Table discussions summary

Discussion topics

The Oxford Radcliffe Hospitals NHS Trust is an economic asset for Oxfordshire, and something which the County can be proud of. It draws staff and patients from around the country, and around the world. How can the Oxford Radcliffe Hospitals work more closely with business and other partners to improve our joint economic futures?

We continue to invest in new drugs, devices and procedures to improve health services but how do we ensure we have the skilled staff to make this investment work in the future?

The UK is currently facing serious problems in the funding and management of health services. Our population is ageing, becoming more and more obese and living longer with chronic diseases, such as diabetes, cancers and heart conditions. This is putting a huge strain on health service resources and is likely to get worse in the future. What needs to be done to ensure that all patients continue to receive the appropriate level of care whilst still balancing the books?

What needs to be done to ensure that a centralised hospital provision for the County does not have any long term adverse effects on Oxfordshire's already busy transport network?

Although there were four discussion topics for the evening which were distributed amongst the tables it seems that the subject discussed throughout was that of resources and rationing. One table leader summarised it thus:

"We spent most of our time wrestling with balancing increasing demand (combination of demography and technology) with limited supply (cash). The reality is that demand side must be managed by rationing, charging or refusal.

Questions of ethics, public good and social responsibility were also raised in a number of the discussions, particularly about who makes the decisions about: rationing, continuation of treatment, which drugs and treatments should be available, to whom and for how long and the like.

The suggestion that encouraging smoking and heavy drinking as a way of reducing patient numbers and thus cutting costs in the NHS and indeed solving the pension crisis were taken with a pinch of low sodium condiment!

1. Funding Mechanism

- Funding should be geared to the age of the populations (as opposed solely to deprivation indices) served by a local trusts. Older populations usually require higher levels of health care. To remove any element of political favouritism by area, the Audit Commission could be asked to devise a formula for health funding by local age-weighting.

Then there were those who thought the system should be changed completely:

- Get rid of the free health service with a safety net for the worse off but don't introduce a USA type system
- Government shouldn't be a delivery body it should set high level strategy
- Need more realistic expectations of what can be provided

2. New sources of revenue

- New taxation system to allow local health tax to supplement central government funding.

- Advertise outside of the hospital's area to attract more NHS patients
- Seek private patients both from UK and overseas with dedicated websites for each faculty, so someone in, say Italy with a kidney problem, could access a relevant website and learn what could be done and what it would cost. Tie this in with a dedicated travel agent would smooth the process of getting the patient to the hospital.
- Charge more “realistic” (i.e. higher) charges for non-EU visitors requiring non-emergency treatment.
- With the proviso that people on benefits and those close to benefit payments are protected, charge for:
    - Hotel aspect of care, meals, linen, etc
    - Missed appointments (need tougher gatekeepers)
    - Lifestyle enhancing procedures, infertility, and conditions consequent on unhealthy lifestyle - offer insurance packages that would cover for any non free procedures or leave this to BUPA etc.
- Provided, certain quality targets are met (e.g. 95% of patients get seen within say 3 weeks and get treatment started within 3 months), then the Trust could sell faster track access for those that can pay, or for companies that want their employees to get more convenient treatment times. Queue jumping would still be an issue, but given the vastly improved waiting times for all other patients it would be easier to counter.
- Health service should recover all its costs of covering accidents through claims on the insurance of those at fault.
- In the long term, mixed funding (private involvement) could be an option.

3. Means of reducing costs

Reduce numbers of patients:

- More investment in preventative measures to reduce need for treatment e.g. like hygienist from dentist - regular check ups and servicing
- Plan on a more ‘holistic’ basis than at present: education on diet (parents and children), more investment in sport for the youth, use by PCTs of increasingly available diagnostic tools for early diagnosis.
- Increasing the responsibility of patients for their own health e.g. obesity, smoking, exercise
- "Polluter pays" policy e.g. large licensing fee for late opening pubs to discourage binge drinking
- Increase public sector support for healthier living e.g. cycle paths
- Carrot and stick approach e.g. no hip operation until the patient loses weight
- Health promotion for employers - healthier living - obesity/binge drinking
- Better management by all employers - should reduce stress related disease, which is growing at an alarming rate.
- Control of advertising for "junk" foods
- Influence businesses that promote unhealthy eating and excessive drinking
- Restrict free procedures to those that mend and cure only.

Reduce in-patient care time:

- Increase investment in modern treatments, procedures and equipment to increase productivity of bed space.
- Increase investment on care in the community.
- Better food will reduce patient's length of stay in hospitals, JR food is not renowned for its quality.
- Reduce bed blocking – and be far tougher on social services – making sure they provide the home care services that would prevent patient deterioration in the first place. They are also squeezed for funds, but the Trust must keep up the pressure so they in their part can increase pressure on the government.
- Generate business from care of elderly at home for as long as possible
- Need to change whole model of care for ageing people - more community care
- Improve joint working between PCTs, acute Trusts, Social Services - co-operation not confrontation.
- Use of new drugs and procedures already NICE approved is often frustrated by internal hospital bureaucrats, particularly where the new procedure removes buying power from one buyer and transfers it to another. Actual instances where this has occurred were voiced. This can delay the use of cheaper procedures.

Better use of resources:

- Simply do not understand why some treatments are available quicker and cheaper in for example France which spends less of its GDP on health. Why do New Zealand and Sweden do it cheaper. What can we learn?
- Outsource to cheaper providers
- Plan capital programmes to ensure running costs will be lower in the future.
- Learn more about supply chain management from the supermarkets
- Bring in Toyota's operations management specialists – the health service is 30 years behind. Learn the lessons from what the acute surgery team learnt from working with the Ferrari formula 1 pit team
- There should be greater emphasis in medical training on achieving better diagnosis using more diagnostics.
- Better use of (mainly IT) technology should be examined. We should not be spending vast sums on re-inventing wheels (NHS Connect and sub-sets.) We should be selecting and buying in tested and successful models from other countries.
- Increase efficient use of resources – this is a never ending task and one easily allowed to slip in a big organization.
- Better use of drugs - Need to ensure that we are prescribing the right drugs, in the right amounts, to the right people (better diagnostics, theranostics). We are currently wasting drugs and money because too high dosage, patients resistant etc.
- Medical audits should be carried out as to the influence of medical companies (especially pharmaceutical reps) on prescribing habits, treatments and their appropriateness.
- Drug companies pushing culture of illness to sell more drugs, e.g. attention deficit etc. Need to be more evidence-based.
- The pharmaceutical industry is "globalised."
    - In the long term should the UK government be seeking to shorten global patent life for some drugs to reduce long-term costs?

  - Should doctors encourage their patients, under guidance, to buy selected drugs on the Internet from the cheapest possible source?

- Don't be bullied by drug companies (cf India)
- GP contracts/consultants overpaid - rigour in contracting
- Fire staff who are not performing; doctors, nurses, porters admin staff even directors. Reduce the time it takes to get rid of doctors, the years it takes on full pay is not only a waste of their salaries but the costs of running disciplinary actions mitigates against taking disciplinary action in the first place.
- Motivation for NHS staff is patchy, more attention to rewarding good staff, suggestion boxes for cost saving ideas with significant rewards for good suggestions.
- No more structural changes – this is more a plea to government than any single Trust. They eat up managerial time and de-motivate everyone.

4. Engagement with the local Economy

- Sir William's comment that the Economic Development Strategy made little reference to the NHS reflects at least in part the absence of engagement by the NHS itself at a senior and consistent level. We look forward to better engagement.
- Having this Centre of Excellence and the associated University research excellence is very important to the local economy.
- It is a draw for the "best in the world"
- Very large local employer
- It does contribute to our overheated property and labour market
- More effort should be made on local procurement
- Health contracts with local employers for their staff (avoiding BUPA/PPP) thus generating income to ease the cash pressure
- Graduates entering the drug industry often need vocational training to ensure they have the practical skills needed as well as the theoretical background knowledge. Courses to provide this are too few, and given their special nature could be expensive to establish. Could this be a service offered by NHS?
- While medical research in Oxford and the UK is perceived from outside Britain as world class and often world-beating, UK primary care is externally perceived as patchy compared to leading, northern and western EU countries. The length of medical training and experience required before independent practice is usually at least 2 years longer in these EU countries. In the absence of a change in UK government policy, social and, where possible, business partners could be approached to help provide more varied opportunities and experiences for general medical and primary care training.
- The NHS needs to be easier to access and understand – employers want a single authoritative contact point.
- Encourage spin outs to work more closely with NHS, de-skill, improve recognition and other non financial methods of incentivisation.
- A "medical/business research cluster" should be established on the same basis as the nanotechnology cluster based at Begbroke. The government should be approached to enhance tax breaks for medical research businesses in such a cluster (or clusters.)
- Technology transfer of ideas out of hospital.

5. Transport
What needs to be done to ensure that a centralised hospital provision for the County does not have any long term adverse effects on Oxfordshire's already busy transport network?

- GPs/decentralised - step back
- Provide sufficient car parks – should there be a multi story?
- Flexible use of 24 hours
- Shuttle system
- Need a hospital park and ride
- Direct route into the hospital site from the northern bypass
- Multiple dedicated bus routes to the hospital
- More home monitoring, treatment, GP operations and thus less need to go to the hospital
- Re-site the JR
- Ban visitors
- The establishment of more, but smaller, satellite centres around a central hub (Oxford) should be explored.