The hospital is dead, long live the hospital

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The hospital is dead, long live the hospital: Sustainable English NHS hospitals in the modern world

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The hospital is dead, long live the hospital
Executive summary

The financial pressure facing the NHS is unprecedented. Over the course of this Parliament the health service must deliver £20 billion of efficiency savings. With 50 per cent of the health budget spent in hospitals, NHS hospital trusts are in the front line in the drive to achieve more for less.

Cutting costs in hospital services means that services need to be transformed, with fewer beds, smaller wards and in some instances complete conversions of the way in which hospitals work. The financial pressures on hospitals are not a short term problem. Some hospitals have been facing difficulties for years, often associated with the delivery of poor quality care, and a growing number will become financially unviable.

Over the course of this Parliament as many as 40 hospitals may have to change radically or close. Currently, hospital failure is averted by granting a variety of forms of interim financial support, yet if the Government is to continue to protect all of England’s hospitals from closure or reconfiguration then this “inefficient hospital fund” could grow to as much as £8 billion. This would mean that the Chancellor would have to find an extra £5 billion to bailout the NHS by 2013.

It is not only financial pressures that are causing hospitals to change. Changing health needs and the challenges of managing care for people with long term conditions make it imperative to develop new health services. Alongside hospital turnarounds to ensure affordable high quality healthcare, integrated care services will have to be organized around patients outside the hospital settings. Integrated care demands that more services are delivered in the community and home, harnessing the potential of modern medicine and the latest technologies.

NHS hospitals currently try to be all things to all people and deliver every healthcare service to everyone. This is no longer clinically or financially sustainable and it holds the NHS back from delivering better, safer and higher quality care. To survive, hospitals need to change their business models. They should become either “solution shops”, which focus on diagnosing patients, or organize treatment efficiently and safely in a “factory” mode of production that delivers “valued added processes” for patients.

To some extent, these modern organisations already exist in the NHS and across the world in emerging economies and more developed countries. But if the NHS is to deliver outcomes that are among the best in the world and remain affordable, all hospitals will have to change the services they offer to patients.

When passed, the Health and Social Care Bill will create more pressures on hospitals to change, through stronger commissioning and extended patient choice. Yet politicians of all parties are still reluctant to support hospital conversion. The Government’s pledge to protect hospitals and create additional barriers to redesigning local services will make it harder for the NHS to deliver £20 billion in savings and maintain quality care.

Key ways in which national policy can support the emergence of better models of healthcare delivery in England include:

- No bailout for the NHS: the learnt behaviour in the NHS is that the Chancellor will always find more money to avoid the embarrassment of a hospital closure. This weakens the case for change for NHS leaders and confuses the incentives for all in the system. For hospitals to change they cannot believe the Government will bail them out.

- Better commissioning: commissioners acting on behalf of patients should disinvest in expensive and poor quality acute services and instead invest more resources in primary and community care, forcing incumbent hospitals to change the services they provide or go out of business.

- Intensify market pressures: greater patient choice and new providers will create real incentives for NHS hospitals and other service providers to modernise in order to deliver better services at a lower cost.

- Failure regime: the Government must set out a clear, transparent and enforceable failure regime for hospitals. This will force hospital leaders to change their business models and empower other organisations to intervene and turn around failed institutions.
Preface

The title of the pamphlet comes from the need for continuity that existed within the English state at the time of a constitutional monarchy. The only way in which the nation could cope with the traumatic change that came about when a monarch died was to recognize that even at the moment of great discontinuity, the state would ensure continuity. The relief given by the existence of the new monarch at the moment of the death of the old allowed the nation to cope with the trauma of change.

In modern times, the public experiences similar trauma and emotions when a hospital is threatened with change, and can be similar to the slogan for the constitutional monarch: it is very difficult that the old is going, but let’s not despair! The new is here now and will continue to serve.

Our pamphlet argues that the old model and concept of the hospital are failing. The next few years will be very hard and hospitals will probably have to change or disappear completely. But do not fear: the new model of healthcare will provide better, safer healthcare and will relieve more pain and distress. But it will be new and the old will have to go.

We publish this at a time when the trauma of the new in the NHS is a political issue that has moved beyond the Westminster square mile. It has moved into people’s hearts and homes and it is difficult for people to see how things could be different and even better than the NHS they cherish.

What is interesting is the core message of this pamphlet, that if NHS hospitals want to be sustainable as long term institutions they will have to change radically, has been absent from nearly all of this political discourse. There may be a lot of discussion about reform, but there has been very little discussion about the main part of the NHS that will need reform – the hospital. One of the reasons why Governments have not tackled this core issue head on is that, however radical a Government wants to be in reforming the NHS, they are frightened of interfering in the public’s relationship with its hospitals.

This pamphlet argues that unless leadership is developed to update the models which hospitals use to organise their services and their business, many of them will continue to disintegrate as places that provide sustainable modern and efficient health services.

We suggest in our conclusion that the Government reform programme could play a role in bringing this about. As things stand, approximately 20 to 30 acute hospital trusts will never become Foundation Trusts. It is also conceivable that about 10 hospitals who have made that status will struggle to maintain that position over time. This means that in the next four years a minimum of 40 hospitals will have to go through a fairly radical transformation process because their current clinical and economic model is not sustainable. At the other end of the scale, the leadership of some of the very good and the best hospitals will recognise that, from a position of strength, they need to radically change their model of operation to fit in with the new demands of a modern health service.

Whilst the Government’s reforms may be silent on the radical changes to NHS hospitals that are needed, if hospitals are to thrive within the lifetime of this Parliament these changes will need to happen. National political leadership could enable this change in a transformative way. But even without that national leadership, hospital transformation and conversion will still take place.
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Introduction: Why are hospitals so hard to change?

In the current healthcare delivery model, the hospital is the enduring symbol of medical organisation. As a consequence hospitals lead to the arousal of strong emotions. For the public, being near a hospital provides them with the security of a modern health service that can save their lives when nearly all hope is lost. That is why the local hospital matters so much to so many people. It is at most a matter of life and death and at the very least, easy access to health care. We have come to expect our hospitals to be able to do every single thing that we want from a healthcare system. This has left most general hospitals trying to succeed by offering everything to everybody, making them amongst the most complex organisations in our society.

- We expect them to do everything they have always done.
- We expect them to do the most advanced medical things in the world.
- We expect them to do all of these things in one place.
- We expect them to be able to treat our individual problems with the same simplicity that we are treated with when we go to an organisation that only has to deal with one thing.

Then we attack the NHS for being inefficient.

- We rightly complain when a doctor that is taking our outpatient clinic gets called away to carry out a specialist operation.
- We complain when a cold spell means that the beds are suddenly full of people who have broken bones as they have fallen over, and we again quite rightly complain when that gets in the way of having a blood test.

This pamphlet raises the question of why the public want hospitals to be static islands of organisational continuity in a sea of change. In fact, because hospitals have not been allowed to change fast enough, many of them are now under greater threat than before. The more we try and prevent hospitals from changing, the more we are condemning the hospital to becoming obsolete in the future. The more we try and prevent hospitals from changing, the more we are condemning the hospital to becoming obsolete in the future. In this area, conservatism will prove fatal. Unlike most other organisations, hospitals make the offer to the public that they will succeed in doing everything for everybody. Because they try and do everything for everybody, the organisations have become used to having massive overheads. In most areas of service those organisations that can make specific offers to specific groups of people or customers reduce their overheads so that they become an integral part of their core business.

But if you pretend to do everything for everybody you will struggle to achieve the efficiencies that arise from the division of labour. It is these overheads layered over every activity which renders hospitals such complex institutions and makes it more difficult for them to thrive in a challenged environment. This pamphlet suggests that within this model there is a lot that can be done to improve efficiency and value for money. But it also suggests that if every hospital continues within the current model, many hospitals will find it impossible to survive.

Most healthcare systems, including the English NHS, think they face unique problems. In fact, many of the problems of change in NHS hospitals are faced by healthcare systems in all developed countries. The title of this pamphlet could be equally applied to the hospitals of Australia, France, and the United States, as well as England.

We claim that the only way hospitals can become sustainable with their current business model will be for the Government to divert considerable amounts of resources to hospitals in order to keep them operating inefficiently. Given the fiscal crisis the money required to keep hospitals operating in an inefficient business model simply does not exist today and will almost inevitably not exist in the future. This increase in demand for NHS healthcare will not be met with an equivalent increase in resource. We are therefore arguing two things.
First, along with nearly everyone else in healthcare we think that a lot of healthcare activity that takes place in hospitals will move out into the community and even into the home. Different settings of care delivery will not attract the level of overheads that hospitals are faced with. There are some estimates that, at any one time, 60 per cent of patients in hospitals should not be there. If this is reduced by even a third there will be a significant loss of income. Unless there are other changes, this has the potential to bankrupt many hospitals.

Second, we are arguing that the core functions of the hospital must be streamlined. At the moment there are several very different organisational and business models within one organisation, all falling over each other and competing for scarce resources. We will articulate how we believe this can be done and what can be achieved with strong and decisive leadership.

Our message, then, is one of belief in the capacity of NHS hospitals to change rather than to succeed in resisting change. This will be very hard and political leadership would make it much easier. With or without that leadership, this will have to happen if the NHS is to thrive.
Hospitals – the core of healthcare?

Hospitals in Western societies represent the core of healthcare for their population. People are born in hospitals every day, and many (too many) die in hospitals too.

The main difference over the centuries is that where they were once recognised as the place to die, hospitals are now seen as the centre for medical treatment, cure and healthcare. This change in role comes from the dramatic medical advancements that have been made in the healthcare sector. The number of hospitals has increased dramatically and now there is a medical institution in every county – creating the experience that everyone expects of a local hospital.¹

The rise of the modern hospital

The modern hospital has three major functions: emergency treatments, elective surgery, and outpatient consultations. These are radically different activities but we treat the fact that hospitals do them all together as straightforward. We expect that these very different aspects of healthcare are brought together into one building. The core of our argument is that pretending that one institution can do everything for everybody has created a jumble of different activities that cause different aspects of healthcare to trip over each other as they compete for resources.

Each of these three main functions has different economic and clinical characteristics.² The advent of orthopaedic surgery in children’s hospitals towards the end of the 19th century brought the modern into the otherwise traditional form of hospitals.³ The successes in the hospitals led to a sense of professionalism on the part of the physicians. The doctors started defining patients according to their diseases rather than their social class or any other discriminatory element.

After the Second World War, the health threats changed. Epidemics were replaced by debilitative diseases.⁴ The rapid scientific advances in medicine helped cure these diseases to a great extent. The world saw the first successful kidney transplant in 1954, which led to a culture of “spare parts medicine”.⁵ By 1970, the world had witnessed a heart transplant and a liver transplant and in more recent years has seen face transplants.⁶

National hospital service

The other major change in the hospital system in the UK was caused by politics. In the mid-20th century the advent of the National Health Service laid the foundation for the next 60 years of transformation. The NHS took over 1,143 voluntary and 1,545 municipal hospitals in England and Wales in 1948.⁷ The NHS is based on central taxation with the public paying for medical services as taxpayers, and this more than anything ensured that there would be sufficient investment for a rational development of hospitals. With this change, the doctors took the roles of public servants and the people started to feel much greater medical safety.

Over the first two decades after coming to existence, the NHS produced numerous reports that altered clinical practice. Committees and advisory councils were the main decision-making bodies and the ministry distanced itself from the running of the hospitals.⁸ Although there were not enough resources to build new hospitals soon after the war, the number of hospitals subsequently rose over the years and the number of cases treated every year increased.

The 1960s saw a lot of developmental money being put into the construction of new hospitals.⁹ By the end of the decade, people were living longer and the major causes of death had changed. The advances in technology changed the face of medical practice and there was an increase in sub-specialisation. The

¹ Granshaw, L. and A. Wear (1992), The rise of the modern hospital in Britain.
³ Granshaw, L. and A. Wear (1992), The rise of the modern hospital in Britain.
⁴ Ibid.
⁵ Ibid.
⁶ Ibid.
⁹ Ibid. Also see, Maybin, J. The reconfiguration of hospital services in England, The King’s Fund.
modern hospital saw ever more complex cases with imaging and diagnostic techniques being employed and
the advent of numerous new drugs and highly meticulous surgeries.\textsuperscript{10}

The number of doctors started growing as did the number of patients. The hospitals started working harder
and the patients were being discharged earlier than ever before. The patients began looking at the hospitals
as places where miracles could take place.\textsuperscript{11}

With the growing advances in the medical field, the political control of the government also affected the
hospitals. The modern management process was experienced by the NHS in the 1980s following the
Griffiths Report.\textsuperscript{12} General Managers were appointed to take care of the functioning of subjective areas.
Clinicians were directly involved in management as well. The National Health Services and Community Act
of 1990 saw the introduction of internal market in the NHS whereby the health authorities stopped
operating the hospitals and purchased care from their own hospitals and hospitals run by other
authorities.\textsuperscript{13} This led to the practitioners becoming fund holders who purchased care for their patients. The
providers, on the other hand, turned into independent trusts. The increasing advances in the techniques
and other technical developments have led to the problems of hospital finance and viability that has
resulted in the hospitals continuously depending upon additional funding.

Hospitals at the core
Every government since the conception of NHS has re-invoked its basic principles. There has been a strong
developmental force leading the NHS along with continuous structural changes. Plamping has suggested
that the people intrinsically associated with the NHS have not wanted the organisation to be different, thus
harvesting a culture of continuity.\textsuperscript{14} Change is not possible by the strategic organisational plans hatched at
the centre as the government does not have much influence on the working of the professionals inside the
institutions. There is a need to look into the guiding principles of the NHS and change them so that the
change can be brought from within, not without.

In most communities hospitals are very important parts of the local economy. They are often the biggest
local employer of highly skilled, skilled and unskilled labour. Whilst trades unionism has lost a lot of its
strength in private sector institutions, within the NHS, and in particular in hospitals, it has remained very
strong in most different parts of the workforce. Thus there are very strong vested interests that resist local
change and limit what a hospital can change and achieve. Since the unions are most powerfully organised at
a national level, they also play a role in protecting the interests of their members at that level too. This
enables them to act as a conservative force both on national and local policy.

It is not possible to change the models of delivery of NHS hospitals without fully engaging with the national
and local vested interests of the entire workforce local and national leadership.

\textsuperscript{10} Granshaw, L. (1999) \textit{The Hospital in History}
\textsuperscript{11} Stern, B. (1970), \textit{Society and Medical Progress}.
\textsuperscript{12} Davidman, M. (1985), \textit{Reorganising the National Health Service: An evaluation of the Griffiths Report}.
The last century has seen innumerable advances in the medical fields and the standard of healthcare has improved tremendously. Because of the rapidity of change in medical technology and the overall processes of care, the set of procedures in hospitals needs to change constantly. When one change happens in the process of care this will have a big impact upon that part of the care pathway, but the rest of the pathway will be going on as before. In 2006, for example, most NHS hospitals in London had started to use digital X-rays. This allowed the imaging part of all care pathways to be carried out much more quickly and the images could be moved around the NHS with great rapidity. However, the parts of the patient pathway either side of the imaging process did not change as rapidly, ensuring that the overall benefits of the new technology were not fully realised. Given the amount of technological change, it is necessary to look at the overall pathway and re-work it every time something new happens.

Take an analogy from another industry: whilst it may be necessary for Toyota to re-design its production line every six months to keep up with the changes in technology, the rapidity of change in hospitals means that hospitals probably need to do this every month. The rapid change in elements of the technology, and the inability to rework the healthcare production line as rapidly as possible, means that hospitals are seen as highly inefficient.

The oversupply of hospitals

In many urban areas there are numerous hospitals in the same geographic areas providing same or similar services, which have led to a duplication of effort and resource. The increasing number of hospitals has diluted the quality of care provided at the different hospitals around the country. While some hospitals have a record of poor service, others have a record of financial deficit, and many have issues related to both quality of care and finance. The problems facing the NHS are not new. At least ten hospitals were facing such concern in 2006, and the situation has just escalated since then. That year, hospitals in Surrey, Lancashire, London and Cornwall, among others, decided to terminate their emergency services. There is a clear need for rationalisation of services and planned change.

The workings of the NHS have been questioned and many health professionals have described some services as mediocre. Various agencies and think tanks have been accusing hospitals of providing mediocre services and improper use of resources, and there has been vigorous debate about demand and capacity. It seems we have now become inured to health regulators publishing reports showing very considerable variation in outputs and outcomes from different hospitals. This is curious, as in a life and death service such as the health service it should outrage the public that there is a five times better chance of being treated well in one NHS hospital versus another. But the public appear to now treat that as normal.

How did we lose the ambition and aspiration for universally excellent hospitals over the years?

This variation in the standards of service delivery coupled with financial problems in breaking even means that a considerable number of hospitals are under pressure. This pressure leads the local media in most parts of England to develop a regular set of stories about their local hospitals being in danger. The headlines warn that wards may close and services may be lost. As a result, the local population are quickly up in arms to save their hospital from closure. Most local politicians from all parties rally round and present petitions to lobby the Secretary of State and, sometimes with some few changes, the hospital is saved until the next scare and the next campaign, usually the next year. In some parts of the country there is a constant campaign against change and closure and some of these have been going on for 20 years.
All of this takes place in localities where nearly everything else has changed. Factories, indeed whole industries, have closed in shorter time spans. Banks have arrived, been taken over, failed and taken over again and their new branches have closed. Transport systems have developed and redeveloped. The face of retail and the high street shop is unrecognizable.

But the hospital must stay the same, apparently unchanging.

The hospital board and its current business model
The sustainability of a hospital heavily depends on its business model. The chief executive and board of the hospital are responsible for the successful operation of the institution.

Organisational failure in private organisations may be classified as the insolvency of a company. In the private sector, this could be a situation where the hospital is running short of funds or resources or is working on losses. This may or may not include issues of quality and clinical outcomes.

When hospitals are run wholly by the state, hospital failure is more difficult to explain. In the past, and indeed currently, where there are deficits in the NHS, additional funding has always been secured. The learnt behaviour in the NHS is that extra funding is always found from the Chancellor of the Exchequer to stop the politically embarrassing closure of the hospital. Therefore the expectation is either that the rest of the NHS will have substantial resources taken away from them, or taxation will be increased to pay for hospital inefficiency. However, in the next few years the fiscal crisis for public expenditure will probably limit the room for creating large scale hospital inefficiency funds.

Hospitals in the NHS are under four powerful sets of threats, each of which we will explore below.

We are seeing a set of disruptive innovations in each of these four areas that will shake the existing business model of the hospital.

Hospital finance at a time of financial squeeze
The funding system of the NHS hospitals is based on the payments that are generated according to the quantity of service provided by them. This system of payments – payment by results – was initially introduced to the NHS in an attempt to improve the efficiency and quality of service. The idea of their introduction was to incentivise hospitals to do more work and therefore to cut the waiting lists that had been a historic problem in the NHS. The hospitals got paid more if they did more work. Whilst this is hardly a revolutionary principle – indeed it is something that is normal in the rest of our society – it was new to the health service and from 2003-2011 has had a profound impact on the way in which the incentives have influenced the system.

The NHS uses national average prices for hospital procedures. The service payment system means that the hospitals will benefit by seeing more and more patients. Simply put, the hospitals get paid for the work they do rather than the results they achieve.

Consequently, the hospital is incentivised to find more sick people to secure more resources. The Nuffield Trust has established this fact by studying the increase in emergency admissions over time and has found that the clinical threshold for emergency admissions has decreased from the conventional levels: you no longer need to be as sick as you used to be to get an emergency bed in a hospital.

In a bid to generate more income, hospitals have begun targeting all possible ranges of patients to increase the services they provide. A gross result of the compartmentalisation of funding in the NHS structure is that whilst GP practices are not paid on a fee for service, hospitals are. In essence, the amount of money hospitals make is directly proportional to the number of people getting sick: a perverse yet accurate statistic. Consequently, we have a funding mechanism that encourages the most expensive organisations to deal with more people without there being a similar encouragement for the less expensive part of the NHS.

Internationally, other health services have incentives for reducing avoidable hospital admissions. In America, the Veteran’s Health Association has been using telehealth coupled with an individualised management approach for some time now. This approach has meant a 25 per cent and 20 per cent

23 House of Commons Health Select Committee (2006), NHS Deficits.
reduction in bed days and admissions respectively. This also resulted in an 85 per cent rating in patient satisfaction. The use of hospital beds in the NHS is over 50 per cent more than the standardised rate of bed use witnessed in Medicare in the United States.

The NHS has become used to using the expensive part of the healthcare system – the hospital. Given the financial pressure on the NHS it is almost inevitable that the NHS will try and reduce costs in the acute sector. This will lead to a significant challenge that most NHS hospitals are already starting to face in the financial year 2011/12. Hospitals will need to manage resources judiciously and more effectively. The management team as well as local administrators need to be financially literate regarding the organisational goals, and a definite business model has to guide that change towards a better future.

The care of people with long term conditions

About 70 per cent of the resources of the NHS are spent on the treatment of long term conditions. These, by their very definition, are conditions that people have for a long period of time. For most of them, once the person has the condition they have to learn to live with it for the rest of their lives.

One of the problems that emerges from the use of the current business model is that it is not meant to deal with long term conditions. The funding structure of the NHS has been constructed so that the GP practices do not get rewarded for providing efficient, preventative services to the patients. Rather, the payments are received by the hospitals as the patients become sicker. Consequently, in this type of healthcare system, there is a larger incentive to admit patients rather than to avoid admissions.

Long term conditions do not need a brief phase of treatment. They need a strong patient pathway. Patients with such conditions are in need of a business model that can help them to stick to their recommended therapies, which could be applicable for a short or a long period of time. A business model focussing on wellness that uses the current technologies and resources is required to disrupt the NHS.

Of the top eleven causes of hospital admissions, eight are long term conditions. The hospitals often fail in the on-going and coordinated support needed by patients. Community hospitals are constantly focussing on providing community care in a localised setting to the people in need of long time care. The shift of care from hospitals is being implemented by combining generalist and specialist services in the community. Placing an emphasis on self-care and community care, the hospitals are trying to reduce the acute hospital use. Personal care plans are another shift towards care outside the hospitals for people with long term conditions.

Some hospitals have built on the community care program, taking from the experience of various local and international innovations. The model for community care draws heavily from the chronic care model by Professor Wagner from Seattle and the “pyramid of care” developed by Kaiser Permanente, the US health provider.

Thus the community care model of NHS focuses on interaction between patients, healthcare providers, and community organisations in an effort to develop a better system of care; and distinction of patients with long term conditions according to their needs.

Given the increase in the numbers of people who will have a long term condition, the future of the NHS depends upon reducing the level of resources spent on each person with such a condition. This will need the development of services which assist the patient to maintain good health, rather than continuing to fund the emergency beds in hospitals that are the most expensive aspects of the NHS and are signs of failure in the patient pathway.

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30 See Reform (2011), Hospitals in the new health service, Reform.
31 Health Foundation (2011), Helping people help themselves.
33 Health Foundation (2011), Helping people help themselves.
35 Department of Health (2005), The national service framework for long term Conditions.
The development of integrated care
Integrated care will use the most modern distributed technology to deliver care. The uses of telecare and telehealth have been put into action to provide care for people with long term conditions in a local setting. Telehealth ensures remote delivery of care to patients, usually with long term conditions, in their own homes. The use of telecommunications and other computer-based systems make remote medical care possible. Fall sensors and other computer-operated alarms are used to monitor the unlikely events related to the conditions of the patients in order to help the hospitals to provide immediate care when required. Similarly, telehealth deals with the exchange of physiological data between the doctors or other medical professionals and the patient at home. Telehealth is primarily used for diagnosis but has also been regularly used in monitoring various conditions related to the conditions of the patients. Recorded data or real-time images are used for clinical inspection which may be required for prevention, diagnosis, or treatment of a disease.

The attitudes towards community care are slowly changing. However, there is much to be done in engaging the public with concepts such as hospital at home, self-care, and self-management.

The development of patient choice
The NHS has started to provide patients choice of hospital, specialist, and treatment. The effect of provider choice on quality and service development, coupled with patient equity and empowerment, has been thoroughly debated in the recent years. However patients like the option of choosing a provider and treatment of their choice.

The choice of secondary care providers for patients has generally been limited by referrals from GPs. Though choice has great potential to drive improvement in healthcare, choice of provider is still fairly limited. This relates more to elective surgery patients where GPs are still acting as decision makers on behalf of the patients. Even if the patient has choice, it usually pertains to the list of care providers allocated by the local primary care trusts. In times of financial stress, the response has been to limit choice rather than expand it.

Patients prioritise their particular choice of provider based on ease of access. The reputation of the service provider is only secondary when selecting a medical service. The third concern the patients have is waiting times. Patients often choose their providers according to the time they have to wait before they can receive the required care/service. Although patients usually choose to stay in the local hospitals due the ease of access, patients also claim that it is because of lack of proper information regarding other health institutions or service providers. There is a paradox in this choice of local care available to patients, as people tend to get confused between choosing to travel for better care and getting average care at a local service provider. And it can be argued that in order to save money people might choose to receive care at an insufficient medical care institution instead of travelling to a better institution, which may be detrimental towards their care.

The paradox of choice has created a market in healthcare where an effective relationship between choice, price, and payment is indispensable. A business model that provides that choice and improves the quality of service in a sustainable manner will be the requirement of NHS hospitals today and tomorrow.

All of these facts put daily pressure upon the current business model of the hospital. If it does not change it will break under these pressures.

39 Department of Health (2010), Liberating the NHS: Equity and Excellence.
Business models in healthcare

Within a hospital, the complicated organisation of numerous departments has to be managed according to a certain plan to avoid chaos and conflict. Running a hospital has to be a balance between the demand for very different sorts of healthcare. This is surrounded by social pressures for hospitals to be able to deliver all the possible services that the local population desires. It is just not possible for a single institution to meet this variety of needs and to survive without unlimited resources.

What is a business model?
Given that there are finite resources, one way of balancing these very different demands is to apply an appropriate business model to the organisation. What do we do in this hospital and how do we use the resources we have at our disposal to deliver what we do? This approach is used by the hospitals to cater to demand in the most efficient way while keeping the resources of the organisation in perspective. den Braber has defined the business model as “an approach that balances the inside-out views of strategy (based on the resources an organisation has) with the outside-in views of strategy (what the competition offers and customers demand).”

A business model needs to be effective and coherent. Business models are strategic models that explain how organisations create the resources to do their business. The main function of the business model is to provide resource solutions for problems, sometimes even before the need arises. The business model helps hospitals to realise the amount of resources available. It also offers an appropriate way of allocating those resources according to demand in the most efficient manner. A good business model maintains a balance between the elements of demand and supply. When the entire process is integrated, starting from admission and ending at discharge, the hospitals can work at substantially lower costs and higher levels of quality.

Much of the application of the idea of business models to the hospital has been developed by the leading US innovation expert Clayton Christensen. He explains how a business needs to be specific:

“Every viable business model starts with a value proposition – a product or service that helps customers do more effectively, affordably and conveniently a job that they have been trying to do ‘We will do everything for everybody’ has never been a viable value proposition for any successful business model that we know of – and yet that is the value proposition manager and directors of general hospitals feel they are obliged to put forth.”

In the private sector, business models are a very efficient means of evaluating the circumstances to find the strategic choice by linking the various strategic domains. A private sector organisation that fails to stick to its business model and starts to carry out activities that are not aimed at its customers, gets into trouble.

The focus of a good business model covers the whole business. So whilst it will be very interested in customer demand for the product, it will also be interested in how that product can be delivered at the best cost and how the wider stakeholders can be recognised as a part of the process. The bottom line for a private sector business model is not simply profit – it recognises the full range of domains to provide appropriate business logic.

The value proposition
The most important component of a business model for the hospitals is the value proposition. How does the hospital provide value for healthcare and how, when that value is created, is that value compensated for. It may seem obvious to say it, but if one hospital creates more value than another, it should receive more resources because it is in a better position to turn resources into value. But up until the development of a tariff in England that was not the case for hospitals. Their income had no real relationship to any conception of the value they created.

The value that is produced by healthcare comes from a combination of clinical outcomes and patient experience. If we have millions of resources per hospital, and one hospital produces a better clinical...
outcome and patient experience than another, then the first hospital produces more value for the same money. If the NHS as a whole wants to thrive, the hospital that produces the better value needs to get more resource so that the public get better value.

Similarly, the hospital that produces less value for the same resources has to find a way of improving its value proposition and this involves a lot of change.

Hospital services that create value are broadly categorised into two phases – diagnosis and treatment. The problem for modern hospitals is that these two very different categories of activity themselves contain a wide range of different service lines. The core of our argument is that, given the variety and complexity of modern medicine, it is probably not possible to find a viable business model that takes care of both the aspects of the full range of diagnosis and the full range of treatment in the one organisation.

These two aspects of what hospitals do lead to two very different business models that currently are used in the hospitals – the solution-shop hospital and value-adding process hospital.  

**Focusing on diagnosis**
The first model springs from the experience that used to be much more common in health services, namely that you have something wrong with you and we do not know what it is. Patients are referred from their GPs to hospital with an understanding that they are clearly ill, but what they have and the extent to which they have it is unknown. The job of the hospital is to find out or diagnose the problem. This model of hospital business emphasises the diagnostic activities within a hospital. This needs a wide range of resources – usually expensive diagnostic equipment, kit, and medical and research staff, not only with a high range of skills but with skills in the uncertainties of medicine. The end result could be a simple treatment that comes from days and days of diagnosis and scientific problem-solving and analysis.

Institutions could be organised to develop and exploit this business model. The problem for hospitals is that such an organisation would be very different from what would be necessary for the other business model that thrives in current hospitals.

**Focusing on treatment**
The second model starts with a very different relationship with the patient. The hospital knows exactly what is wrong with the patient and needs to organise treatment for that patient as safely and as efficiently as possible. This has the hospital creating a series of value-adding processes within the hospital. By and large this involves a simple surgery or therapy mechanism that the hospital carries out hundreds or thousands of times a month.

There are two different ways in which these two business models add value to the nation’s healthcare. For example, if we do not know what is wrong with a patient, how many diagnoses will be needed before any value is created? How much time will be needed with an intuitive doctor before the diagnosis is delivered? It is impossible to know, so the payment needs to be around an outcome with a particular fee for that service. Very differently, the value adding services are usually based on the outcomes. We know what is wrong with you when you come in and we organise the service you need on that basis. You then fit in to the slot that has been prepared for you and if the procedure is delivered correctly for a person of your age and morbidity then you leave within a certain time. You are part of a service line that involves doing this to thousands of people and we make our surplus out of going for volume and making value out of that volume. Paying for this service on a fee-for-service makes sense to the provider.

Overall the business model for a hospital functions on the basis of service-for-demand; that is there are more procedures for a greater number of diagnosed sick people coming to hospital. If correctly applied this model can be beneficial for the NHS through the delivery of economies of scale. The current problem is that nearly all hospitals try and carry out both of these models within the single organisation and typically they get in each other’s way, tripping over each other every hour of every day. No single hospital can with safety and efficiency employ two different business models within the same operating unit. Trying to do so can create organisational and clinical incoherence as the models have very different processes. The models work on different business formulas and make profits or losses in different ways.

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The hospital is dead, long live the hospital

How do NHS hospitals develop brand new business models?

Different services and industries are littered with organisations that faltered because they did not keep up with this change. When companies such as IBM and Microsoft fail to move forward or do not move fast enough, the communications industry moves forward with others. Facebook and Twitter do so. Apple and Google are two companies that recovered from the verge of disaster by dramatically changing their business models.

In their earlier days, Google had a very important search engine but there was no source of revenue linked with their service even though it was being used millions of times a day. When there was no stable source of revenue, Google started with selling search appliances and search technologies to other companies in the same markets. This changed in 2003 when Google launched AdWords a program that allowed various businesses to advertise. It catered to the people that would search for various things on Google.com. The company reported revenue of $21 billion in advertising alone in the year 2008. The new business model that focused on lending the core service of Google to advertisers proved to be highly beneficial.

This is a good example of a new business model since it looks at a way in which the core product of the old business model can be used to develop revenue for the organisation.

Disruptive innovation
This act of introducing a new business model to improve the conditions of a business is known as disruptive innovation. All of the new products outlined above were introduced in such a way as to disrupt the way in which the previous industry worked. Disruptive innovation can be understood as any improvement that enhances a service in an unprecedented manner in the market. Many companies resist innovation and fail due to a relentless application of old behaviour. Businesses are required to focus on the target market in order to apply disruptive innovation. The basic requirements of the consumers have to be identified and changed. The requirements that are introduced as innovations at a given time become a necessity after some time.

Old business models may stop providing the necessary benefits to the company as they work in a given frame of time. Old business models create an environment that may inhibit the new business models and even repulse them.

The NHS is facing increasing challenges and there is a dire need for new business models and the disruptive innovation that creates them. There is a need for a business model that improves the quality of care, copes with the increase in the demand of care, employs new effective technology, and finds a solution to the financial challenges that the NHS faces.

Resisting disruption
The NHS is applying the logic that other major services have used, yet the very language that other services and industries use is problematic within the NHS. We can intellectually agree that a “disruptive innovation” is necessary to change the way in which a service works but the language causes problems within the NHS. The notion of welcoming disruption for the NHS is not an easy one. The NHS and most who work in it believes that it needs stability to carry out its work and therefore it organises strongly against any major disruption. It will take some brave people within the NHS to argue for the necessity of disruption above stability and then to help organise that disruptive innovation.

Disruptive innovation is about making complicated and expensive activities simpler and affordable for an organisation. Technology helps in combining the various inputs of staff and machinery to convert it into something that is valuable to the consumer.

54 Ibid.
55 Reform (2011), A lot more for a lot less: disruptive innovation in healthcare, Reform.
56 Ibid.
Most studies of innovation show that many of the innovative business models are formulated outside of the existing institutions from new organisations that are free to think up new models.\(^{57}\) The start-ups do not need to refer to the old models and take bold steps in achieving what they intend to. The new company has to think about building quality and achieving profit rather than sustaining quality or increasing the profit.

If you are an existing provider – as all NHS hospitals are, developing a new business model within your existing organisation is very hard. The leadership of the organisation needs to create an environment that invokes new ideas. The leaders need “to put the elements in place that will make business model innovation not a periodic, dramatic upheaval but a regular corporate capability – one that occupies the focused attention of a small group of people full-time, rather than the part-time attention of a large group of people only in times of crisis”.\(^{58}\)

**Developing new business models in NHS hospitals**

How would this process work for NHS hospitals? First, it needs to start with a frank honesty in discussion with the public and their expectations of what hospitals can provide. However at the moment because the NHS has ducked this discussion with the public about what hospitals do, the public has the idea that every hospital will provide every patient with everything.

This will be made much easier for the hospital leadership if there is some clear political leadership making the case for radical change. Before you can persuade the public that something new needs to happen you must persuade them that a part of what is the old system is not working.

The NHS has historically had a poor track record in discussing options with the public.\(^{59}\) Too often NHS managers have been believed that the public will always defend the status quo. Given this anxiety from NHS managers, change is usually hidden from the public until the very last minute. The public then react with some fury to being excluded.

The new business model is based upon the need for a fresh customer value proposition and this creates the blueprints for the business model. How will this organisation create better health outcomes plus better patient experience for the same or less resource?

A new business model for an acute trust must identify a novel value from a novel source. In many other industries new value is uncovered through working in different ways with customers.\(^{60}\) The same will be true of health. Patients have the possibility of adding very considerable value to the healthcare that they receive from a hospital. If they were to be encouraged into the value creation activities of medical staff, their kit and drugs, this would have a dramatic impact on how the value of health outcomes could be constructed.\(^{61}\)

The difficult issue for the hospital board is that the hospital needs to be disrupted by the new model. It needs to stop doing what it has done and develop new ways into the market of sickness. Yet often in the very recent past the same board has been congratulating the organisation with success criteria from the old business model. The future demands that the organisation cede market share to the new disruptive business models, patient by patient, disease by disease, starting at the simplest end of the spectrum of disorders that they now serve.\(^{62}\)

The main business of healthcare that needs to be reworked is the business of long term conditions, especially if about 70 per cent of the NHS resource is spent on the over 15 million people who are suffering from such conditions.\(^{63}\) For a hospital to thrive a major part of any new business model will depend upon developing new ways for working with people with long term conditions. The technologies should help transform care for patients with long term conditions so that maintaining wellness is the main objective, not treating diseases. This disruption is central to the vision of an improved and reformed NHS.

\(^{57}\) Christensen, C. et al (2009), The Innovator’s Prescription: A disruptive solution for health care.


\(^{59}\) Reform (2011), Clinical commissioning and integrated care, Reform.

\(^{60}\) Christensen, C. (1997), The Innovator’s Dilemma: When new technologies cause great firms to fail.

\(^{61}\) Reform (2011), A lot more for a lot less: disruptive innovation in healthcare, Reform.


\(^{63}\) Department of Health (2011) dh.gov.uk
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Implementing brand new business models

The NHS is not bad at innovating. But it is bad at diffusing that innovation. There are very small patches of good ideas but they are not embedded because they do not have to be broadly embedded. In other services the failure to keep up with the very latest set of ideas clearly leads to organisational failure. This means that in those environments all organisations, if they want to survive, have to look for innovation.

Internal ventures
In these other services the success of an organisation or firm that creates new business models is based on a collection of incremental and disruptive innovations. Different companies adopt different business models like acquisitions, internal and joint ventures. The internal ventures are distinct structures that are developed to implement routines or practices that are novel to the organisation. This places the responsibility to drive the new business model on a specific part of the old organisation. The board are deliberately setting one part of the organisation up to champion the new. It may be a separate division or an individual project within the organisation. It can also be a physically separate division located away from the rest of the organisation. These objectives may not even be in the line of function with the rest of the organisation. Internal ventures are usually used unilaterally to commercialise novel and unique technology.

Joint ventures
NHS organisations are in a good position to develop such an organisational structure. But it needs a stability of senior management to see this through. In the NHS even the most senior hospital managers hold office for less than two years. This period of time is too short to implement such changes. Joint ventures are relationships formed between organisations. There can be one or more partners that let the primary or the founding organisation gain access to the knowledge of the partners in a mutually beneficial setting. Developing a new business model with an external organisation provides the host with the opportunity of bringing in brand new skills to rework the organisation. When an organisation is not able to achieve new technological advances or willing to take the risk of developing technologies themselves, they usually engage in joint ventures. The new joint venture can then develop technologies and commercialise them with the help of the unique skills and capabilities of each organisation. After the relationship between the various partners is completely established, new policies and routines are put into place in pursuit of the specific objectives that drive the venture. The NHS can easily transfer the financial risk by using this approach. Depending upon the design of the venture and the role of each partner, the financial burden could be taken off NHS and shared by the partners. Joint ventures can also be really helpful in working on technological advances and improving patient care services.

Acquisitions
While joint ventures may be a way forward, acquisitions can also be an option. Acquisitions are separate organisational structures that have already been exploiting those technologies. The acquisition helps the originating organisation to gain access to new technologies all together and various novel and tested ways of using and implementing the technologies. This type of organisation structure can be very beneficial but there are certain shortcomings. As with the internal ventures, acquisitions prove to be a problem in terms of a conflict between the culture of NHS and the acquisition where the culture seems to dominate the created organisation.

The new business model has to concentrate on new value from a totally new source. This cannot be achieved overnight and the process of advancement has to be nurtured overtime to bring in a successful change. The NHS needs to consider the payment for service mechanism and that patients can be a possible source of value. The patients need to provide value to the system by developing greater activity working with their healthcare as happens in some other industries.

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64 Reform (2011), A lot more for a lot less: disruptive innovation in healthcare, Reform.
68 Reform (2011), A lot more for a lot less: disruptive innovation in healthcare, Reform.
The new hospitals

Any NHS hospital board that recognises the need to develop a new business model will need to fully understand their own situation both now and for the next 10 or 20 years.

Hospitals for patients
First the new model for healthcare must start and continue with the full involvement of the public and patients. If anyone wanting to improve the health services of the hospital who does not engage the public from the very beginning will have a very serious reaction against any change. The public will need to believe the case for change before they agree to any change at all and in some instances may still disagree.

The NHS is used to seeing the patients as uniformly resistant to change. Every senior NHS manager has a long war story of attempted change, that which has been in the trenches against the public and their representatives for decades. But not all public organisations are against change. The major patient groups that organise patients with long term conditions have been arguing for progressive change for some time. In September 2010 these arguments crystallised in a pamphlet called How to deliver high quality, patient centred, cost effective care: Consensus solutions from the voluntary sector.

This pamphlet was produced by the ten major patient groups across the different conditions, and throughout it argues for moving patient care outside of hospitals. This was published by The King’s Fund and is full of real life examples of how care could and should be moved out of hospitals.

To develop a new business model for a hospital, NHS leaders must start by talking to these organisations about the new patient pathways. The hospital leaders and the patient organisations must agree that the hospital cannot provide everything for everybody. This is the most difficult part of the discussion with the public because they are made anxious about the fact that their local hospital will not be providing all services going forward. The truth is no single hospital is providing everything for everybody. There is already a great deal of specialisation and the necessity of moving patients around at different parts of the patient pathway. It is vital that the hospital demonstrates that while developing one speciality other providers will deliver different services.

The solution shop
Solution shops are hospitals for patients who enter not knowing what is wrong with them. This starts by recognising that if a hospital organises diagnosis around series of sequential interventions, moving the patient between department after department, this not only takes time and wastes resources, but it can mean that the necessary joint set of skills are not brought together to develop a solution.

The Cleveland Clinic in Ohio is considered a good example of a hospital that has disintegrated its traditional departments and re-organised around disease groups. The colorectal surgeons in the gastrointestinal discipline of the clinic now work alongside gastroenterologists, bringing together medical and surgical expertise around a disease area. Similarly, they have a number of different solution shops, cardiovascular being another example. There is a solution shop for neurology and psychiatry that has numerous neurologists, neurosurgeons and psychiatrists working together in an integrated way to optimize the service in terms of better diagnosis and more effective therapeutic outcome.

Innovation in electronic medical records systems is one factor that keeps Cleveland Clinic at the top of the pack. At the heart of these innovations is their multidimensional database management. All patient data is consolidated in an electronic medical record (EMR). More than just a convenience, the EMR helps improve the quality of care. As C. Martin Harris, the Chief Information Officer, has put it: "Patients who can access information from their own EMR are empowered with more control over their individual healthcare. They become active partners in care delivery, and communication between providers and patients is significantly improved." At the same time, the EMR has improved productivity significantly for the physicians and staff members, who can access the system across a network supporting more than 8,000 concurrent users in the central hospital and multiple remote medical facilities. According to Harris: “The primary benefit is that we have the ability to manage all of our data – administrative as well as clinical – from a single database.”

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70 The King’s Fund (2010), How to deliver high quality, patient centred, cost effective care: Consensus solutions from the voluntary sector.
72 InterSystems (2011), “Cleveland Clinic uses caché to improve doctor-patient communication”, intersystem.com
73 Ibid.
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The Mayo Clinic has similar characteristics. All the patients have to go through various solution shops with various specialists and procedures. These procedures and specialists coupled with the relevant technology are interconnected with other specialties to create an environment of efficient medical service by providing the best possible diagnosis in the minimum time and at the minimum cost with maximum results. After the diagnosis, the patients are informed about their situation and advised to either go to the value-adding process institution to get treated or some other organisation. If the patients tend to use the value-adding service, they are charged on a fee-for-outcome basis. The patients have a greater choice in this respect and the service is highly satisfactory and less time consuming.

Integrated solution shops
The solution shops have been very effective in the institutions that have adopted them. An intricately integrated solution shop can readily tackle all the problems of the present and near future. These integrated solution shops work more effectively than disjointed solution shops as the former can concentrate on more than one system in a body. This ensures better diagnosis of an ailment and lets clinicians study the problem from the core perspective, which may be an interdependent intersection of two or more vital systems of the human body. Focussing on one of the systems cannot heal the multi-faceted nature of the disease. The integrated nature of the disease needs an integrated healthcare solution.

Coherent solution shops are in a position to charge fee-for-service rates that cover the cost of the services and also reflect the value of the hospital’s work. The reimbursement formulas prevalent in the current healthcare system constrain and distort this. Care is based on intuitive medicine and will continue to do so for the time being as most of the learning in this field takes place from the feedback from the treatment decisions. Thus, diagnosis and therapy in focussed solution shops have to be the same and this puts the patients in the care of a complete and competent team. Subsequently, on the other hand, the organisational structure of the prevalent general hospitals, with disjointed departments of specialty care, means that individuals seeking care are left in the care of individuals.

The solution shops within a general hospital are set to tackle any disorder concerning any part of the body. To get ahead of the curve, NHS hospitals would need to have one of every type of diagnostic equipment and one consultant (minimum) from every subspecialty in every general hospital. This is not financially sustainable or clinically viable.

The factory mode of production
Christensen’s alternative business model is the value added model. This model starts with a clear diagnosis and prognosis of what is wrong with the patient. The problem for the hospital here is to organise the care in such a way as to construct a safe, efficient production line which develops the best possible value for money. A great deal of hospital care can be organised this way.

This model needs to focus on building better surgical centres and creating competency and quality of experience for the patients in terms of various high-volume procedures. It focuses on improving the clinical practice in order to ascertain better outcomes from treatment for particular conditions.

The NHS has begun to move in this direction and the productivity and improved outcome of these interventions has already had an impact. However such parts of hospitals are usually not as ruthlessly separated from the rest of the hospital as they need to be.

One of the best examples of where this happens at the moment is the South West London Orthopaedic Centre.

South West London Elective Orthopaedic Centre
The Elective Orthopaedic Centre (EOC) was created through the partnership of four acute Trusts: Epsom and St Helier University Hospitals NHS Trust, Kingston Hospital NHS Trust, Croydon Health Services NHS Trust (previously known as Mayday) and St George’s Healthcare NHS Trust.

For the fourth consecutive year (2009/10), the centre has carried out the largest recorded volume of joint replacements in the UK and stands as one of the largest hip and knee replacement centers in Europe.
date, the EOC has treated around 14,000 patients with the almost unique accolade of a zero MRSA cross contamination rate. Through the combined experience of 28 consultant orthopaedic surgeons, the EOC is able to draw upon a considerable diversity of knowledge and experience.

The EOC’s pathways reduce costs and increase throughput through its state of art surgical facility. Operating theatres are used to near maximum capacity and with slot utilisation at 98 per cent throughout the year. Therefore with demand rising and utilisation high, the EOC has embarked on the commissioning of a fifth operating theatre to complement its four existing theatre suites.

Outcomes data has shown that the EOC has the lowest complication rate for hip and knee arthroplasty in terms of infection, dislocation, deep venous thrombosis, and blood transfusion within the United Kingdom, as well as some of the shortest length of stay for hip replacements.

The EOC had already developed a streamlined care pathway since it opened six years ago. This has continued to evolve into a robust enhanced recovery programme. This starts with a multi layered approach to patient education consisting of patient leaflets, a patient education DVD, and face to face assessments when necessary. Discharge planning starts at initial contact with the patient receiving a home evaluation booklet which is returned to the centre and reviewed before admission. Actions are taken as required based on this information and type of surgery. Discharge planning continues post-operatively with daily communication and discussions with the patient by the therapy and nursing staff as well as dedicated discharge planners, letting patients know an expected day of discharge according to their progress to assist their planning. The wards have daily review meetings involving the multidisciplinary team to review discharge arrangements and patients’ progress. There are also now targeted multidisciplinary pre--assessment clinics for patients with complex rehabilitation needs.

The anaesthetic is clearly key for enhanced recovery. The EOC determines the patients’ fitness for surgery with nurse led pre--assessment clinics. Depending on patient’s complexities and presenting co-morbidities, specialist clinics with the anaesthetists are available for targeted patients. Enhanced recovery also depends on post op pain management. New surgical techniques involving infiltration of local anaesthetic around the operation site which improves patient recovery have also been adopted.

The reduction of spinal opiates during the anaesthetic and using the local infiltration of local anaesthesia as targeted analgesia also reduces nausea and vomiting so often suffered by patients post operatively as a side effect of the opiates used for analgesia.

With effective post-op pain control, patients can be mobilised immediately after their surgery. Physiotherapists are available until 8pm and are available to mobilise patients on same day of surgery. Daily ward rounds by the intensivists who manage the medical issues of the patients enable prompt diagnosis and management of complications as soon as they arise. Advanced nurse practitioners on wards proactively manage patients and order investigations as required, minimising delays in organising further investigations.

Nutrition before and post-surgery is a key consideration to patient wellbeing. Staggered admission times, reduced pre-operative starving times, lower opiates, less nausea and vomiting and rapid progress to normal diet, all contributes to making a difference to patients. On discharge, there are comprehensive follow up services arranged via a web of different healthcare organisations provided by the PCT’s and hospital trusts’ within the communities patients live in.

Excellent communications systems are used to enable transfer of patients to integrated rehabilitation teams or rehabilitation facilities to ensure patients can be managed at home. The EOC collects comprehensive data for patient discharge locations. The further development of enhanced recovery is backed up by continued review of the clinical evidence.

This is an important example of a value added model of care where the care takes place primarily within the hospital. A considerable amount of existing hospital activity can be much better organised within this existing business model.

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80 Ibid.
81 Ibid.
82 Ibid.
83 Ibid.
New hospitals for new needs
Hospitals based in a community setup or focused on treatment of chronic or long term conditions can decide to sum up their capabilities for networks, working with them in order to help the patients modify their lifestyles so that they can stay as healthy as possible. In a situation where resources are low and there are a number of pressures affecting the performance of the hospitals, like today, the institutions need to come up with clear strategies that can help to sustain and develop the critical functions so that they can mark a presence in the marketplace.

However, to thrive in the new care settings of long term conditions hospitals will need to develop a set of radical business models where nearly all of the care is based outside the walls of the hospital. In England, from April 2011 some 40 hospitals have the opportunity to develop a very different business model because they are taking over the community health services that have previously been provided by primary care trusts. These services have developed in an entirely different setting from that of the hospital, and it will not be easy to organise them in a new way from within a hospital.

Such a new model must recognise that nearly all care pathways start and finish outside of the hospital and puts the patient at the heart of the model. The hospital plays a crucial role, but for most people with a long term condition, this will represent one hour out of the 5,000 hours a year they spend caring for themselves at home.

Unsurprisingly, value in healthcare will primarily be added during the 5,000 hours when the patients and their carers are looking after themselves. If the hospital believes that value is primarily added during that single hour or few days of intervention, this is a misconception.

However, many hospitals and clinicians recognise this and have started to consider care beyond the hospital walls through the effective use of telehealth. At the Ulster Hospital in Dundonald, diabetes management was tackled by Dr Roy Harper in 2009. The aim was to empower patients to become better self-managers of their diabetes through education and self-management and to efficiently titrate patients just starting on insulin to achieve optimal blood sugar control. Patients were trained to use the monitors including their glucometer and all readings are transmitted. Nurses carry out a triaging process and escalate patients according to protocols designed with the specialist nursing team. Virtual clinics are held to review patients who require extra support or a change in medication. The team is able to review real time data without the need for a hospital visit by the patient or a home visit by a community nurse.

New hospitals and specialist care
At the same time, the effectiveness of value-adding process clinics needs to be evaluated. A lot of confusion can arise in distinction and characterisation of specialty and general hospitals. Some specialty hospitals are focused solution shops, which allow them to put integrated processes into place that bring together the work of multiple specialties in order to optimise the delivery of value proposition. Specialty hospitals are mainly value-adding process (VAP) hospitals and include surgery centres and inpatient services coupled with ambulatory services. Some of the hospitals specialise in only certain kinds of surgeries while other hospitals may specialise in more than one. VAP hospitals can also integrate services like the solution shops in order to increase the effectiveness of various processes and services. Unlike solution shops, the VAP hospitals can integrate the entire process, starting from the pre-admission and ending at the discharge of the cured patient. By integrating their processes in this way, the VAP hospitals can easily reduce their cost of work with greater levels of quality and patient satisfaction.

Hospitals need to focus on developing new business models for a better future and more efficient patient care. There is a possibility of applying both the above mentioned business models in order to deliver better service and manage resources in a more efficient manner. But focussing on a single business model that caters to the most important requirement should be the prerogative of every hospital if it is to sustain and provide quality care.
A national wellness service

Hospitals need work with primary care providers to concentrate on a model that promotes wellness rather than one that focuses on treatment of acute ailments. The focus should be on keeping the people healthy and avoid as many hospital admissions as possible. A healthier citizen will require and utilise fewer resources. The healthier the people, the better it is for the hospitals. This is especially the case for patients with long term conditions. With the advent of technology, patients with chronic diseases like diabetes can connect to the care team through mobile technology, where people monitoring can detect any irregularities and record the data for diagnosis.  

Acute hospitals are sick and need to heal themselves. To thrive in the present and future environment they need to focus on a radical change – an overall transformation. They need to focus on developing a successful business model and not try to be everything to everyone. The population is ageing and the demand for quality healthcare is growing. Demand is exceeding the resources and the hospitals need to disrupt their services for a business model that focuses on providing efficient service to as many people as possible within the given resources. 

A new business model has to shape the hospitals in a way that the structure becomes both sustainable and efficient. Hospitals should align with GPs and improve the management of chronic diseases, and implement the latest technologies in an integrated way to deliver the best care at the best cost. NHS hospitals have to move fast and the hospitals that move earlier than others towards this direction will ultimately determine their fate.
The Coalition Government is developing its NHS reform programme in the face of a great deal of conflict. Given that one of the main rationales that the Government is giving for the reform of the NHS is the need to develop significantly better outcomes from roughly the same level of resource and given the extent of the NHS resource that is spent on hospitals, you would expect a major part of the discussions to have been about NHS hospitals.

But it would be politically naive to expect any political party (let alone a Government that consists of two political parties), to consciously admit to the public that they were engaged in a reform programme that was going to radically convert hospitals from their current use to future uses. There is a strong feeling amongst politicians that this is an impossible task. Therefore the major set of changes that everyone in the NHS knows is just going to happen, is the one that leading politicians cannot talk about.

There are however a number of parts of the Governments reform programme which will help to drive this change programme in the nation’s NHS hospitals.

**Clinically led commissioning**

Whilst the Government has revised its original intention and timeline of placing nearly all local NHS Commissioning in the hands of GPs, it is still its intention that commissioning should be ultimately undertaken or at the very least, strengthened, with much greater clinical input. Given the number of people in every hospital that should not be there, it is inconceivable that a strengthening of commissioning will not limit the current income streams of hospitals. In some hospitals this will lead to considerable change; in others it will be marginal. But if the local hospital is already under pressure a marginal decrease in income caused by tougher commissioning may well lead some hospitals to fail financially.

**All trusts moving to Foundation Trust status**

We are already seeing a number of hospitals saying that given the timetable set by the Government to see all trusts become Foundation Trusts, some will clearly not make it. This is leading to the merger or demerger of a number of hospital trusts. The speed of these changes will mean that some hospitals will in the next few years have to radically change their current business model.

**Improving patient choice and the information revolution**

Whatever the outcome of the Government’s changes in its policy on competition in the NHS, it will not be possible to reign in the amount of information that patients will get about different doctors and hospitals. Even if the Government does nothing patients will be getting much more information through the media (such as social networking sites) and technology such as iPhone applications. It only needs 10 per cent of patients to start making choices based upon this information for hospitals who do not have a good reputation to feel the financial pain caused by patients choosing somewhere else. Hospitals that are already under financial pressure would be unable to continue as before if they have a 10 per cent drop in their income. Such organisations will have to undergo business model change.

**The failure regime for NHS hospitals will have to be developed**

In 1996 the first school in England was referred to as a failing school. Over the next ten years the public and parents recognised that such a label and the impact that had upon the school and how it operated, gave the public the information that exists all the time with teachers and educationists. It is now accepted as an important part of school improvement.  

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Whilst the new Labour Government in 2001 gave a number of hospitals a zero star rating, no government has had the courage to say what the doctors and nurses in those institutions often know – that their hospital is failing. In the next couple of years, the pressure on a large number of hospitals will be such that the Government is going to have to create a publicly safe regime that will recognise and label failure. It is only when a hospital board recognises that the institution is failing, that the board can then start the process of turnaround.

The point of a failure regime is not to deal with hospital failure after it has happened, but to deal with it in the period when the organisation starts to falter. The first point of a failure regime is to stop the worst aspects of failure from happening by intervening earlier. The second is for the system regulator such as Monitor to recognise that if an organisation is going to fail, then it is their responsibility to ensure that the people in that locality will be able to rely on sustainable and safe services provided by other organisations. Monitor, as with other regulators, needs to be able to guarantee public access to NHS services even if the particular institution that has delivered those services is likely to fail. Regulators across various industries have often come under criticism for failure to intervene in a timely manner to prevent a crisis. It is imperative that Monitor uses the delegated power to act decisively in the event of failure.

In the interim period (until such time as all hospitals fall under the jurisdiction of a regulator), a similar approach should be adopted by the Department of Health. Courage to act decisively will be key to intervening in a timely manner.

**NHS resources**

The changes outlined in this pamphlet will become imperative as the resource allocation to and within the NHS struggles to cope with rising demand and inflation. Any further shocks to the English economy from outside the nation will also have a dramatic impact on public expenditure. Currently, hospital failure is averted by granting of loans and other forms of interim financial support. However, this has the potential to grow to as much as £8 billion in the lifetime of this Parliament, which is what will be needed as an “inefficient hospital fund”. The aim of this fund would be to deliver a number of bailouts to what will be an increasing number of hospitals that will only be able to survive by the largesse of such a fund. Unless something drastic happens to the nation’s NHS hospitals, we predict that by 2013, the then Secretary of State will have to find an extra £5 billion from the Treasury to secure the continuation of all hospitals. As a proportion of the overall NHS budget, this does not seem to be unmanageable but for other Government departments, this is a significant amount of money. It is difficult to see any Chancellor of Exchequer that wants to have a political future simply giving the NHS that quantum of money to spend on inefficiency.

Finally, unless there is an appetite to continue to subsidise the NHS, any Government plucky on NHS reform will drive hard on greater efficiency and efficacy and that in turn will force new models of NHS hospitals to develop.
The hospital is dead, long live the hospital

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