Review of operational controls and an assessment of cost containment measures for HSE West

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Content

1. Key Messages

1.1 Context

At the end of 2009, HSE West was overspent by €83 million (3%) against budget. This comprises an acute hospital overspend of €26 million, a pension overspend of €65 million, an ambulance overspend of €5 million and a €13 million underspend across LHOs. For 2010, the HSE West has a budget of €2.3 billion which includes ambulance and other corporate services. This revised budget of €2.3 billion is after further reductions to reflect the impact of public sector pay reductions, the ongoing recruitment moratorium and other efficiency/value for money measures. This budget includes €176 million in respect of National Pensions. This budget also reflects an expected increase in income from private and other charges of €20.8 million across the acute hospitals.

Adjusting for National Pensions, the revised budget for 2010 is €303 million (12.3%) lower than the revised 2009 budget and €385 million (15%) lower than 2009 outturn.

The National Service Plan 2010 also assumes that inpatient activity would reduce nationally by 9.1%, daycase activity would increase by 1.6%, and that emergency department presentations and outpatient attendances would remain as at last year's outturn. The target reduction for elective waiting times is that no adult waits longer than 6 months for treatment and for children no longer than 3 months.

As at the end of March 2010 the actual WTEs across HSE West were 683 lower than the ceiling; predominantly within PCCC.

Given the reductions in the budget allocations for 2010, organisations have been required to identify savings/cost containment plans to achieve breakeven at year end. Whilst some initiatives have been identified locally and are underway, the savings to be achieved in the remaining six months of 2010 is estimated to be €107m by HSE West Corporate Finance (excluding the increased income targets).

We were tasked with supporting the HSE West in a review of operational controls and identifying further savings which could be achieved to support the reduction of the financial deficit. In particular, our review focussed on six sites in HSE West with the highest estimated financial deficits:

- University College Hospital, Galway

- Mayo General Hospital
- Sligo General Hospital
- Letterkenny General Hospital
- Portiuncula Acute Hospital
- Local Health Office, Galway.

Over a two week period in early May, a number of site visits and interviews were held, including a visit to Mayo PCCC; which was considered to represent good practice. This rapid information gathering process involved mainly local managers including the General Managers of each site, HSE corporate team, National Procurement and, for GUH, interviews with Clinicians. The site visits included a review and assessment of operational controls and the achievability of the breakeven/cost containment plans.

1.2 The outcome of our review

A commentary on the operational controls based on the short site visits and interviews has been documented in a supporting appendix. Given the time constraints for this review, our observations are based on discussions with a number of senior staff from each site together with any documentation provided by the organisation to support their actions.

Further work has been undertaken to assess the impact of a wide range of initiatives to breakeven, which has involved individuals from HSE West Regional Assurance Team and the team of the Assistant National Director for Finance. With the national constraints and limitations around pay and workforce, these savings are inevitably focussed on non-pay and income collection/generation.

A separate document has been prepared which contains revised local action plans and further estimates of cost savings which were identified during the review.

The outputs of the review have been shared with the HSE West Regional Assurance Team. It is planned to share the outcome with the General Managers from each of the visited sites and to members of the HSE Board.

1.3 Key messages on the management of the current budget

Given the forecast financial deficit, it will be extremely difficult for HSE West to achieve breakeven at year end and still achieve its service plan targets.

Of the hospitals and PCCCs visited, there is evidence of internal controls being strengthened, including pre-authorisation of overtime, management of sickness and absenteeism, authorisation of requisitions and invoices over a certain threshold, and recovery of debts. For example, at Mayo General Hospital, where a number of initiatives are underway include monthly performance tracking, a electronic rostering system linked with payroll, web-based requisition approval system for non-pay items, and a KANBAN system to support improved stock management. At Sligo General Hospital, a Budget Working Group has been established, involving senior staff and meeting weekly.

In the sites visited, there is also a wide range of initiatives being taken to reduce and manage costs, including ward and theatre closures, cessation of elective workload, use of lower costs unlicensed drugs, and redeployment of nursing staff to cover wards.

However, despite these measures and initiatives, there still appears to be a lack of ownership with some budget holders about their budgetary responsibilities; predominantly in response to the budgets being historically based and not linked to activity and staff. In addition, there is a perception that financial management and the achievement of breakeven is a general manager or finance staff function.

Finally, given the age of some of the financial systems in operation across some sites, financial management information is not easily accessible for immediate querying and decision making.

Going forward:

- There should be the ability to move funds between acute hospital and PCCC, particularly in light of new community developments where the investment has been made but the service in still in its infancy;
- A zero based budgeting exercise should be undertaken to ensure the equitable, needs based distribution of the available budgeted resources to services/departments within organisations;

- There needs to be more collective accountability to ensure that financial management is everyone's responsibility, including all service managers and clinicians;
- Operational controls could be strengthened by optimising 'subject-matter expertise', which may reside in either an individual organisation or at corporate level. There is no time to restructure but action should be taken to share knowledge and expertise;
- An agreed set of routinely reported financial management information should be developed at organisational and regional RDO level including, cash flow, income and expenditure and KPIs relating financial information to staffing and activity.

1.4 Key messages on the governance structures in place

There is evidence at GUH of formal management structures and collective decision-making involving clinicians to address cost reductions, including an Executive Management Team. Other sites have Executive/Management Boards and a clear management structure at senior manager level.

Although organisations have already taken actions to include clinicians in decision making, there is a need for further clinical leadership and more involvement of clinicians in hospital executive functions.

There is evidence of too few qualified finance professionals supporting local management.

The governance arrangements in the RDO's office have been strengthened through the HSE West Regional Assurance Team, with further plans to involve operational leads and clinicians.

Going forward:

- Organisations should actively pursue opportunities to gain clinical involvement in key management functions;
- The RDO's office support local managers and hold them accountable, rather than over-centralise the controls;
- HSE West should explore opportunities to redeploy corporate staff to support individual organisations.

1.5 Identification of critical areas of over expenditure

As stated earlier, the budget allocation between pay and non-pay and down to individual service/departmental level is largely a product of historical allocations and therefore, identifying areas of over-expenditure may be arguable. However, notwithstanding that, there are a number of key areas where additional costs are being incurred which could be reduced through the implementation of new and innovative ways of working.

Chief amongst these is overtime payments to clinical staff. To address this, could mean:

- For NCHDs:
  - Moving away from traditional rota patterns to cross specialty and cross site working. This would achieve a saving on NCHD overtime working. Given the shortage of NCHDs for the July 2010 intake, this creates a pressure and an opportunity in the system to introduce new ways of working to keep services safe in 2010;
  - Implementation of service reconfigurations;
  - Actions be implemented in 2011 requiring a national policy change for NCHDs to receive basic rate of pay up to 48 hours within 7am to 7pm, thereby achieving a significant reduction in overtime payments and other allowances;
- For nursing:
  - Consolidating services and/or closing beds to reduce overtime payments;
  - Using less senior nursing staff to provide additional cover for shifts either through an internal nursing bank or newly qualified staff. Currently, the moratorium on recruitment is creating a perverse incentive to use existing highly qualified and highly paid staff to cover additional shifts;
- For clinical support:
  - Providing cross cover support out of hours between organisations for imaging and pathology services;
  - Implementing a centralised laboratory system for HSE West.

Other areas considered to be overspending or which are not providing good value for money include:

- Procurement of drugs and medicine, medical and surgical supplies, blood and blood products, medical gases, aids and appliances, and dressings;
- Leased property costs;
- Patient transport.

Income collection and generation is considered to be an area which is current under-performing due to the economic situation nationally and private beds being used for infection control and isolation. There is a need for improved payment mechanisms.

1.6 Action plan for cost containment

The latest budget for 2010 is lower than that identified in the HSE National Service Plan and whilst part of the reduction is described at a national level as 'cost neutral', it is evident that this is not how the local services are responding. The reduction in public sector pay, the employment controls and the continued recruitment moratorium is leading to 'unintended consequences', in that there is evidence of increased cost due to expensive, premium rates for agency, overtime working and part time staff working additional hours. The achievability of a 9% reduction in inpatients and significant improvements in wait times for elective patients, outlined in the HSE National plan, is also questionable.

Based on performance as at the end of April 2010, the financial deficit for HSE West was €46 million. Forecasting for year end, suggests a deficit of over €107 million.

Organisations have been developing and refining their individual cost containment plans. During our review, the estimated savings identified by the six sites visited produced a total of €54 million.

However, some of the actions identified by these local organisations have not been approved by HSE West as these would reverse recent investment in service developments or shift costs within HSE West e.g. redesignation of cancer beds at UCH and shifting costs between hospitals and PCCC. In addition, we have produced revised estimates for some of the initiatives identified by the organisations based on our assessment of their achievability.

Of the €54 million identified across the six visited sites, we consider that only €35.7 million is achievable. Assuming a similar proportion could be achieved across all other HSE West organisations, could mean that to date a total of €59 million savings/cost containment has been identified. However, it is not clear if the six month timescale to the end of 2010 to implement these actions and achieve the savings is realistic, and, therefore, based on our assessment of those actions identified by organisations which could be achieved in 2010, the total level of savings is €38 million.

As a separate exercise, we have identified a series of actions which we consider can support achievement of breakeven in HSE West at year end. Some of these actions address similar areas to those already identified by the organisations; although these have been independently quantified, and others are newly identified areas.

With the national constraints and limitations around pay and workforce, the savings are inevitably focussed on non-pay, reducing overtime and income collection/generation. On income generation, the action is to improve bed management so that private beds are available - it does not assume any additional increase in demand for private healthcare. In 2010, savings on procurement through price reductions are between €9.4 million to €19 million and a significant proportion of other savings in 2010 rely on other non pay reductions. The total savings identified across procurement and other non-pay reductions are up to a maximum of €28 million for 2010 based on joint working of National procurement and HSE West. Action plans developed locally against these items have identified €22 million.

Actions and their associated savings have been categorised and given a rating in terms of their achievability and timescales reflecting the realistic implementation of the action and impact on savings have been assigned. The impact of this is:

- Savings identified for a significant proportion of actions/initiatives will not be realised until 2011 and beyond; and
- Virtually all of the savings identified have been rated as moderate or difficult to achieve.

Actions and their associated savings have also been identified at different levels: within an organisation; combined action across a group of organisations; regional actions; and those requiring national changes. The greatest potential for cost reduction is when organisations work collaboratively in delivering service change;

From the actions we have assessed and independently quantified, the total savings identified for HSE West as being achievable within the six month timeframe remaining for 2010 is between €44 million and €54 million.

The full year impact of actions started now but with the savings identified in 2011 would be in the region of €95 million.

It may be possible that some actions/initiatives could be implemented earlier but this would require the support from HSE Corporate.

Achieving all the actions identified from discussions with individual members of the HSE West Regional Assurance Team which have been quantified and regardless of timescales identifies a total saving of €128 million for HSE West. Implementing these actions and achieving this level of saving may take up to 2 years.

Beyond 2010, the major initiatives identified include service reconfiguration (consolidation of acute services) and the redesign of clinical support services (pathology). These initiatives have already been subject to National and Regional reviews.

The HSE nationally and particularly in the West must develop an effective communications strategy which conveys to the public and staff any measures being undertaken to reduce inefficiency and costs and that the measures will not compromise patient safety or the future sustainability of clinical services.

Given the scale of the cost reduction, action needs to be taken by HSE West to provide assurances that clinical risk and ensuring patient safety is being managed at a local level.

For 2010, however, there is still a shortfall of between €53 million to €63 million. This is a significant shortfall between the measures set out and the reduction required, and if breakeven is to be achieved in 2010, then more radical solutions are required in the way that health services are affected with the resources available.

1.7 Closing the breakeven gap

Given the timescale of our review and the complexity, we have not estimated the potential savings from rationalisation of acute hospital services and other service reconfigurations. In the medium term, this could include the closure of a hospital and the transfer of beds to another site with the redeployment of permanent staff from and the cessation of temporary staff contracts at each of the sites. This should reduce NCHD overtime costs through improved rotas as medical staff will now be covering fewer sites.

Given that over 60% of gross expenditure (HSE West, 2009) relates to pay, significant cost reduction programmes have to include a reduction in the workforce including early retirement, redundancies and wider redeployment of key clinical and non clinical staff.

In the absence of any workforce transformation, including redundancies, other radical solutions need to be identified and supported. These actions need to be significant and have immediate impact to support the closure of the financial gap in the last six months of 2010. These could include:

- Further termination of temporary contracts across HSE West and within voluntary organisations for 6 months at no pay, although the majority are frontline and this will limit services. For example, the termination of 1,000 temporary contracts for 6 months could achieve a saving of €15-20 million. This is likely to result in the downsizing and/or curtailment of some services;
- The cessation of services, for example:
  - curtailing elective procedures for selected periods to reduce theatre use and beds with the redeployment of staff, the termination of temporary contracts and reduction in overtime;
- Reducing day case provision from 5 days to 4 days a week;
- Amalgamating beds across specialties e.g. female surgical and gynaecology; ensuring the management of clinical risks and patient safety;
- Introducing a needs led review of home helps and home care services. It is estimated that this could achieve savings of between €5-7 million;
- Introducing waiting lists for aids and appliances;
- No more consultant appointments to new posts i.e. no further service developments until 2011;
- Further reduction in grants to voluntary organisations (already assumed an overall reduction of €6 million within current cost containment plans);
- Redeploy corporate staff to support and strengthen controls in the local sites including Finance; and
- Change the arrangements for attributing financial savings on early retirements on efficiency grounds. This could be an action locally although currently this results in the regional WTE ceiling and financial budget being withdrawn (estimated to approximately €6.8 million over 6 months).

However, even these actions may not be sufficient to close the financial deficit gap and possibly some of those actions already identified but which require a longer lead time to implement, need to be escalated. Examples of this could include:

- Reducing NCHD overtime by 4-7 hours per doctor through rota redesign (an estimated saving of approximately €4 million over 6 months);

- Maximising the collection of income by streamlining processes and the relationship with private health insurers (an estimated saving of approximately €3 million over 6 months);
- Increase in private patient income through improved management of existing beds (an estimated saving of €1.8 million)
- Closing community nursing unit and acute mental health beds (an estimated saving of €1 million);
- Developing a region-wide drugs formulary (an estimated saving of €0.8 million);
- Reducing nurse staffing levels to international benchmarks (an estimated saving of €0.6 million over 6 months);
- Reduction patient transport costs by 10% (an estimated saving of €0.5 million over 6 months);
- Implementing acute hospital and other service reconfigurations, not yet quantified but could release significant savings.

1.8 Implementation

Delivering the cost containment plans to achieve the savings to support breakeven by year end will be a significant challenge and require a clear accountability framework and dedicated resources to support the actions.

The RDO will be responsible for leading and coordinating the implementation of the actions and for performance managing organisations against the target savings set with the support and governance of the HSE West Regional Assurance Team. There will also need to be the full support of all HSE corporate functions to this task, including Finance, Human Resources and Communications.

At an organisational level, there will need to be the full engagement, support, accountability and leadership of senior management and clinicians from each organisation in HSE West.

Whilst there is no wish to over-centralise the control and management of local savings plans, non-routine purchases over a certain threshold e.g. €50k, would need to be signed off by the RDO.

1.9 Procurement

Procurement is a key area for significantly reducing costs by optimising critical mass and minimising variations in practice between organisations where the fundamental aim must be to harness 'subject-matter expertise' and exploit critical mass in purchasing power and logistics across all supply functions.

At present, the supplies and procurement resources in HSE West are dispersed between individual organisations in HSE West and the HSE Procurement Directorate – all, however, are part of the same organisation, the HSE.

To optimise 'subject-matter expertise', which may reside in either an individual organisation or in the Procurement Directorate, all current supplies and procurement resources and personnel across HSE West should be 'professionally aligned' with the Procurement Directorate, which is responsible for policy and strategy across the HSE for servicing, contracting, logistics and inventory. 'Aligning' professional expertise and resources in this way to deliver significant increases in efficiency will involve changing the reporting relationship of supplies managers and procurement staff on professional lines with the Procurement Directorate but still maintaining local accountability to local management – this is not about structural change, there is no time for this – it should be about consolidating expertise.

Local initiatives will continue to be pursued along with national programmes, and there needs to be complete transparency of national and local prices so that industrial scale benefits can apply across the whole HSE.

'Aligning' resources in this way will mean that the HSE Procurement Directorate will be responsible for delivering the procurement, logistics and inventory savings in 2010 and in full year terms.