



Cost Improvement

Achieving engagement by evolving culture

As the NHS enters a period of considerable financial famine, the cost improvement programme or CIP is set to become part of everyday practice for most services. However, service leaders are more likely to find that their teams are reluctant compliers than enthusiastic engagers and this persisting culture ensures that CIP will remain difficult, painful and potentially inadequate as services strive for financial stability against rising demands and falling revenue.

CIP – the really old, the recent and the likely future

In days of old (the good old days), most CIP was limited to aggressively negotiating with suppliers to shave small percentages off supply costs. However, with the passage of time, many of the larger supply contracts have been negotiated to a bare poles level, with little room for further reductions. Furthermore, greater collaborative and centralised purchasing has indeed resulted in cost reductions but suppliers are left with little wiggle-room in a very harsh economic climate.

However, with the advent of the market economy in healthcare, facilitated through the Payment by Results (PbR) system, services have been able to achieve CIP targets through improved service capacity and efficiency, without necessarily lowering costs at all i.e. they have conducted more work for essentially the same money. However, recent mutterings suggest that this practice may well have to come to an end as PCTs assign contract levels for providers, over which they may well receive a different tariff. If this indeed becomes reality, it will mean that attracting more patients remains vital for service funding and viability but not

quite so effective in cost improvement, as these extra 'discounted' patients have little impact on reducing the average cost of care.

CIP in the future is going to have to focus on areas that have traditionally been considered taboo from a cost reduction perspective. With 60% of NHS expenditure going on staffing, examining workforce re-design becomes an unpalatable necessity that will result in many heated discussions over who is capable of doing what and at what level of effectiveness. Services will have to examine their cost base every which way, looking at key areas of spend, total pathway expenditure, patient-level expenditure and more. Some of the decisions may be hard but without question the choices made need to be intelligently thought through with as much objectivity as is humanly possible when placed in what appears to be a position of Hobson's choice.

The engagement imperative

What is clear is that service leaders will need to rely on proactive, positive engagement by their clinical teams if they are going to achieve the levels necessary to achieve sustainability in an increasingly cash-strapped environment. Traditionally, teams have tended towards only reluctant engagement, often seeing CIP is purely a cost-cutting exercise usually focused on things they hold dear or feel are important in the quality of service they deliver. As the cuts become deeper and the options more limited, this perception of CIP is only going to get worse. Furthermore, CIP has typically been a 'management' activity, with service leaders simply deciding where cuts could be made. Going forward, the responsibility for CIP will lie across the whole team; nursing, medical, allied and administration all playing

their part in keeping resource wastage to an absolute minimum. At a clinical level, this is an unwelcomed focus and it is going to take a significant shift in culture to become embedded in the day-to-day life of clinical teams.

Cultural evolution

Evolving the culture of an organisation is said to take around 7 years. Without question, services will need to achieve substantial CIP targets well within that timeframe and so it does seem that the organisational evolutionary challenge is a significant one. Equally, given the timescales involved, when embarking on a cultural change it is vital that leaders consider just what kind of culture they want to create. Large scale cultural change is best planned around the critical behaviours and success factors for an organisation. To do that requires leaders to thoroughly understand the environment they are in and the factors influencing success within it. This question is not fully answered yet as the NHS evolves into something that it hasn't been before, with very little history in this form on which to make objective judgements.

Traditional 'cultures' within organisations tend to focus on how the people of the organisation interact. Although many models of organisational culture exist, this Interpersonal Interactions Model is a commonly used one, broken down as follows:

- **Power Culture:** Strong, directive leaders distribute resources and deploy staff with authority as the key driver. When overdone, you can find fear, abuse of power for personal gain, and political positioning.

- **Achievement culture:** Provides rewards for successful results rather than unproductive efforts. Work teams tend to be self-directed and rules/ structure serve the system. Sustaining energy and enthusiasm over time can be difficult.
- **Support Culture:** Employees are valued at a personal level, as well as a worker and workplace harmony is important. Sometimes this culture lacks the external drive and focus of more task-orientated cultures.
- **Role Culture:** Clearly identified roles and the rule of law, coupled to a reward system, lead to stability, justice and efficiency. This culture can suffer from impersonal operating procedures and a stifling of creativity and innovation.

Typical NHS organisations have many cultures within but what is clear is that overall the culture tends towards an amalgamation of power and role cultures, leading to bureaucratic control systems and comparatively little autonomy or leadership within the ranks. This present culture does seem at odds with wanting the workforce to enthusiastically engage in something such as CIP that it sees as largely detrimental to itself. Furthermore, we see the typical problems arising out of both cultures present in the NHS, each dangerous to successful CIP, with services protecting their assets over their peers, ensuring that individuals gain and a strong culture of politicking. To create robust, successful

services requires a more achievement/ support culture with careful attention to avoiding the pitfalls. However, as is often the case, there is no single model that covers the range of key cultural elements necessary to excel in the modern, competitive marketplace.

As service leaders seek to change culture within services, they will run up against the full range of existing NHS and staff values. The culture arising lies deeply within and is unlikely to change without first a baseline of 'need'. As staff begin to appreciate the necessity of operating with a different mindset, so leaders can evolve those minds towards a wider range of focus including financial frugality, attention to detail, collective responsibility for the financial position and an embedded belief that CIP protects quality of care by ensuring financial sustainability, rather than undermining quality of care by cutting corners. However, that last Holy Grail is unlikely to be achieved until we restore a culture of flexibility, innovation and drive. Arguably this does exist already, it just isn't focused on finance, instead it is devoted to clinical improvement, much nearer and dearer to the heart of the average clinical professional.

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Optimising Cost Improvement Programmes at a Service Level

Fostering engagement, commitment & proactivity towards CIP

With the NHS entering a period of considerable financial famine, it is imperative that clinical teams approach CIP in a manner that delivers financial sustainability without undermining clinical quality. However, many service leaders struggle to get the necessary engagement and commitment to CIP that they really need to ensure success.

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Open course or in-house programme

- Understanding the financial shortfall in NHS funding
- The wider context – cost improvement as part of disaster aversion
- Beyond cutting corners – taking an intelligent approach
- Building a cost improvement ethos throughout the team
- Ensuring continuous attention to cost management
- The carrot of reinvestment – spending savings on better things
- Ensuring that the benefits of cost improvement are explicit to the team
- Establishing an effective cost improvement strategy
- Setting positive cost improvement goals
- Cost management reporting within the team
- Understanding your cost base – as a service and by patient
- Use of patient pathway analysis to elucidate cost savings
- Patient differentiation approaches to optimise resource consumption
- Overcoming team resistance to cost improvement
- Financial prioritisation – avoiding the sharp slice trap
- Understanding the principles of return on investment (ROI)
- Making clinical excellence the absolute baseline
- Improving clinical effectiveness through cost reduction
- Adopting a 'lean' approach to service delivery
- Using technology to improve leanness
- Service re-design as a cost saving strategy
- Evolving staffing structure as part of a wider strategic plan
- Use of training as an effective cost-saving strategy
- Innovation – improving performance whilst reducing cost
- The patient as innovator & prioritiser
- Leveraging funding for cost improvement innovations – sources & strategies
- Clinical coding – ensuring you get paid for what you do
- Case mix strategies to achieve cost improvement targets
- Economies of scale – creating cost efficiency by improving income
- Partnering & pooling for cost improvement
- Business planning in a lean environment
- Strategies for cost containment when it gets out of hand
- Managing offenders positively – gaining maximum engagement

