Press Cuttings

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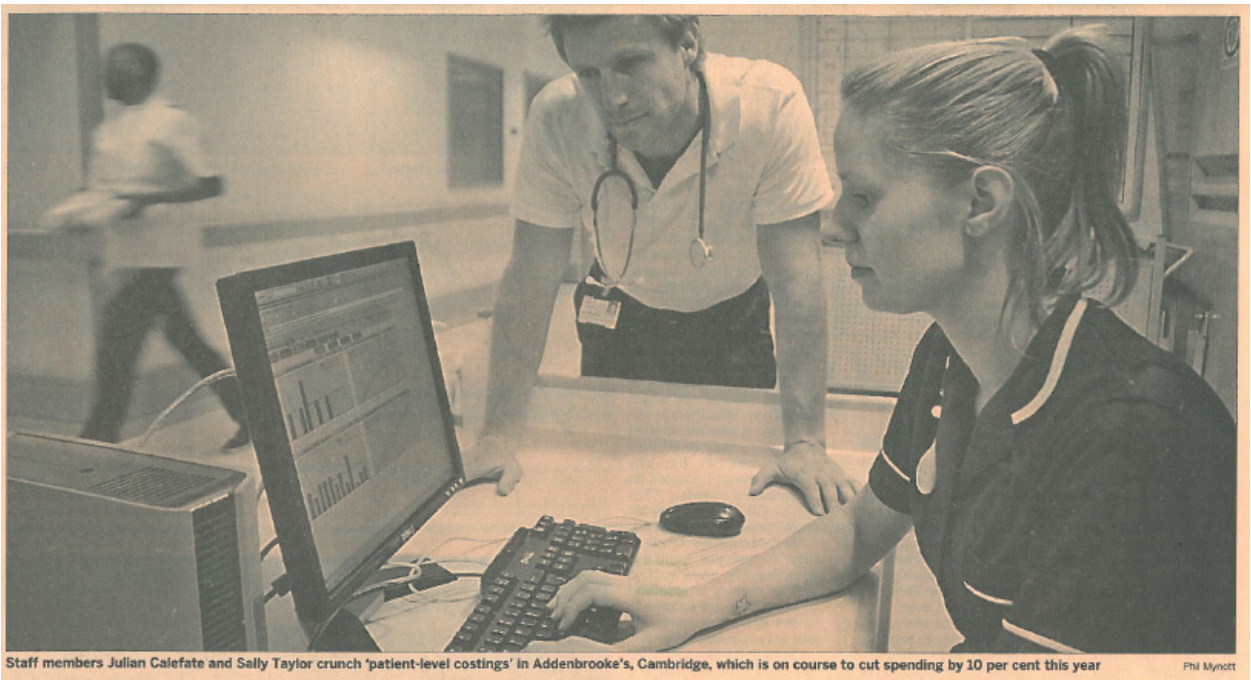

Staff members Julian Calefate and Sally Taylor crunch 'patient-level costings' in Addenbrooke's, Cambridge, which is on course to cut spending by 10 per cent this year Phil Mynott

Hospital puts each patient's costs under microscope

NHS savings drive

A Cambridge institution is using detailed data to pinpoint inefficient spending, discovers Sarah Neville

In his office at Addenbrooke's hospital in Cambridge, Gareth Goodier, chief executive, is examining a chart that smacks more of the company boardroom than the cash-strapped National Health Service.

A series of bars on a computer screen show which specialisms are making the hospital money and which are not. Another click or two and the names of a group of surgeons are summoned. All have performed the same procedure on similar patients but there are startling variations in the number of diagnostic tests each has ordered – varying from three to 47.

At will, he can also discover what he calls the "hotel bill" for each discharged patient, composed of the cost of their ward time, laboratory investigations and "every last detail", so it can be instantly discerned whether the patient's stay has left the hospital out of pocket.

"Our system shows you make a profit of about £80 is made if a cataract operation is performed as a day case," Dr Goodier said, "but this becomes a loss of £15 to £20 if a patient stays overnight."

The language of the balance sheet momentarily surprises in the context of the NHS, which historically has had little idea of how much its "free-to-all" care is costing.

But since ministers have set it an ambitious target of saving £20bn by 2015, doctors and administrators are being forced to focus as never before on ways to eliminate waste.

Dr Goodier, a forceful Australian, is convinced that the type of data he collects is central to achieving that goal. "I don't think there's any other way to manage this challenge," he says.

It is doctors who, with a stroke of a signature, run up costs, he points out. "The doctor's pen is the most expensive item in the place. He chooses how long the patient stays in, he chooses the number of investigations, he chooses the drugs – [and] how expensive they are – and while lay people think that medicine is a science and that there are few options, there are in fact considerable options – you can waste an enormous amount of money."

Addenbrooke's solution has been twofold: to put doctors in charge of each of its divisions, so called "clinical leadership", and to give 1,000 senior doctors and nurses access to highly granular data on the costs of treatment, and their performance on a range of other indicators, via a tool called QlikView, developed by QlikTech, a US-based technology company founded in Sweden. The combination has helped to ensure that it is on course to meet its tough 10 per cent savings target for this financial year, he says.

Healthy profits

Hospitals across the world are using data to sharpen doctors' focus on the bottom line. But few have gone as far down that route as the Narayana Hrudayalaya group in India, **writes Sarah Neville.**

Each day, senior doctors and administrators in the 14 hospitals it runs receive SMS messages of the profit and loss account from the day before.

Daily dissemination of the information is vital because it allows staff – who focus on keeping the cost of treatment as low as possible – to take rapid remedial action, says Dr Devi Shetty, founder.

He says: "If on the 14th of the month I realise . . . we are not making any margin, then for the next one week we try to reduce the discount given to the patient so the ebitda [earnings before interest, taxes, depreciation and amortisation] margin comes to a healthy level."

Dr Goodier emphasises that when variations are noticed they do not trigger a stern edict from the chief executive's office. Rather, they are "the starting point for an intellectual conversation" on whether they are warranted.

Substantial reductions have come from cutting the number of patients staying overnight, although Dr Goodier emphasises: "There's never any pressure in terms of sending the patient home prematurely – that has to be clearly stated. Our primary concern is always the quality of patient care and we have one of the lowest mortality figures in the country."

Its success raises the question of why so few NHS hospitals have a deep understanding of their costs. Several hospitals use the QlikView system and others have their own programs but the figure amounts to no more than 20, Dr Goodier estimates.

Chris Calkin, finance director of North Staffordshire NHS Trust, who speaks for the representative body of health service finance staff, the Healthcare Financial Management Association, says stringency across the NHS is leading managers and clinicians to confront their true cost base. A recent Department of Health survey showed almost nine out of 10 had brought in, or were planning, so-called patient-level costings.

Collecting such information is also producing much-needed scrutiny of whether differing costs reflect anomalies in how patients are treated.

"Patient-level costing is as much a clinical tool as a management tool," says Mr Calkin.

Nick Seddon of the think-tank Reform, who has studied the drivers of productivity in healthcare systems worldwide, said gathering performance data not only harnessed the natural competitiveness of clinicians but was also a social "good", because it gave patients vital insights into the quality of care.

It had "the potential to be a truly disruptive innovation", he said.