



The NHS is going through a period of great change and not all of it seems particularly well planned.

Reducing staff numbers, cutting budgets and turning organisations upside down, all at the same time, is not exactly ‘text-book’.

We asked readers for their scenarios, how all this upheaval might work out.

This thought provoking and absorbing contribution is from Ian S. Rickard. He paints a convincing and realistic picture of system failure and its impact on NHS staff.

Ian is a former NHS and Social Care Commissioner. He is also a Registered Nurse and Behavioural Psychotherapist, Cognitive and Behavioural Psychotherapy Supervisor and a Health and Social Care Design Analyst.

He can be reached at <mailto:ian@derwenlas.co.uk>

Introduction:

Innovation implies opportunity. Unless modified though, over the next twelve months, the Lansley proposal is more likely only to threaten both better health outcomes in general and value for the taxpayers’ pound in particular. My reasons for this claim are here:

Loss of Corporate Wisdom:

Rehiring those formerly employed in strategic commissioning, in the mooted new commissioning assistance agencies, albeit privately, in reduced numbers, will put the design experts in the wrong place at the wrong time. The first casualty of the changes will be information. Timely and accurate information is essential to successful planning.

Marginal Cost Increases:

Money supply governance will become the second casualty, as a result of a steep and rapid rise in marginal costs. This burgeoning crisis will probably be noticeable by the third quarter.

This is because the relationship between activity, costs and spend will become harder to monitor, because of the information problem.

Accurately measuring outcomes and activity will quickly become virtually impossible because the only available commissioning plans, agreements and Key Indicators will have been abandoned.

Demand Management Compromised:

As public health intelligence becomes unavailable, and in the absence of commissioning guidance, demand management will become less robust than hitherto. Some demand will be interpreted as emergent need, leading to consortia purchasing extra activity as they seek to demonstrate competence at meeting need.

Some Providers will not always have sufficient capacity to undertake this newly commissioned activity, as they will not have planned to meet the new demand. So, further supply will have to be hastily created, causing the rise in marginal costs.

Money Supply Crisis:

The more money we spend on responding 'marginally', the less we'll have left for our core services. So, some of these will be reduced. Very quickly, an imbalance will set-in; with an overprovision of some pathways and episodes, at high extra cost, and a resultant reduction in other provision, but with their associated fixed costs still having to be met.

The risk is that we will end up truly wasting money, with some resources lying idle but consuming the cost of, for example, maintenance, and with other facilities unable to increase capacity without new spend.

A new danger will then loom: in order to cope, agencies will begin to run deficits as the financial year turns, with the 'overspend' itself carrying over and threatening the new financial year's proposed estimated pricing of proposed activity.

Other Unintended Consequences:

Demand for healthcare is likely to increase. Perhaps most notably in the first quarter of 2011, as the reductions in social care (departmental savings of 25% are being called for) will cause an increase in acute physical and mental ill-health, across the ages range. Again, the urgent commissioning of extra unplanned responses will be costly, adding to the new year's burdens.

Helplessness At Work:

Stress related ill health amongst managers and practitioners would increase as the workforce attempts rapidly to adapt to organisational change, exacerbating both supply and demand problems, and reducing the health benefit associated with meaningful employment.