per cent of their people chronically ill and they need to make a lot of savings in the next few years, which is a kind of realistic scenario. And the doctors and the management of that region say “please, please help us.” What kind of part of that health system would you put on the phone or the internet, etc? How would you work with them? What would you take out? What would be your ideal model if you could work with such a region in a fundamentally different way?

Thomas Kibasi: Thank you. Pedro first, perhaps.

Pedro Yiigoyen: I’d say there are two clear changes to be made [?]. In first case cutting down on primary

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care visits. Answering patients questions such as: “what do I have, do I have to go see a doctor?” over the phone. That’s a clear-cut case. It’s not a matter of whether you use either the phone, the web, or an SMS. We’re talking about mobile health. Let’s look at the introduction of video-conferencing a few years ago in business. Has it saved tonnes of money and travel arrangements and this and that? Does it work? It works. So let’s go case-by-case. An obvious example would be chronic disease management. People don’t visit doctors if they stick to a protocol, and we can follow them at home instead of them having to come in. The gains are spectacular in terms of economics.

**Joanne Shaw:** I mean it’s a very appealing question. I think the way that we would approach such a hypothetical would be to say it’s actually not just about what we do. It’s about what you are prepared to do as a region. And so I think our experience would lead us to tackle two things: urgent care, unscheduled care and the support of people with long-term conditions.

So on unscheduled care I think what we would be looking for is a multi-channel front door to urgent care fronted by self-assessment tools so that one was encouraged to go through a self-assessment route becoming better informed and able to make better informed choices about where to go next. And we would be saying to that region, what you need to do is to provide an up-to-date, current, accurate comprehensive map of what facilities are available. And that would be available not just through us as the front door but to every individual on their mobile devices, at home, so that they can make well-informed choices. And that would be fantastic. You wouldn’t need us to do that. That would make a big difference.

On the long-term chronic care we all know what the opportunities are there. It’s about giving people access to support in the home along the pyramid of acuity so that people who are most ill and have the highest risk of admissions have the technology and more intensive monitoring all the way down the spectrum to give people who are at risk of developing long-term conditions, providing coaching and advice to improve their lifestyles. And I think a huge amount could be done.

**Thomas Kibasi:** Great. Thank you very much. One final question, as I promised, the lady in green just at the back. I hope it will be a quick one.

**Rachel Bartlett:** Rachel Bartlett from NHS London. We’ve talked a lot about integration and I thought your acknowledgement of the possibility that NHS Direct is seen as fragmented from GP care was a very honest kind of reflection. And I wonder if you’ve got any thoughts about how you might link in and integrate that national NHS Direct service with local GP patient care?

**Joanne Shaw:** I think it can be done. It will obviously be facilitated tremendously when the records are available. And I think we’re all very unclear about when that might be. But I would say that there is a great deal of flexibility even within a national system. And actually what it relies upon is establishing good relationships between people in a national organisation like ours and people who are delivering face-to-face care in the localities. So I mean I would submit that the answer to your question is there can be lots of flexibility but it’s actually about creating the kinds of relationships where we both understand. We understand the problems that you have and that you’re trying to solve and then we can adapt to help you.

**Thomas Kibasi:** Thank you very much indeed. So all that remains is to join me in thanking the speakers. Thank you.

[applause]

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**Session 5 – Innovative delivery in the NHS**

**Andrew Haldenby:** Well good afternoon, ladies and gentlemen, after an absolutely delicious lunch. And we have two – just two sessions now. And I shall just hand straight over to Nick Seddon to introduce the first of those.

**Nick Seddon:** Thanks Andrew. So we’ve had a morning looking at the challenge with Stephen Dorrell and Nico. We’ve looked at some solutions from the UK and from around the world. And our focus for this session is value for patients and innovation. And I suppose if we’ve been opening our eyes and perhaps the doors to innovation around the world, then this is a session that is about reminding us that we also innovate here. The question is about sharing it, about diffusing it, about innovation often being additional rather than replacing stuff. There is also Paul Corrigan’s point to bear in mind: if it’s disruptive innovation that we want then you have to have the disruptive bit.

We have four fantastic speakers who all know a lot about this. The first is Peter Carter who is our host – and again, Peter, thank you so much for hosting us here – and the Chief Executive and General Secretary of the Royal College of Nurses. Peter has a background – a long-running background – both as a nurse and as a manager in healthcare, in the London Mental Health Trust. So he knows all about this.

The second speaker is Jane Collins who is the Chief Executive of Great Ormond Street Hospital – also known as GOSH – and she comes from a background as a consultant paediatric neurologist. And one of the reasons why GOSH is interesting – there are many reasons why it’s interesting but one is some of the process innovation that they’ve done by looking at other industries and particularly, since we like things that sound exciting, working with Formula One.
And the third speaker is Alastair Dick from Serco, Managing Director of Serco Health. And Alastair, again in an innovative organisation and with a background in innovation at the Boston Consulting Group. He was also the head of business liaison at the Labour Party among other things in the past.

And then the fourth speaker is Peter Ellis who is the Managing Director of EMEA at the PharmaTrust UK. And for those – a brief introduction to PharmaTrust: it’s a Canadian company that has developed what I think is a very disruptive technology which is a kind of kiosk dispensing service for pharmaceuticals. So it sort of provides real-time access for patients to pharma. And Peter’s background is again in healthcare management – he managed one of the biggest and best health science centres in Canada. So that’s quite enough from me for now. So first up, Peter. Oh, and you’ve all got five minutes and I’m going to start tinkling a glass if you take more.

Peter Carter: OK. I’m going to stick with my five minutes and can I just say for those of you that haven’t been to the Royal College of Nursing before I hope you’ve enjoyed the facilities and we do hire them out to people. So a bit of a marketing. Great lunches. Lots of other rooms and stuff. So that’s enough of that.

OK. Look, first of all it’s been an absolute pleasure to host this. And there has been some really exciting discussion. But also I just thought it was a superb morning and I’m really looking forward to the write-up of this. So down to business. I’m going to canter through because five minutes is not very long and just say some things that may be very obvious to you but I’m going to assume some of you will not know where the Royal College of Nursing is positioned on some of these challenging issues that are facing us.

The first thing to get absolutely explicit about, the Royal College of Nursing fully accepts and fully acknowledges that money has to be saved. We’re not an organisation that has got its head in the sand and assumes that somehow this can pass the health service by. Absolute nonsense. The country to all intents and purposes is broke, and whilst the previous government we know tripled investment, one of the problems is so much of the money was not well invested. Money was simply thrown at doing the same things in the same old way. And of course there were some improvements – and so there should have been if you’re going to triple investment. Frankly the economy gains that should have been realised simply were not.

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One of the things – some of our members find this hard to hear from me – one of the things that we’ve consistently said is that until you address the over-provision of acute hospitals, particularly in our metropolitan areas, you’re going to keep on pouring billions of pounds into a system without breaking out of that loop. So we have consistently said that we will support the whole or part closure or relocation of services providing it is on the back of a well thought through, well demonstrated business plan, because some of the service closures that you see are not well thought through and frankly will not in the long term achieve the results that we would wish.

The Royal College of Nursing has this campaign which is called Frontline First which has got three components. First of all we just want to be clear about what is being cut and where, and what is being changed and where hospitals can demonstrate that this takes things forward. Even though things may change for our members we will applaud that and we will support it. We will not support it where we feel this is short termism. The second part of the campaign was to ask our members to tell us about waste – waste in the system. And the third part was on innovation. And because I’ve only got a few minutes I’m just going to canter through a couple of things.

In relation to waste in the service, we literally have had thousands of members emailing us with examples of waste in the NHS. I have just a couple of those examples to share with you. The first thing is that literally hundreds of nurses wrote in to tell us
What we say is you need to do is to get into intelligent service redesign. You need to look at where are we treating people, how are we treating people.

about poor procurement practice. And just two months ago the National Audit Office published a report where they were saying that in some hospitals procurement is so poor “people are sometimes sitting yards apart from each other purchasing the same product with price differentials of up to 185 per cent”. So when we talk about saving money and we see people doing some of this short term stuff on, say, specialist nurses, what we’re saying – and I agree with Sue Slipman’s comment – is that you’ve got some big wins at the top that you could implement that could save some of these huge sums which could help ameliorate the problems.

Now just on innovation, McKinsey’s – now it must be 18 months, two years ago – published what we thought was a very good and very interesting report which attracted widespread interest. And one of the things that was particularly interesting to us is that they demonstrated that in some hospitals at some times up to 40 per cent of people do not need to be there for all the reasons that people will understand.

Well I just want to give you – and then I really am getting there, Nick – two examples. Carol Gill, a specialist nurse in Bradford, she developed a training package for healthcare assistants looking after people in the community with long term conditions, a training package to detect the early signs of pressure ulcers. Now pressure ulcers cost the NHS £2.4 billion per annum. Within six weeks there was a 25 per cent reduction just in that small local service. And it’s very frustrating that we can’t seem to be able to get elsewhere in the NHS to pick that up and say we found a solution to a problem.

And then our other member, Marina Lupardi in Northern Ireland, she developed a chronic illness management system which required the local trust to invest in 16 additional nurses in the community. However, the effect within nine months was a 59 per cent reduction in bed days. So that was a very good example of invest to save. The results we’ve audited.

She won a national award for that scheme. And that’s an example of invest to save. The results we’ve audited. However, the effect within nine months was a 59 per cent reduction in bed days. So that was a very good example of invest to save. The results we’ve audited. She won a national award for that scheme. And that’s just two examples of individual nurses developing schemes that can make a real impact on the savings target needed within the NHS. Sorry Nick. I blew the time but I hope it was worth it.

[applause]

Nick Seddon: No more mercy.

Jane Collins: I will just start rehearsing the fact that delivering innovation in the NHS is difficult. And then I’m not going to say more about the difficulties.

I, like many people here, were probably inspired by what Dr Shetty has accomplished in India and that should be the challenge to us in the NHS.

Obviously there are many, many ways of delivering innovation in the NHS and there have been a number of different organisations which are there to help those of us who work, either in acute trusts like I do or in other NHS organisations, to deliver innovation. But we’re still not good at it. And some of the points Peter made about not being able to spread
innovation even when we actually are innovative is something which is a real challenge.

Earlier this morning Joanne Shaw made the point that actually clinicians of course spread innovation much better than management or systems or processes. Actually that’s not true. I used to be a consultant so perhaps I can say this and admit this. It is said that it takes 17 years to get a new development, a new treatment, from the moment of being developed actually out to most patients. 17 years. So actually clinicians are not very good at taking on new ways of doing things either. And if, thinking back to my clinical practice, it’s hampered by the fact that you tended to use the things you knew. And that, I think, is reflected therefore across the whole NHS.

So what can we do to try and encourage people to innovate? Obviously as a chief executive of a hospital I can mainly influence the hospital. I do recognise that when one wants to innovate you need to look well beyond the hospital and make sure that the people who send you patients and the places your patients go out to are part of that. But what we’ve done very much is to concentrate on what we can in theory control. And I want to talk a little bit about some of the things that we have found have been helpful.

The first really is to get buy-in to what you are trying to achieve. And what we recognised four or five years ago was that one of the areas which really makes people – all staff: managers and clinical staff – feel that they are coming to work to do a good job is to focus on quality and safety. So actually we were doing quality and safety to save money before the QIPP agenda, which actually has been really helpful because it has meant that we’ve been ahead of the curve. So we recognised that quality and safety was a way of saving money. There is a business case for quality. With the costing systems in the NHS it can be quite difficult to prove that, but actually as time has gone by we have been able to evidence that there is a business case for quality.

So if you take that approach, then what can you do to get people to buy in? And I was helped by a programme that I was on which McKinsey ran with the NHS Institute some years ago to think about a story about why one wanted to do this. And again I suppose I sit somewhere between Paul Corrigan’s view that you have to argue and push people into doing things and Joanne’s view about you have to persuade, to think that this middle way of a compulsive story which really engages people may be the way to get people to innovate at least in single organisations and maybe in integrated organisations as well. And as a result of information from patients – very importantly parents in our case, obviously – incidents, complaints, and from staff the story could be put down to three very simple phrases and they have been our objectives since early 2007. And they are “no wait”, “no waste” and “zero harm”. And you can see that there is quality, safety, efficiency within all those. And those three phrases now have got real traction in our organisation. And one of the things I find great pleasure in is hearing staff quoting those three phrases – this fits within “no waits” – because what we did was we rebuilt everything we did around those three objectives.

And I suppose one of the reasons why innovation can be difficult in the NHS is we keep changing things. And one of the things that I’ve learned from this story is you have to just keep going. So having got the story and having got those objectives, gradually more and more people have been bound into that. And the most difficult group were the consultants – the medical staff. But the encouraging thing is that some of them are now the greatest champions. And one of the ways we’ve helped them feel more enthusiastic is to do a bit more exotic type of work with them. And Formula One, Nick, would be in that category. So we already had a relationship with Formula One through our cardiothoracic team. And they’ve gone on working with us – not so much at the moment, but Ross Brawn has been incredibly helpful over the years. And we’ve looked at the processes and the way they do things and then compared it with ours. And one piece of work we did was to look at transferring a baby after cardiac surgery from theatre to the intensive care area. And we worked with Formula One on the pit stop. And when I talk to staff about this I put some actions in so I’m going to do the same for you.

So if we were to think about the transfer in an NHS organisation – and GOSH is pretty good but certainly not perfect – it would be like the car going away from the pit stop with three wheels on. But when you look at it – when you look at the Formula One races, and I have to say I really don’t, but I do know now quite a lot about it – is, you know, they all jump out and then they jump back in again, all the wheels are in place, everything is done exactly right. And that’s because they practice. And that’s because they stick to the same routine each and every time. And that has been an incredibly important lesson for us.

We’ve also had very useful benefits working with John Lewis around customer care. The NHS could learn – well GOSH has learnt a lot; I’m sure the rest of the NHS could learn a lot from the customer care. When you go into John Lewis you’re looking around for something. For me actually getting to the top shelf in Waitrose is always a challenge, but
somebody almost immediately comes to help me to get something off the shelf. And that’s the sort of NHS we want. So I think there are a lot of opportunities for learning from other organisations. That and getting the fundamental story of why you’re wanting to do stuff I think helps innovation actually get traction and allows it to spread across the organisation. I think from the point of view of storytelling it would be much more difficult to do that in an integrated care system, but I’m sure that one would be able to get round it. And I think we’ve got to do that. We’ve got to do much more of that if we want to be able to get through the next few years and actually improve quality and safety for patients despite the financial restrictions. So this is a journey. We’re not there completely yet but we are making huge progress. Thank you very much.

Nick Seddon: Jane, thank you. Jane, that was fantastic. Thank you.

Alastair Dick: Right, I wanted to just take a slightly different point of view, I think very much echoing Jane’s view of the problem, if you like, but taking an alternative approach to actually what some of the solutions might be. For me looking across the NHS there is a huge amount of innovation that happens and we’ve talked a lot this morning about the potential of innovation. But often the challenge is not actually understanding what innovation is required so much as actually working out how to disperse that. The key insight that I think Serco brings to this – and it brings it to healthcare from a number of different sectors and many years of experience of working in it – is that actually in many cases innovation in terms of technical change, in terms of process change, in terms of how you do things, is quite often crucially dependent upon actually innovation in terms of how structures work, how organisations work, and how the incentives behind them require people to work together.

Now it sounds like pretty dry stuff but I’ll do my best of talking through exactly what this means. First we should be, I think, very clear that the NHS is not bad at all at innovation. In fact the NHS has been hugely successful through its history in driving innovation. But if you look at the way in which healthcare is changing there are couple of key things coming up. There is a huge challenge around driving greater savings out and the pace at which innovation is starting to happen is quickening, particularly in technology. And what that says is the barrier, the requirement to deliver more change more quickly is going to ask more and more of the NHS.

I was struck, again, by a fantastic McKinsey study which took a very interesting example of where the NHS was performing well but actually simultaneously giving a very good example of how innovation was not actually being dispersed through. It took a very basic bit of best practice whereby if you are an acute cardiac patient and are brought into hospital, best practice says you should be seen by a cardiologist within 24 hours. This is pretty simple stuff. This is not investment in new technology, anything like that. Many years after introducing this they found that in a good 90 per cent of cases across the NHS this was happening, but if you went to certain hospitals only one in three cases coming in were actually receiving that level of care. Now if you think, well actually that level of care was quite critical for your future prospects, that was actually a fairly terrifying prospect.

So innovation and the dispersal of innovation is very important.

The Serco view of this, bringing this from many different sectors, is there are three obvious things that you can bring to bear which in terms of their detail require real innovation. The first is creating innovative new commercial structures that allow you to incentivise all the players together and to bring in new capabilities to make things happen. I’ll give you an example of this. Serco a couple of years ago created a joint venture with two leading London healthcare trusts – Guy’s and St Thomas’ and King’s College Hospital – to deliver pathology. We’d had a long history going right the way back to the Carter Review where the changes that were required in pathology were well understood, but they were incredibly hard to implement. By creating a joint venture agreement what we were able to do was create an entity which was still majority-owned by the NHS but within which everyone’s incentives were able to be aligned towards really integrating the best of private sector nouse together with a really clear understanding of what those hospitals needed to do to improve their pathology. So that’s the first key item.

The second is really innovating the way in which governance structures and accountabilities work. And now this is where we get into the extremely dry bit. What this is about is saying do we have the clarity to hold people to account, and have we made sure that every piece of governance that we’re requiring of people is genuinely in the best interest of the patient.
And quite often when you do create new entities, new ways of doing things, actually revisiting the arrangements within which we manage things is crucial. So that was very much part of what we did in GSTS, our pathology joint venture, but also very much what we’ve done elsewhere. And the key that comes out of that is real clarity of accountability and the real ability to hold people to account. What that then gives you is a sense of people starting to drive the innovation by themselves rather than requiring people from the top to tell them what they need to do. Definitely it comes with a good story, Jane, I think absolutely. So they’re not alternatives by any means.

The third thing for us that is critical in driving innovation is actually catalysing change. And this is very often the challenge for management teams within an area, within a hospital or any part of the NHS, where the current team are too stretched to delivering what is a very challenging current situation, current service, to actually take on a whole change programme to make a disruptive change happen. And this is the role Serco often plays bringing in a team that actually can give bandwidth initially – but also people who are specialists in making disruptive change happen and can therefore free up the management resources to actually catalyse the changes that are required.

So relatively simple bits of commercial and structural innovation, if you like. None of this is groundbreaking. But for me the critical underpinning to all of the other disruptive change is, and I think in many senses we’ll leave some of the really fantastic technological change to others, and my interest is in really how you use these sorts of things to make them happen.

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Nick Seddon: Brilliant. [applause]

Nick Seddon: Thank you Alastair. Peter, you’re up.

Peter Ellis: Thank you. Peter Carter started off the session talking about drugs and medicines and this is where we’re going to finish, in looking at medicines management as a topic. It is probably to me, having entered this area through my role with PharmaTrust, is one of the more “Cinderella” neglected areas of focus. We spend £13 billion on drugs every year, but the way that we manage medicines and ensure they are effective is, I believe, a major opportunity for innovation. And that’s the area that PharmaTrust have focused on.

PharmaTrust has a number of pieces of technology. The large centre there, which is called a MedCentre. That holds 2,500 drugs and provides the opportunity to provide patients with and fill their prescriptions at the point of care.

The MedHome product. It provides them with their particular mealtime medication in a pouch with whatever mixture of particular interventions they are on and reminds them of when they take it. And it can, if you actually take it to another level of technology, you can put a placebo in there that actually is activated by the stomach and would provide a signal to say that the patient actually swallowed it, never mind having removed it.

And then the final piece of technology there is called MedDirect which is a means of providing patients access to drugs by dropping off a prescription and picking it up at a later point.

But core to that is all this is under the control of a pharmacist. And our basic premise is we are taking pharmacists and pharmacy to the point of care, making them the most accessible primary care provider on a 24/7 basis. And the whole point is they actively communicate with the patient. The major impact we’ve had in Canada is in fact patients saying they’ve never had an uninterrupted discussion with a pharmacist before which they do get with this technology, but also the pharmacist has direct visual access into the technology, into the MedCentre and does supervise the specific picking of products and the fulfilment of the patient’s prescription.

These we see being located in a number of settings. Currently in Canada they are available in clinics and in hospitals, and that’s where we are currently deploying them in the UK. But the opportunity is obviously in remote communities, in long term care facilities offering both the MedCentre and the MedHome capability. In pharmacies themselves – retail pharmacies – who want to better manage their queues or grocers or drug stores or other stores that want to offer pharmacy services. Employers who are looking at providing direct access to medicines for their employees in their place of work. And similarly supporting home care with the MedHome device.

The reason for these remote solutions and remote technology approaches are really about taking dispensing to the point of care. And I’ll get into some of the reasons for that in a minute, but it is important that patients do get access to their medicines, and get access to their medicines with the proper advice of a pharmacist. And some of the issues that Peter was talking about earlier stem probably from the fact that today in England you can get your prescription never having spoken to a pharmacist or had any kind of communication with a professional that looks at your overall medication history.
Reimbursement is another thing we’re looking at trying to, again, be disruptive in. We can see opportunities to bring our services together and provide a means by which both prescribing and dispensing are integrated, and we can also, as we heard this morning, move to more capitated risk-shared approaches. We believe we can obviously serve remote areas well and provide specific language or specialty advice. We can make, as we said, the pharmacist the most available of the primary care professions in a community and allow them to focus on what they’re trained for which is giving clinical advice, not behind a counter, as they call it, “sticking, picking and licking,” which is the sort of routine tasks that can well be automated. And we think this – and why we label this disruptive is because it does allow a complete rethink of the value chain and a completely different approach to how medicines are managed.

This is taking a little bit of information produced from the London School of Pharmacy by Nick Barbour as to why medicines are not effective. And he looked at the various reasons why medicines don’t achieve their purpose, whether it is a prescribing error initially which it can be, whether patients fail to get their prescriptions filled, which they do in up to 20 per cent of the time, whether it’s a dispensing error within the pharmacy itself, or more importantly whether it’s a patient compliance issue which accounts for a significant portion of the reason for those failures. But the consequences, if you add all these together, means that in about 60 per cent plus of cases medicines do not fully achieve what they were intended to do, and it’s how do we address those particular issues. Now we can’t pretend to be a full service in everything, but in each of these particular areas – prescribing, fulfilling, dispensing, adherence, clinical outcome – by offering patients access to their medicines with appropriate advice at the point of care you can start to eat away at those problems and vastly improve or reduce the failure rate.

We’re currently deploying in the UK. We’ve got four or five trial sites. We’ve been meeting with regulators and, as was hinted at this morning, we’ve obviously got major issues with some of the professional bodies who see us as the antichrist, and also with some of the existing retail pharmacy chains who equally view us in that regard. But we’re really about how to improve service to patients and taking dispensing to the point of care. It will need a different business model. We’re also working on the whole reform of commissioning as to how we can take this and use it to improve the whole commissioning of medicines and medicines management. And we do have a demonstration machine in our offices in Hammersmith, and you’re more than welcome to come and visit us if you so desire.

[Nick Seddon: Fantastic. There’s a lot here. Can we keep up with the pace? Good quality costs less. Innovating processes and innovating customer care. Access. Use. They are all different ways of talking about the value chain. And I wonder whether or not people have questions and want to probe. No? Oh well. I mean my question then to each of you is does it pay to save money in the NHS? So to start perhaps with you, Jane, I mean you’ve said good quality costs less. Is there an incentive across the board to do so?]

JANE COLLINS: Sadly no, because obviously if you avoid ventilator associated pneumonia or surgical site infection then the patient gets home more quickly. And so therefore if you can’t replace that patient with another patient, then you need to resize your organisation. But I think that we have to try and maintain a position where we’re trying to think what is right for the patient. And therefore we have to live with the consequences. Now we will be shrinking as acute hospitals across the board, and one way of being able to shrink which doesn’t cause problems for patients is to focus on quality and safety. So in a way it’s supporting the inevitable because more care will need to be delivered in the community and indeed can be delivered in the community. But the way we can play our part is ensuring that we get patients out. But it doesn’t make financial sense. It makes financial sense to the NHS undoubtedly, but not necessarily to individual organisations.

[Nick Seddon: And Alastair, from a business point of view?]

ALASTAIR DICK: I think that’s at the core of certainly what I was trying to argue that in a sense if you look across much of the NHS there are many, many situations where we know exactly what needs to happen but the incentives aren’t there for the individual agents to actually do things. The key thing really though is that quite often you find that organisations and the people inside them because of the way in which organisational frontiers are set out, and because of the individual incentives of people within organisations, they have very little incentive to make things happen. And I think there are two or three different ways you can do it. One is actually...
A lot more for a lot less: Disruptive innovation in healthcare

working with partners to actually reshape organisational boundaries which actually is quite achievable, and the second is thinking about how you incentivise staff and management in order to do it. And there are all sorts of new organisational structures which you can now introduce, whether it’s things like social enterprise or mutuals which really do have a huge impact in terms of incentivising teams, or whether it’s thinking about things like joint ventures which is much more about how you bring two organisations which don’t have their incentives aligned and reorganise them so that they can really focus on a single set of objectives and therefore drive the changes that they need to.

Nick Seddon: Thank you, and Peter – Peter Carter first – one of the things that we’ve been reflecting on a lot this morning is innovation and carrying the workforce with you. And I mean you’ve said that you’re kind of behind intelligent reconfiguration, so one set of reflections might be on that line. I’m just also interested by Dr Shetty’s example of the sort of EBITDAR on your phone and wonder whether or not you think that nurses would like to have something similar.

Peter Carter: Well in some cases they do. I mean the problem with the NHS is although it’s a national health service in many respects it’s a federated health service. And you find in adjoining boroughs or counties huge differentials in how they operate things. I mean last year I was down visiting a service in Wiltshire where there was a team of six district nurses who maintained a huge number of people with long term conditions in the community, but they used tele-assessment and they used it very effectively. But they do have a small ward in the grounds of Swindon Hospital because occasionally people have to come in. And I visited the ward as well as seeing the service in operation, and I was quite interested because most of the patients with long term conditions were middle-aged to elderly, and I spoke to a woman in her 70s whose husband had been admitted.

And I first of all asked her how did she get on with the technology? And she said initially we were quite frightened by it, but the district nurse came out, talked us through it, and it’s actually very, very simple. And I then said to her how effective has it been? She said well I don’t really know apart from the fact that until we had this bit of kit – which cost £3,000 by the way – on average my husband had – he’s got COPD – about five admissions a year. And since we’ve had this bit of kit he has had one admission a year. And that’s just a really good example.

The next day I visited another service in an adjoining county and I mentioned this and they said, “Oh, what’s that?” And you think how can it be that people don’t know about this stuff? I mean there is no transfer across. And it’s incredibly frustrating to know that there are real solutions out there, but somehow because it’s left to a local and often very narrow, parochial – and it is territorial – people aren’t thinking, albeit unintentionally, what is right for the patient. People are tending to think about their organisational survival. And one of the great things which I hope comes out of these reforms is the way in which PCTs are no longer providing. That’s now going to be predominantly back into acute hospitals to have the seamless care. And so hopefully people will get into this transforming community services agenda because it’s not going out of their organisation although it is going out of hospital.

Nick Seddon: Thank you, Peter. And Peter Ellis, I suppose from the position of trying to bring an innovation into the NHS, perhaps say a bit more about the reaction of the service at different levels. And then also, I suppose, drawing from some of your own experience of hospital reconfiguration in London, I don’t know whether or not I can tease a bit of that back story out.

Peter Ellis: Well I think it’s been stated this morning that we’re dealing with some of the high priests in the church in terms of the professions with an innovation like this. I mean we’ve taken the approach of collaboration and trying to bring the professions along, I have to say there is a point where you do think if they’re not ready to jump on the bus you’re going to slam the bus into reverse and run them over because there is a point at which your tolerance of that – and you’ve seen that. I found it interesting this morning that NHS Direct, you know, 12 years later it’s still struggling with some of the basic tenants that it was set up to achieve because of the inability to move certain parties along.

Having left the NHS and worked in teaching hospitals many years ago, I come back to the UK to be somewhat distressed by the state of things. It was partly this issue that was motivating me because I felt, you know, how does innovation happen in the NHS? And one way was to try and join the academic and the clinical in a more close collaboration. I mean some references, I think complementary, were made about the NHS being a great centre of innovation in the past. My problem is using the word “NHS” as being this. I don’t think the NHS drove the innovation. I think individuals did and they did it almost fighting the system. So they deserve an even bigger medal for
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having achieved anything. And it’s how does the system and the structures and the alignment of funding and reimbursement and incentives encourage the sort of behaviours you want to see in the system.

And that’s what we’re talking about from PharmaTrust. If we can move to a more risk-shared, capitated way of paying for medicines management, which our technology allows you to do because you don’t need to separate the dispensing piece from the prescribing piece, you can start then to create behaviours in prescribing and dispensing and support of patients that achieves everybody’s goal which is a reduction of unplanned and untoward admissions. If we’ve got – whatever the number is – eight or 15 per cent of our unplanned admissions are due to medicine failures or errors, we’ve got to tackle it and tackle it in a different way. And just playing at the fringes isn’t going to do it. You’re going to have to redesign the way medicines are managed, and we’re hoping our technology becomes an enabler of some of the rethinking of that process.

Nick Seddon: Thank you. I don’t know if there are any questions from the floor or you’re all going to have a think. But Jane, have people from other hospitals around the country visited and said we want to steal your Formula One idea? Do you – I mean is there creative stealing going on?

Jane Collins: Yes there is. Clearly Formula One aren’t going to go to every NHS hospital because they’re there to run races, aren’t they, or whatever they do. Certainly people are interested in that. But I do think – and that’s what’s very frustrating – that it needs to be framed in a way which is meaningful within that organisation. And there will be a different culture and it needs to be framed in that way. I mean I share Peter’s frustration because I agree there are individuals’ innovations and the NHS isn’t good at innovation. And that’s because of the cultural problem. The stories are a way of getting over some of that. I think the way that we’ve been able to help more organisations is we’ve been able to collect data in a very consistent way over a period of time, and we have run charts for everything. And when people see that – and that’s something being rolled out in the academic health science centre we’re part of – UCL Partners – then they very much want to steal that.

Nick Seddon: Thank you. And Peter Carter, this morning we were talking about glasnost and perestroika. So we’re talking about the spread of best practice, the spread of good ways of doing things. What about the spread of transparency and how people do things in different hospitals? Are you up for that?

Peter Carter: Yes, look Nick, I mean first of all if I can – I’ll try and keep it succinct. We know that you don’t need registered nurses to do all of the things that patients might need in hospitals. So I partly had some sympathy with Dr Shetty although I agreed with most of what he said. But what I thought he missed out was in terms of his example of do you need a nurse with a BSc to assist in theatres. Well no you don’t, but what you need are people that are well trained to do whatever they’re going to do. And in lots of theatres there are ODAs (Operating Department Assistant) that do this extremely well. I think that people get very defensive and very protective. So one of the things I’m certainly very pleased to say to this audience and I know that there are people from the press here, is that we have no problem with reviewing skill mix, and there will be times when you will need healthcare assistants – because they are affordable – to do things that perhaps in a different era was almost entirely done by registered nurses. I mean that’s real.

The trick is are they properly trained and are they properly supervised? And I’m saddened to say in many of our hospitals people – registered nurses are replaced by healthcare assistants and they’re not given as much an hour’s training. They go on to wards and they’re asked to pick it up as they go along.

Now I know you asked me about perestroika and glasnost but I think people need to know this. Because when you see some of these apparent failures in nursing care, well it’s failures in care. I mean Jane mentioned John Lewis. I mean John Lewis is an exemplar. Do you think on a Monday morning a member of staff turns up and they put a John Lewis tunic on them and send them on to the shop floor and say, “Well, you kind of pick it up as you go along.” Of course they wouldn’t do that. They train people. They make sure that they can do it.

In so many of our hospital boards I’m afraid to say it’s exactly what happens. People are put on predominantly elderly care wards, and all of those things seem easy – like wound care, feeding elderly people in bed, manoeuvring them, hydration – all these things seem so simple, people are just picking it up as they go along. And you end up with some of the shocking scandals that we’ve seen in our health service. Now one of the things that I think we’ve got to be better at doing is opening this up and getting a clear understanding of it. First of all what do you need from the workforce? And I’ve already declared that you don’t need registered nurses to do many of these things, but you do need the ratio to be right and the supervision. But you do need that workforce to be properly trained and properly regulated. I don’t know if that helps, Nick.

Nick Seddon: No, no. That’s fantastic. And Alastair, you were talking about innovative commercial structures and innovative governance and accountability. And I sort of nodded along in
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...we have no problem with reviewing skill mix, and there will be times when you will need healthcare assistants – because they are affordable – to do things that perhaps in a different era was almost entirely done by registered nurses.

...there is a general impression that more governance is better governance.

Agreement and then realised that actually I think there is very little of that in what I see around this country in terms of perhaps where the bottom lines – some sense of clarity about who is responsible for something. When we watch what’s going on in Mid Staffs at the moment there is a clear lack of accountability for certain things. And just again an opportunity to expand on that as a question or as a problem.

Alastair Dick: It is very difficult to deal with. For me facing up to this in many situations where we work with NHS organisations, trying to think of how to design things better, actually very often you find that historically there is a general impression that more governance is better governance. And actually anything you can do to create very clear accountabilities so that actually you have the governance but it’s very clearly allocated and also that it doesn’t reduce risk at the point of driving out any possibility of innovation. And so actually the process of revisiting it is almost as critical as actually bringing any sort of fantastic new insights that there’s a general way of dealing with it. But quite often simply by revisiting it you can strip out what has actually been, layer upon layer, laid over the years to actually prevent innovation happening.

Nick Seddon: Peter Ellis, any final comments on any of that? You don’t have to.

Peter Ellis: My other issue – and I was spouting as a Yorkshireman earlier – is to do with devolution. I still think we’ve got an issue trying to deal with England as England. And we see things in Scotland and Wales that are happening in healthcare because I think they’ve got joined up governance at a lower level and they’ve got the ability to move across education, social services, health, and industrial policy. And we’re still struggling with this bloody thing called England. You know there are 5 million people in Yorkshire. It’s as big as Scotland. It could look after its own health economy, the things that matter. I lived in Canada for 25 years. The provinces did everything that mattered to you as an individual – healthcare, transport. Let the federal government play around with economics and whether we go to war, but the things that matter to people like the housing and education are done at a local level. All politics is local –

Nick Seddon: Peter, thanks so very much. Well thank you all so much for your thoughts and reflections there. I started off by saying that the NHS is good at innovation but not at spreading it. And I’ve had that fairly quashed. So that at least is a useful learning. I think we’ve had a good opportunity to look at this question of how to diffuse and also how to kind of realise and rethink the value chain. So thank you all for focusing our minds very much indeed.

[applause]

Session 6 – Policy levers for innovative delivery

Andrew Haldenby: Thank you. Can I ask our last panel – Lord Warner, George Leahy, Ali Para, Nick Timmins – to come to the front. Fantastico. So our final session – and Nico Henke will have to forgive us because probably in this session we’re not going to look forward 100 years at all. We’re going to be quite focused on the here and now. And I think the idea is we’re going to – we’ve talked so much today about the reality of innovation, but this final session is to talk about the policy side of this. You know, Richmond House, Parliament, MPs, Ministers, civil servants – what exactly is the contribution of policy here? I mean, does policy make a difference? We’ve heard today quite clearly that some people are innovating like crazy completely separate to whatever is going on at the national policy level. They’re just getting on and doing it so perhaps in a way policy is irrelevant. Or actually is it the case that there are some policies holding things back, holding innovation back? And innovation is happening despite the system, not because of it? And so we do want to change the policy framework. And what is that policy framework? Well of course we know there are huge bodies of policy in regard to provision, commissioning, workforce, capital infrastructure, training – all of the key factors of production. And of course particularly the QIPP programme which we know aims to save £20 billion by 2014.

So I think what I’d like to hear from each of our panel members is if they do think that policy matters for innovation, disruptive innovation, what are the one or two key policy changes which they would each like to see going forward. And I think we finish on a high in terms of our speakers in the order that they will speak: Lord Warner – Norman Warner – someone who has written policy himself as a Minister and someone who is now developing policy or he’s the precursor to policy in his role on the commission on funding of social care. So welcome Norman. George Leahy is Deputy Director of Innovation Policy at the Department of Health himself, so a policy maker and someone with 20 years experience in public health, primarily in east London. Ali Parsa is the Managing
Partner of Circle which will be known, I suspect, to everyone here and is an innovative, disruptive organisation bringing a new kind of business model into British healthcare, both with the NHS and the private sector. And also, of course, Circle recently took on the responsibility for the management of Hinchingbrooke Hospital. So someone who I suspect has got views on the policy framework in the UK. And finally Nick Timmins, Public Policy Editor at the Financial Times and also of course an author, academic and historian of the NHS. Nick is someone who is not only absolutely up-to-date with the state of play with the NHS today but has looked at every significant change throughout all of its life. I don’t think we can do much better than that. So I will hold you fiercely to five or six minutes each and we will begin with Norman Warner please.

Norman Warner: Thank you very much, Andrew, and good afternoon ladies and gentlemen. Of course policy is actually important. But policy is the easy bit. Any fool can dream up a policy, particularly if you’re surrounded by dozens and dozens of civil servants who are just dying to tell you what the policy should be. So there is no problem with policy. The problem is, I think, two-fold. First of all, if you haven’t got any mechanisms for making a policy happen you’re going to fail. And the second thing is that the NHS has heard it all before. So when you newcomers come along there is this touching belief, I think, amongst many in the political class that you only have to say it two or three times. Well actually you have to say it about 10,000 times to the NHS and you have to keep saying it. And they’re looking all the time to see if you’ve gone off message at all or whether there is any hope for them that you’ve forgotten what the policy was, or if there is a new guy coming along because you won’t be there very long and he will change the policy.

And the period when I left government was the period when everyone knew that Tony Blair was going and Gordon Brown would be succeeding him. Virtually every person I spoke to in that period about – from the private sector – about competition said: is Brown going to carry on Blair’s policy? And it became very apparent that he wasn’t. And so what you’ve got is a problem of actually convincing everybody that your policy will continue for a period of time and people will stick with it. And the NHS has got really, really good at playing the numbers. So a lot of the time they just wait for times to change.

The keen reformers in the NHS get on and do it. They then get a bit worried that they’re going to get left stranded. And somebody else comes along like Andy Burnham and says “actually forget all this stuff about competition, the NHS is the preferred provider.” Now that really does leave quite a few people in the NHS really up a creek without a paddle because they’ve backed the previous horse and the previous horse has disappeared. He’s run off the track. That’s a real, real problem, I think, for changing the NHS.

However, I think the other thing about this is you’ve got to have a policy on money, because the thing that people notice they haven’t got is money. So if you can actually relate policy to money, you’re starting to get somewhere. And one of the problems that we did in the last Government was to give the NHS far too much money without sufficient conditionality. And that’s not me just saying that – well it is me saying that. But I’ve also got the Office of National Statistics to back me up.

The Office of National Statistics says that inputs went up by nearly 60 per cent between 1997 and 2007 and outputs reduced by four per cent. Any other business that achieved that – they would have been insolvent. They would have been taken over. The directors would probably have been in court. All sorts of terrible things were happening. But the NHS sails on. And I just want to give you a quote from Simon Jenkins in The Guardian this morning. This is his description of the NHS: “an obese and distant dinosaur lumbering across the horizon weighed down by 60 years of bureaucratic fat, tradition and restrictive practices”. Well that’s a bit over the top, even for Simon. But nevertheless there are some substantial elements of truth in that, particularly the stuff about restrictive practices, bureaucracy and tradition.

And I think that is where you end up as a minister, is think: how the hell do I get this leviathan to change? And that’s really, really difficult. And most of the people in the NHS are nice people. So they don’t want you to do nasty things to them. They don’t want you to be rude. They want you to be concerned and considerate and loving and cherishing. But the sad fact of life is being endlessly cherishing doesn’t deliver the bacon. And the sad fact of life is, as Nuffield found, when they looked at targets the NHS and other professionals hated targets. When Nuffield looked at targets – where Scotland didn’t have targets – they actually found we delivered more efficiency and better services for patients as the result of targets. Linked to investment of course, but without the targets those changes wouldn’t have been made. So we had some policies on targets. We had some policies on competition. We had some policies on choice, all of which will make things change.
Unfortunately we also had a policy on tariff which we didn’t do properly. And tariff is actually where we have a policy which has been extremely good at shoving shed loads of money into acute hospitals and you now have a very good system of supplier-induced demand which has been the result – accidental – of a policy of implementing a tariff fairly half-heartedly and without sufficient discrimination.

I’ve got lots of things I could say about what we should do, but a big thing we should not do as a policy is let the NHS off the hook on finances. We should really, really stick to the Nicholson Challenge, as Stephen Dorrell calls it. And one of the things we should really, really do is to actually recognise that if you want to save £20 billion a year after four years, at least 50 per cent of that has to come out of acute hospitals because they are 50 per cent of the budget. So we should be really, really firm that the acute sector has to deliver £10 billion to £12 billion of that savings over the four years. No ifs. No buts. What we need is Lansley not talking about all sorts of other interesting things, but actually saying, boys and girls, you’ve got to deliver in the acute sector 50 per cent of the budget. So we should be really, really firm that the acute sector has to deliver £10 billion to £12 billion of that savings over the four years. And actually give them some ideas like competitive tendering for MRI scans, consolidating and opening up the pathology services to save at least half a billion pounds in the £2.5 billion budget, paying acute hospitals for chronic cases in acute medical wards, 50 per cent of that tariff of about £3,000 a week so that there would be an incentive to use nursing homes rather than acute hospitals. We’ve got to do things like that. You’ve got to have a policy which is actually going to drive the finances which will get you to where you want to.

I won’t say any more because I’ve got lots here. I could go on forever. I don’t want to give McKinsey too much free consultancy material, but all I would say is that if we weaken on competition, all will be lost, because if you weaken on competition you keep out of the marketplace in the NHS many of the people who have got the innovative ideas which bring about change. And we saw it with elective surgery. The purpose-built ISTCs provided a better patient experience for NHS patients than much of the in-house capability. And in some cases they were doing it cheaper, and some of them have survived because their service is so good. So no weakening on competition. Concentrate on the money, but have some mechanisms that will deliver your policy when you dream them up in Richmond House. Thanks.

[applause]

Andrew Haldenby: Thank you. Norman, thank you very much. George Leahy.

George Leahy: Good afternoon everyone. As you can see I’m head of innovation at the Department of Health. I hope that doesn’t sound like too much of a contradiction to you all. I’m sure that may be Norman’s point of view. I really want to show – in quite a short period of time and very light touch in some ways – that there are, I think, limited levers that we can put in place at a national level. And that it doesn’t actually have to be the Department of Health – I would also like to emphasise that – that can support and promote innovation in the NHS.

I think it’s important to understand where the barriers are, and I thought the last session was very good at bringing quite a lot of that. Certainly our analysis of where the issues around innovation are, match with what has been said already, which actually isn’t the lack of ideas. The people are there, as was quite powerfully put in the last session, there are lots of staff and people with a lot of ideas wanting to do the change. But actually – and this is where we would come from in a slightly different perspective to concepts of innovation – that is innovation includes adoption and diffusion and actually that is the place where the NHS doesn’t do so well.

What I want to talk about – and it was what Jane said in the last session really, picked up on quite a lot – is there are issues of culture and issues of systems that we need to address within the NHS. And there are limited things I think we can do at a national level around that, but I can outline a few things that we have been trying to do and what might happen for the future. I think it’s fair to say there are several characteristics of organisations that would be deemed innovative, and they include things like vision and leadership – ie showing the importance of innovation for the long term sustainability of an organisation. They support and encourage partnerships and collaborations both within their organisations and without. I think Alastair’s example of the joint venture on pathology is a really good example of how to do that.

Very important, and I think very hard in the NHS, is the creation of the space, the time and the resources for staff to be creative. And that isn’t just a creative idea spark. That is: “I saw that is good; I can do it over here”, and having the headspace to do that.

There is the issue, I think, of managing risk well
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and the acceptance of failure. And I think that will be a key thing I will come on to later. We’ve certainly found – although we’re trying to do something about it – that there is an insufficient celebration of reward and success of those that are innovating, and again not just the ideas but those that are putting ideas into practice. And I think crucial to all of this is these issues around knowledge management. Actually knowing what’s out there that you can pick up, adopt, adapt, and having access to evidence that it’s probably going to work.

So that’s the characteristics, and we’ve been working on some of those areas. We have created innovation funds, both at regional level and on the national level. And that’s to help with that issue of headspace and bringing in new entrants to some extent. We’ve created the Healthcare Innovation Expo which is about trying to pull together the service and industry where they can actually start to think about what future collaborations they might have.

We’ve got the Challenge prizes which we finally managed to release last Friday. We’ve got three broad winners, one of which is the fantastic service delivery on renal dialysis in the home, in Manchester, a fantastic new diagnostic from the MRC Cancer Unit in Cambridge around oesophageal cancer. Some really, really good interesting stuff.

The thing about what I suppose people might say is very typical of us civil servants is that we created a duty to promote innovation. We’re probably the only country that could do that as well, I think. However it did legitimise attention and create activity for people to have the concessions: Are you an innovator organisation, should you be an innovative organisation, how are you going to meet your financial constraints and targets if you don’t innovate? It allowed that conversation to happen and the innovation funds were part of supporting that. The hardest thing of all though, I think, is the issue around the attitude and management of risk and the attitude to failure. And I think that isn’t just in the NHS. I think that’s a structural thing about public sector and I’ll come on to what I mean by that in a moment.

To move on to systems, systems are hard to get right. And when you don’t get them right – and quite often most systems don’t work at some point in some way in some form and they certainly can work against innovation. That’s what you would expect to happen. Good financial information and information flows are important for rewarding people in the right place at the right time for doing the right thing, but very, very hard to get right.

Commissioning along the pathway can also be really fragmented. That’s part of the system. You’ve got different commissioners with different responsibilities with many providers. Who gets the rewards – where, when – is a really difficult thing and actually quite often falls between different stools. A good example we have here is the e-vent system at the Royal Brompton. This is a pathway redesign which actually redesigned all the way down the pathway down into the patient’s home. The patients in this case are premature babies who are on long term ventilation. The stay on average nine months in hospital. This pathway redesign which takes them home quicker means they stay in hospital six months instead of nine months. But actually does the Brompton get the benefit of that? Do the social care commissioners want to take on what the implication of that is? That fracturing is a problem and it’s a difficult one to solve.

From my point of view the policy which we can work – and clearly the where department is working very hard on – is commissioning for outcomes. That has to be one of the ways forward and again that isn’t an easy thing to do. But if you can commission on outcomes you know what an outcome actually is as opposed to the outputs – is very important. But if you can build that into issues of longer contracts – ie not on the annual financial balancing acts that everybody has to do – and that shares and manages the risk and provides greater rewards for those that not only achieve the outcome but can go beyond that outcome that was specified in the first place. I think that is very crucial.

I think that in limited ways we’ve moved forward. We’ve had three years of doing this programme work and it is starting to shift things around. Additionally the plan for growth that was released with the budget sees health and healthcare as actually contributors to the economy. But that will depend on innovation and bringing innovators into the system.

One small part of the plan for growth was the announcement that the NHS Chief Executive will produce a report on the adoption and diffusion of innovation in the NHS and what can make it work, and in some respects reviewing what we’ve done so far, what are the best things, what can we push. Sir Ian Carruthers is overseeing the process. My team will be delivering it. It will report by November. We’ll have an inclusive process. I think that’s one of the key things we’ve got to build into this which is about talking to people like yourselves, to industry, to academia, third sector as well clearly as the NHS itself. From a key policy change point of view my opinion is that the risk
management of failure and the tolerance of failure, i.e., using failure to learn from, is one of the key things that we need to create a culture of in this country. The problem—that extends from the top from both DH and politicians—is, I think, that nobody wants to fail, it’s not a thing that public servants are allowed to do. And if you create a system that doesn’t allow you to fail, you're never going to find the learning to go further forward. Thank you.

[applause]


Ali Parsa: Thank you very much, Andrew. Now this morning when I arrived—you need to trust me on this—I had a speech. And then I had the inspired though of arriving in the morning to listen to others and learn from them. And as a result I’ve figured out that actually everybody said things that I was going to say in a much more articulate way. So I threw that speech away and instead I’m going to share with you some convoluted collection of thoughts. So bear with me until Andrew says my five minutes is up.

Rowenna asked a very interesting question to Dr Shetty. She said “do you have any plans to come into the UK”. And he said, in a very diplomatic way, “that actually the NHS is fantastic” and “no thank you”. Actually what he was going to say and I’m sure he would have said is “no chance on earth that I can come here and be given the regulatory things I need to be able to work in here.” That’s the truth of the matter. There’s an organisation—Aravind—in India who can do cataracts for £30 a go. What are the chances of them being able to come here? That’s the truth of the matter.

So before I tell you about the policy that I think we need to focus on, let me tell you a little bit of a personal story. I as a child had the delusion of wanting to be a judo player. Now for those of you who can see me and for those of you who are sitting in the back you know there is not much to see—don’t worry—you will know that the chances of becoming a great judo player are pretty minimal. But I had this great coach who told me that don’t worry, policy and things. You should actually tell people what you do. Just look at what my partners have done in Nottingham. In a single year or two 700 NHS staff, members of the Royal College, coming in and being empowered to do what they know best how to do, they improved their productivity by 20 per cent. Much more importantly, if you go to our facility—to their theatre than the NHS target. 992 out of every 1,000 patients they have they recommend it to a friend or family. You don’t get that in a five-star hotel. And as a result of that they—93 per cent of them—say they are satisfied, 73 per cent of which say they are very satisfied with their job. It all started by figuring out how to change a light bulb. That’s the number. Ten.

Go to your hospital. Ask. Figure out the process. So the thing I ask my partners to do is by next time I come here figure out how you do that with three people. And you may say three is too many, but with health and safety—you can’t do it any better.

And in the process of empowering people to figure out how they change a light bulb with three people, look what my partners have done in Nottingham. Andrew told me earlier you always come and talk about

"From a key policy change of view my opinion is that the risk management of failure and the tolerance of failure, i.e., using failure to learn from, is one of the key things that we need to create a culture of in this country. The problem—that extends from the top from both DH and politicians—is, I think, that nobody wants to fail, it’s not a thing that public servants are allowed to do. And if you create a system that doesn’t allow you to fail, you’re never going to find the learning to go further forward."

Are you an innovator organisation, should you be an innovative organisation, how are you going to meet your financial constraints and targets if you don’t innovate?

I’m going to get you a black belt in judo. And he did that by doing a simple thing. He just focused on one single problem at a time. And he got me all the way to my black belt examination. I did happen to go on to my knee during my examination and therefore never worry—you will know that the chances of becoming a great judo player are pretty minimal. But I had this great coach who told me that don’t worry, Rajiv’s doing a simple thing. Figure out—figure out how Dr Shetty can come to England and set up here. Figure out how Aravind can come to England. Because the future is already here. It’s just badly distributed. There are others in the world who can do fantastic stuff with healthcare. It’s just we can’t. We’re not doing it here. And speaking of doing one thing at a time, innovation is not that difficult.

I tell you when I go and we take over a hospital and I go there I always ask the team I’ve taken over for a very simple question. How many people does it take in this hospital to change a light bulb? Hands up those of you who think it takes ten people on average in the NHS to change a light bulb. That’s the number. Ten.
month in Britain with avoidable mistakes. That’s why we need to change. Not just to save money, but because we’re killing people that shouldn’t die and are dying completely unnecessarily because we haven’t figured out how to do the total quality control stuff that Toyota and other manufacturers have figured out to do with their processes. How difficult is that? By the way most of these people would have a hell of a time during the process too. You could almost know that the last meal people have had was not the greatest meal they had. So the patient experience is not that great either.

So we started Circle on a very simple idea that there is so much money being spent here. Can we, with this money, go and do the following. Can we create a hospital designed, say, by Norman Foster that wins every award there is to win for the best facility in the country or in the world? He recently actually just won the award for the best public space globally. Can we get the team that brought Mandarin Oriental into the UK to do the service? Can we then get staff from a five-star hotel to deliver the service? Can we bring a Michelin starred chef to cook for them every single day – not to design the facility but to cook for them every single day. And can we get rid of medical mistakes in the process? And can we deliver that to NHS patients at NHS prices?

Three years ago you would have laughed at me. Today we do that in Bath. And last month we saw in Circle Bath 10,000 patients. How many of those patients went back to theatre, do you think? Out of 10,000? Now those of you who run hospitals know that number is very big on average. One. By completely managing the processes, as Toyota would, we reduced return to theatre to a single patient out of 10,000. That’s what we need to do in the NHS.

Now what was the reaction on everything we want to do? I tell you people talked a lot about NHS and stifling innovation. I tell you the bigger problem we had was with the private sector guys. They were trying to kill us much more than the NHS was. And if they were sitting here I would love one day to have a debate or write about the shenanigans we had to do with this private equity-owned, private companies and what they tried to do to us, right? I mean shameful.

But right now two things are happening in this country, I’m ashamed to say both of them instigated by Circle which goes to say how much we’re not doing what we should be doing that will fundamentally change the game. One of them is the study that the OFT is doing, and we refer the entire private sector to the Office of Fair Trading to go and look what the private sector is doing and how it is impossible for Dr Shetty to get in here because he would never get a network agreement with an insurer. Very difficult to get. And I hope that the OFT will fix that. And the second, is we referred a large number of PCTs to the CCP – Co-operation and Competition Panel – to say, why is it that PCTs do not stick to the constitution of the National Health Service, which is allow choice? If we can fix those two, we can fix it. Fantastically I managed to talk for five minutes so thank you so much.

**So my advice to policy makers is this. Do one single thing. Figure out – figure out how Dr Shetty can come to England and set up here. Figure out how Aravind can come to England. Because the future is already here. It’s just badly distributed.**

If I came back to you here and I said that two 747s are falling out of the skies every single month, what would you do with our airline industry? You’d shut it down. That’s how many people we are losing every single month in Britain with avoidable mistakes. That’s why we need to change.

Andrew Haldenby: Thank you. And Nick Timmins.

Nick Timmins: Hi, good afternoon. Good to be here. I’ll just make three quick points I think really. John Maynard Keynes wrote a great deal and spoke a great deal and said many things and Robert Skidelsky, when he did his biography, spoke even more and said even more. My favourite Keynes quote is: “When the evidence changes, I change my mind. What do you do?” So over the years there are a number of things which I think I’ve changed my mind on when it comes to the NHS and I’ll talk about just two of them. One is structure and the other is competition. I’ll take competition first.

I think there has always been a sort of paradox at the heart of the NHS because as Stephen Dorrell observed this morning and others have made the point, clinicians and doctors in particular are highly competitive people. They always were and they still are. And when it comes to adopting a new treatment they always want to be first or at least second or third. And certainly that’s true in the teaching hospitals but its true elsewhere. I think it’s worth remembering that the first test tube baby was delivered by a gynaecologist in Oldham, not at one of the great teaching hospitals. There is something deeply competitive. And when I was a lad that competition between teaching hospitals in particular also seemed to lead to service redesign as well. There was competition over how the services were designed.

And somewhere down the years after 1974 as we went through these great tiered structures and management changes and what have you, that got lost. So although they’re competitive on treatments they’re not competitive on service redesign. And if you asked me to list what I think are the greatest weaknesses of the NHS, it’s not the ones people would normally cite. I think it’s been our failure to engage doctors in management effectively over the years so they actually take responsibility for the budgets and
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the way things are run. And then there are repeated attempts to improve that – and there are some going on at the moment that is probably a bit more hopeful. But it’s been a longstanding running difficult problem.

So the paradox is that while they are competitive the service has been deeply uncompetitive when it comes to service redesign. And you get this sort of point that Peter Carter made earlier where there is something going on around the corner and the people next door don’t know anything about it. So I think one of the elements of competition that has been valuable has been the way that introducing new players has brought changes. The independent sector treatment centres, chemotherapy at home, intravenous antibiotics at home – all of these involve new entrants coming in and helping to stimulate change. So a bit of competition there is healthy. I mean it works in other parts of life so why on earth should it not work in health.

And my other thought is sort of related but it’s to do with structures. I mean when I was first reporting on the NHS – going back a long way – there was a grand 1974 reorganisation in the NHS. It was obsessed with regions, areas and districts and getting the structures right and co-terminosities and we got everything lined up perfectly with everything else. And that’s played through almost every reorganisation we’ve been through. You get worried about the structures as though if only we could get the structure right, everything else would flow: quality, value for money, patient satisfaction – despite the fact that quality, value for money and patient satisfaction were missing from any of those conversations and don’t seem to have any impact on them.

So one of the things I would hope might come out of this reform and might come out of others is actually we could get less obsessed with structure and more happy to live with the fact that you can deliver healthcare in different ways, through different structures, and still have something that’s called the National Health Service. It’s got the same values. It does the same things. But it doesn’t have to be run in the same way everywhere. And there is good evidence for this.

And Stephen Dorrell, possibly because he’s too modest, never tells this tale on his own behalf. But when he was Secretary of State back in 1996-97 and we’d been through the outcome of GP fundholding and the resistance to GP fundholding by other commissioning groups and we had all sorts of interesting experiments that were going on about how to commission care. And there were in fact, at that time, four things called “total purchasing pilots”. In essence they consisted of the local GPs with whatever advice they chose to take commissioning the entire range of healthcare locally. They weren’t in total control. The local health authority in the days before primary care trusts actually signed the cheques and provided tonnes of support, but essentially the GPs were commissioning the care. And these were GP consortia by another name. And they were established without a single line of legislation with no ministerial fanfare. And when I tried to write them up no one would take a blind bit of interest. So what is all that about? It does sort of turn to this thing – as Andrew Lansley has said – I could have done most of this without the legislation.

But I think what sort of comes out of that is that you could indeed let the structures be different in different places and see what happens. So within the overarching nature of the NHS you’ve got the goal of high quality care delivered free at the point of use but delivered in different ways in different places at the same time. The structures don’t have to be the same everywhere. Now that’s not some sort of Maoist plea to let a thousand flowers bloom. I mean anyone who is a gardener knows if you chuck 1,000 seeds around all over the ground not many will germinate and grow. But it is a plea to let sort self-seeded ceilings give it a go to see what happens. Evaluate them as they go along, celebrate those that work, understand why those that failed failed and learn from both how to do it better next time. And that has to be one of the ways in which the service will actually find its route to a better way through.

And I have one final thought which is deeply depressing for the end, but the challenge clearly is how does the NHS get through four years of four per cent efficiency savings and can it be done. Well I have no idea whether it can deliver it but I think it’s an almighty tall order. I have a suspicion that probably, if they really went for it, – some commissioners could
get somewhere close to that over three or four years by really commissioning the stuff that keeps people out of hospital when they don’t need to be there, by taking services out of hospital that don’t need to be there you probably could get somewhere near that figure. The problem is the outcome of that would probably be a bunch of completely bankrupt hospitals because they wouldn’t be able to adapt their estate and their staffing fast enough to deal with change.

And if you think about it already there are some 20 NHS trusts that are currently technically speaking only in business because they are surviving on assorted bungs and loans from the system. Right now, after the years of plenty, if you start doing the sorts of things that need to be done to try and make the sorts of savings that are needed, hospitals are really going to suffer because they won’t be able to adapt fast enough.

And when the British public thinks about the health service it thinks only about hospitals. And the political fall-out from dozens and dozens of bankrupt hospitals will be just dire. Thank you.

Andrew Haldenby: Well there we are. We’ve got specific ideas. Competition – well all of our speakers think policy does matter. Norman Warner, Ali Parsa, Nick Timmins – all saying this key theme of competition is important. And Ali, just the nuance that we need to apply competition rules both to the public and the private sectors, and Nick Timmins particularly emphasising new entrants. And then George Leahy taking a slightly different point and looking at what can directives do from the centre, and he focused on giving space to NHS staff, giving them time to innovate with some money to do that. And also a different idea of a duty to promote innovation. So a stick as well as a carrot, if you like.

I asked for ideas and we’ve got ideas. So are these the right ideas? We’ve got 12 minutes to discuss it, so does anybody want to – great, we’ve got three. So we’ll start at the back and then we’ll go to Simon in the middle.

Nick Hoile: It’s Nick Hoile from Advocate Policy and Public Affairs. If I can draw on some comments from the last session as well and combine them with what was said in this session. Peter Ellis and Peter Carter both used examples of medicines management as areas where there was inefficiency and there needs to be innovation. And we’ve done quite a lot of work with patient groups to produce a guide about how patients access medicines right across their lifecycle which draws on some of that. But then Peter Carter gave the example of a patient who was effectively hoarding medicines. And I’m sure there are lots of innovative solutions about how nurses and prescribers work there. But what struck me as the most innovative solution was that the patient actually just stopping the supply of medicines getting there themselves. So in terms of policy levers, to what extent are policy levers going to come from DoH and from politicians, and to what extent is a lever for innovation actually just a patient taking things into their own hands? And if that’s the case, then is one of the major policy levers to better educate and inform patients, so that they innovation them from the bottom?

Andrew Haldenby: Very good. And Amy Pott.

Simon Hill: Thanks Andrew. Simon Hill from Cerner. Just supposing that the reforms on the table at the moment in one form or another do go through and we do then have significant closures of acute hospitals in about 2013, what policy and perhaps political advice would the panel give to any of the political parties in order to go on to win any potential general election in 2015?

Amy Pott: Amy Pott from Baxter. My question is – I guess it’s something I’ve observed in policy terms – but we talk a lot about acute trusts falling over because the incentives are stacked the wrong way. And if you’re looking at trying to put patients into the community, into the home, obviously an acute trust doesn’t want that to happen. One thing I have observed recently I thought was really interesting was where a commissioner and a provider split the tariff. So they recognised that there was a win-win situation for both of them where the patient could go into the community but the acute trust would keep a certain amount of that payment for them in case – well, for the consultant to be reviewing them etc, etc. And it was just a very simple idea and one way in which innovation between the home and the hostel is working. And I hadn’t come across it before and I just thought it was very simple.
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Andrew Haldenby: Thank you. Well that bears directly on what Norman was saying about the tariff. So – well, let me just ask the panel if they want to come in on all of those, and I think we must ask Norman to talk about the tariff and Nick in particular to talk on this political question of hospital closure. But I'll leave it up to you. And we'll just go along starting with George.

George Leahy: OK. I think the point about the patient responsibilities is an interesting one. I think certainly one of the things that we feel we've not worked hard enough on or maybe needs to happen in whatever new system appears out of this is how do you get patient pull in the system to drive innovation. Most of what my message was is a lot of it is very difficult. It's very hard to see what the mechanisms the patient has to actually drive things forward are actually in a vulnerable and helpless position. I think the example that we've just quoted repeatedly wasn't so much that the patient wanted to horde them. They just didn't want them but they didn't know how to stop them coming. And that's half the problem that patients have. I think on splitting the tariff, that's exactly the sort of thing we want to see people doing but clearly that would have to be partially on a promise or a structural deal that is about long term structural change so that eventually in that capacity in hospital would have to close down. And that's the hard bit.

Andrew Haldenby: Thank you. Nick, do you want to come in on any or all of those?

Nick Timmins: Well, on the tariff I've always – I clearly don't get this but I had always assumed that the tariff was there to be a sort of guide price. If you pay this you can't go wrong. No one is going to shoot you. Whereas actually it's become something very rigid that is applied entirely, and it does not seem to be being adapted where it would clearly be in the interest of both purchaser and provider locally to do so. And it seems to me that it just needs to be freed up for people to understand that – it's like when people used to say when the IT guy buys IBM – big blue – you can't go wrong. And if you use the tariff price, no one is going to kill you. But actually you can play with what's in the tariff and what it does and how you spend it and where you spend it. And that clearly has to come if we are to get anywhere into moving things out of hospital that need to be moved out of hospital and certainly money is not coming in. So that seems sort of self-evident really.

On policy advice about how do you win a 2015 election, well, the only thing I think I could say to a Minister in that position is actually don't worry. Elections are not won and lost on the NHS. I mean the NHS likes to think so. The NHS likes to think that the health service votes will be the one that decide the election. But actually elections are decided by something much deeper which is essentially people's perception of will they be better off under the next lot and have this lot proved semi-competent. So you can have a huge row with the NHS, and of course it won't help with your campaign but it won't necessarily be the deciding factor.

And we have got a kind of example of that. And we should remember the '91 reforms and the '92 election. I mean throughout '89-'90 the government was losing by-elections on landslides over Ken Clarke's reform. I mean complete landslides. Tory seats were going Labour. And when it came in '91 despite the fact they shovelled a load of money into the NHS to try and keep it quiet – Guy's fired 600 people and were generating headlines all over the place; it was all pretty controversial – Major still won.

Andrew Haldenby: Ali.

Ali Parsa: I'll just follow up on this and talk about the thing I'm least qualified to talk about which is what would you do to win the elections. And I think it's a really important thing in this. This Government for reasons beyond actually its own control, as did Margaret Thatcher when she inherited Britain in 1979 post the IMF intervention, has got to disrupt the existing structure and got to make major changes. If you wondered, the state is responsible for 53 per cent of the GDP in Britain. If you want to bring it down to the average of Labour which was 40 per cent, there is a 20 per cent shrink that needs to happen. That's a massive disruption.

My only thing in this is that, you're never going to win on this side. People are going to be upset and complaining about this. Do what Margaret Thatcher almost did by default – and I don't believe she did it by design but by default – and that was as you disrupt this side make sure you create opportunities and challenges and possibilities for people who become beneficiaries of your change. And make sure you do that so fast and furious that by the time the election comes the balance is in the hands of those who have more possibilities as the result of your change than
those who complain. And the evidence of the last year unfortunately was that the Government has got that one simple single truth wrong, and unless they move further and faster to create possibilities and potentials they are going to lose it.

Andrew Haldenby: Thank you. And Norman Warner.

Norman Warner: Thank you. The tariff first of all. I mean the tariff work has never been completed properly and it was always the intention that you should be able to disaggregate the tariff. Given where we are now I would just abandon ship on the tariff in the sense of central control and say look, you guys locally negotiate the deals yourself using the tariff as a guideline, as Nick said, because I think if we wait for the nerds in the Department of Health to come up with a new tariffs, as Patricia Hewitt et al unwisely did, we could be here for a very long time.

On winning the election, I mean elections in my view – like Nick’s – are really won by judgements about the people you want to be your Prime Minister and economic competence. Incumbents, when the economic news is bad, tend to have a rough time. So I don’t think the NHS is the be-all. But I think there is quite an interesting issue about whether you show your competence as a government by the way you’re running the NHS, which is a big chunk of the public sector. What’s missing is a credible mechanism for dealing with what is now inevitably a big chunk of NHS acute hospitals which look like battleships after the First World War. They can’t all be scuttled off Scarpa Flow, so we’ve got to do something else with them.

And I think the best bet in town, which is what I’m going to start making more speeches about, is the Canadian experience in the 1990s. And you actually set up what they called hospital conversion commissions for different parts of the country. You keep some degree of political control in the sense that you tell them what the financial framework is. But you let them do the heavy lifting at the local level by actually reshaping the services probably on most of these hospital sites. The Canadians kept most of the sites. They just did different things on them. And they captured the public’s attention by blowing up one of the hospitals, and Patricia Hewitt et al unwisely did, we could be here for a very long time.

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... But I think there is quite an interesting issue about whether you show your competence as a government by the way you’re running the NHS, which is a big chunk of the public sector. What’s missing is a credible mechanism for dealing with what is now inevitably a big chunk of NHS acute hospitals which look like battleships after the First World War.

...The Canadians kept most of the... I found it particularly interesting that not only MediCall of Mexico had done something for incredibly low cost with great results, but NHS Direct, if you add it all up and reflect on what has been done – in particularly around the flu contained by various other pieces relatively to what the NHS traditionally would have done – I think we should all say that was extremely well done. And in this future of multi-channel managing the patient without

Session 7 – Closing remarks

Nicolaus Henke: All right. What a day. It started all so well. And where did we end? It was quite a journey and if I just try to play back, really, the day, I would like to structure this in four quick points. The first one is we started incredibly hopeful with four areas of true innovation with some of what I would say are probably good examples of the best in the world in four particular areas of innovation in the room. And we heard about focused factories and we probably saw what is, in cardiac care, frighteningly close to the world’s best, not only in productivity but also in clinical outcomes. And a lot of people – for example in Cleveland and other places – are scratching their hair about that. And we are wondering now what is holding us back to have some of this.

We then saw technology-enabled networks and I found it particularly interesting that not only MediCall of Mexico had done something for incredibly low cost with great results, but NHS Direct. If you add it all up and reflect on what has been done – in particularly around the flu contained by various other pieces relatively to what the NHS traditionally would have done – I think we should all say that was extremely well done. And in this future of multi-channel managing the patient without
physical contact, do we have an asset here which is under appreciated? Everybody likes to complain about the NHS Direct and I think the team is a little bit of a beaten dog as a disruptive innovator within the system. Can we, as this 111 project comes to fruition, do much, much more with that asset? And what can we all do to help that.

The third one is integrated care. We saw Valencia and I encourage you to go there. We saw just the tip of the iceberg but it is absolutely incredible. You can go anywhere in Torrevieja with your mobile phone. You type the word “urgent” into a certain number and you get by return SMS in 12 seconds a list of the primary care centres and the hospitals next to the GPS point you happen to be in. You double-click on it and you get a Google map to it and they expect you at the primary care centre. And everything is done without any paper. So it is an incredible system and the whole thing is for 600 euro per capita per year. And it’s done in Europe and it’s done with physicians and clinical leaders and etc. So it’s interesting – again why couldn’t we do some of this?

And the final one, I think a lot of people got quite excited about some aspects of franchising. Specsavers was an example. There may be more opportunities like that. For example, in cardiac care Cleveland Clinic tries to run the cardiac care facilities of 50 hospitals in the United States. Why couldn’t our friend help on a couple of cardiac wards in this country? So that’s, I think, how we started.

Then a little discomfort set in. I think around lunchtime the work group began to stretch and hmm, how does this all work. It was the usual, in these kinds of sessions, the usual chase for the silver bullet. We need to now find the one thing we all agree and so when we leave today we need to have the one thing which saves the whole thing and the £20 billion and the reforms and everything and re-election and social care. And then there are the paediatricians and of course maternal health.

There will not be that silver bullet. And I think the hope set in in a couple of areas. Ali demonstrated with his comments how easy it is to run a hospital – you know, just to figure out how to change the light bulb, which was incredibly encouraging. But I think there is a lot of truth in there. Can we simplify this and do one thing at a time? I thought Peter’s points on reconfiguration – and there is a readiness. People begin to see that something must change because of all the usual challenges that we have gone through. We probably are much more change ready than we were five years ago. And personally I think my only regret in this area is that a method which Ara Darzi began to develop potentially could have been tried a little more intensely. And I hope in some way the reform with future consortia etc can pick up that trend again.

And the final one, I think a lot of people in the hallway conversations said, the final reason why these next two years may be different from the past is it is really credible for the first time that there isn’t additional money. In every single system or country I have seen where really at some point the money at some point ran tight, change occurred. And I think we are at this unfreezing point. And the key thing is not to get overly nervous about it. There is this discomfort and you sense it almost in this room because this room is probably foreseeing what is going to happen in the next three years better than many people at the front line. But I think taking full opportunity, taking full advantage of this discontinuity is quite important.

What could be done? Number one, if there are a couple of quite under-performing – financially under-performing – health economies, could we try in three or four places something like Valencia. All the contracts have been written, the IT software is there, the management structures – you know, we just need to adapt it. Some translation is necessary as we learned again today. But anyway can we just do that and try in that way also out integrated care in a way which we haven’t. And I love the simplicity of the capitation model they have. I love the way how they can have those things – hospitals and primary care together – can actually influence vs those things they can’t.

The second thing is, can we really do what Ali said and try and figure out a place where our friends from India can help out on a cardiac or surgical hospital? There are a couple of them that need a little bit of help for all sorts of tariff and other reasons. And giving them the ability to do some of the systems they do – why not? Can we challenge MediCall and NHS Direct to take a region? It seems like Yorkshire seems to be the leading candidate from the day. And tell us not with complicated analysis but a couple of bold pages how you could fundamentally transform the interface between the patient and the health service in that particular region and how, as 111 gets implemented, how that pilot gets created etc. And you could go on. It’s not difficult to see how some of the things which we talked about today could be tried. If we resist the temptation then to kind of nationally roll it out and make it compulsory for everyone.

What does it all mean for policy? I think in terms of glasnost – I think nobody disagreed with the glasnost point. We should just accelerate that. On the perestroika side what you probably will need is three simple changes to the reform drafts. One is making sure that – I don’t think that takes legislative change – making sure that the national commissioning board behaves like a strategic commissioner. There are implications to that.
Secondly making sure that the consortia are really accountable for money in multiple ways. And there are various ways to achieve that. And the third thing is simplifying the provision legislation and making again sure – I think that’s what everybody today has said; that’s what I hear the room saying – whatever we do on competition and integration and all these other things, the most important thing actually is making sure that the provision players, ie the hospitals, know how much money they will get for what kind of level of performance, and that that’s it. And then what they need to do with that. I think given that that reality is kicking in – referring to the point before – it’s relatively easy to foresee. So these three things would potentially help to make some of the other things happen. With that I stop. Thank you.

Nick Seddon: Nicolaus, thank you. Your mind is so systematic that you’ve actually resolved all of the problems of the day and we actually now know how to apply all of this. So that leaves all of the page of notes that I’ve written down totally redundant. Well we’ve talked about – it really does – money, we’ve talked about the money. We’ve talked about innovation. What I’ve loved about today particularly is we’ve not talked about the health and social care bill. We’ve talked not about problems or kind of got stuck in issues. We’ve looked at solutions. We’ve looked at ways forward. We’ve tried to raise up the best practice from the UK and around the world and say maybe there’s a way to do this. It can be done. And my goodness it does need to be done. As Stephen Dorrell set out right at the start, the problem is serious. And I sort of over-quote my favourite physicist – probably the only physicist I know – the Kiwi Ernest Rutherford. He said “we haven’t got the money so we have to think”. And that is what today has been about. It’s been trying to do the constructive thinking.

I think there are some challenges for us in the material we’ve gone through. I love Norman Warner’s Canadian hospital commission – conversion commission. But there is a big challenge in how we deal with failure because, as Paul Corrigan pointed out, if you want innovation we can do innovation. But the question is how do you get disruptive innovation. And I do think that there is a challenge for us to work through. And then in terms of how we translate rather than transplant from abroad, I’m completely with Ali on this. Let’s just go figure out – it’s about the will to do it.

That’s quite enough from me. I just have two final things to mention. One is a thank you very, very much indeed to the Royal College of Nurses and to McKinsey. Your support is absolutely priceless. And it’s not just financial support; it’s intellectual capital. So thank you so much. I just completely turbo burst the kind of event that we’re able to put on and the kind of information and ideas that we’re able to sort of generate and put out in the public domain for us to be able to work with you. So thank you so much.

And the good news, Malcolm Durham’s question – who is listening? – I mentioned earlier it may be a question after this day of who is reading. But we will publish a transcript. We will send it to the secretary of state. We will send it to the Prime Minister. And so these things will be listened to, I think, in the right places. And the rest is up to them for, as the Prime Minister said a year ago, to lead is to choose. So thank you all very much indeed. Have a good rested afternoon.

It’s not difficult to see how some of the things which we talked about today could be tried. If we resist the temptation then to kind of nationally roll it out and make it compulsory for everyone.