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ACUTE FUTURE

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LOOKING FOR A NEW MODEL

A ROUNDTABLE DEBATE ON THE ROLE OF THE HOSPITAL

HOSPITALS UNDER '

The likely transition to a smaller acute sector, managers' 'hopeless' promotion of change and a controversial proposal to reshape services all provoked lively debate at a recent *HSJ* roundtable on the future of hospitals. Alison Moore reports

There can be no more contentious or important subject in healthcare than what acute hospitals will look like in the future – but an *HSJ* roundtable found a good deal of agreement between our varied panel about the challenges they face at the moment and what could be the shape of things to come.

The task – described by *HSJ*'s editor Alastair McLellan as "sorting out the problems of the NHS in around 90 minutes" – was to identify the challenges that the system currently faces, what hospitals ought to look like in 2020 and how this vision could be sold to public, staff and politicians.

Mr McLellan started the debate, which was sponsored by McKinsey Hospital Institute, by asking what were the two most important challenges facing hospitals over the next three years. Not surprisingly, there were many candidates.

Gordon Coutts, chief executive of Colchester Hospital University Foundation Trust, said that managing the "turmoil and uncertainty" around the transition from primary care trusts to clinical commissioning groups and the National Commissioning Board was one challenge. But the sector would also need to develop scale that was sustainable.

And Heart of England Foundation Trust chief executive Mark Newbold highlighted the difficulties of changing the nature of the acute hospital while also managing the finances and holding the line on quality and performance.

"I don't think any of us have done 4 or 5 per cent 'productivity improvement' in the face of flat income," he said. The NHS also had to work as a system while the culture and incentives did not support this, he said.

'What we are seeing already in other countries is hospitals beginning to disassemble themselves'

But NHS Clinical Commissioners interim chair Charles Alessi looked at what was perhaps a broader picture. The acute sector was going to be growing smaller, rather than getting bigger, which would need to be met by leadership both in hospitals and in PCTs and then CCGs. And he said the system needed to move to looking at population health, a perspective which was very different from an activity-based system focused on individuals. "What we are seeing already in other countries is hospitals beginning to disassemble themselves," he said.

Sir Len Fenwick, who has been a chief executive for 35 years and seen many reconfigurations, saw the challenge as delivering vertical integration and ensuring that health and wellbeing boards match up to their expectations.

But he was also concerned about what he termed the "targets of terror", which imposed punitive penalties on organisations that failed to meet them. His trust – Newcastle Hospitals – had seen *C difficile* cases fall but had now been set a very stringent target. "Once we have 95 cases of *C diff* the fine for the next 10 cases is £1.3m per case. I have been obliged to reserve £13m. I have to keep this money aside and it is not being used effectively," he said.

Peter Griffiths described himself as the chair of "a small and perfectly formed" trust – the Queen Victoria Hospital Foundation Trust in East Grinstead, West Sussex, which specialises in reconstructive surgery and rehabilitation. He saw a key challenge as sustaining the hospital while at the same time redesigning processes. But a second was how to provide consultants with the information that would enable them to get into outcomes and outcome measurement. That could "give us an even greater edge in the marketplace than we have now," he said.

The financial challenge underlays many panellists' view of the challenges the hospital sector faces. McKinsey principal Penny Dash said: "I think it is doable but will require people to work in very different ways." She also stressed the importance of a whole system approach. While there was much talk of reducing the size of the acute sector, the out of hospital sector was "woefully" set up to cope with that.

And she added the third challenge "should be quality but I don't think it will be because we don't have a population set up to look at it. Instead we look at things like *C diff* rather than outcomes."

Deep impact

King's Fund deputy director of policy Candace Imison pointed out the differing impact of the challenging situation on hospitals. Small trusts might be particularly affected. But there was also a challenge in aligning the workforce with the needs of the patients, rather than the needs of institutions.

ROUNDTABLE PARTICIPANTS

Alastair McLellan, *HSJ* editor, chair
Dr Penny Dash, principal, McKinsey
Candace Imison, deputy director of policy, The King's Fund
Dr Mark Newbold, chief executive of Heart of England Foundation Trust
Dr Linda Patterson, clinical vice-president of the Royal College of Physicians
Dr Charles Alessi, interim chair of NHS Clinical Commissioners
Dr Gordon Coutts, chief executive of Colchester Hospital University Foundation Trust
Dr Mark Goldman, independent healthcare consultant and interim chief executive
Michael Watson, operations director at Circle
Sir Len Fenwick, chief executive of Newcastle upon Tyne Hospitals Foundation Trust
Peter Griffiths, chair of the Foundation Trust Network and chair at Queen Victoria Hospital Foundation Trust
Mandy Wearne, director of service experience at NHS North West

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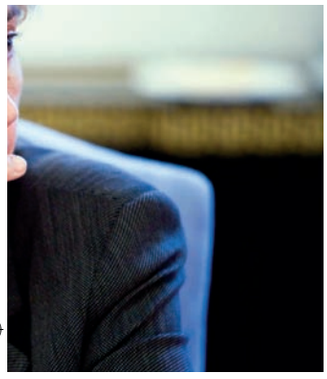
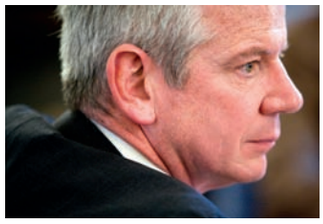


The panel, top row, from left: Penny Dash; Mark Newbold; Linda Patterson. Second row, from left: Candace Imison; Charles Alessi. Third row, from left: Michael Watson; Gordon Coutts; Mark Goldman; Alastair McLellan. Bottom row, from left: Sir Len Fenwick; Peter Griffiths; Mandy Wearne



Independent healthcare consultant Mark Goldman said that acute hospitals would be particularly stretched to make the sort of quality improvements that regulators were now looking for.

The difficulties in taking a systematic, long term view when so much thinking was short term was picked up on by Michael Watson, operations director for Circle.

The challenge for the NHS was to have a new relationship with the people it served, said patient experience expert Mandy Wearne, who added that patients were also the best early warning system of things going wrong.

Royal College of Physicians clinical vice-president Linda Patterson said, on the ground, people were seeing a rise in admissions and change in the patients coming in, who increasingly had three or four co-morbidities. A quarter of people in hospital had dementia.

There was also a need to ensure that patient experience improved and they were not "passed around like parcels."

'It feels like clinical outcomes-led change is more possible now than I can remember'

This point was picked up by Mr McLellan, who asked the panel whether they expected to see fewer emergency admissions in five years' time. Only Dr Alessi thought they would decline, while Dr Dash suggested "success would be to keep it flat".

But are there also grounds for optimism in what might appear to be quite gloomy picture? Most panellists could find a ray of sunshine over the next two to three years – though sometimes with an edge. Dr Newbold felt that, if nothing else, the NHS could not have a "hotter burning platform" than it currently had from which to pursue change. "It feels like clinical outcomes-led change is more possible now than I can remember," he said.

Dr Alessi said he was seeing more and more clinicians who were thinking in an integrated way about population health, while Sir Len pointed out how much progress towards integration had been made in his area in the past 10 years. His foundation trust was beginning to invest in a range of services where it was working with the local authority.

"I think there will still be the volume of presentations into the emergency care system but people will be turned round quite quickly with shared care," he said.

Mr Griffiths saw hope in the emergence of a variety of approaches to organisational consolidation. "Let a thousand

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There were real grounds for optimism among the panellists, particularly in the greater role that patients were taking in hospitals and potentially in patient care; and the role of new technology, including social media and patient access to records. However, there were also calls for more innovation

flowers bloom ... Let's not have one size fits all," he said, calling for innovation and creativity around this.

Dr Dash pointed out 10 years ago she was working on the Thames Gateway development and there was an expectation four new hospitals would be needed because of it – two south of the river and two north. Luckily they were never built.

There was now a recognition that older people needed a different model of care but this also needed change in primary care, she said. Primary care would have to redesign itself.

There was also movement on the issue of quality with senior people in the health service recognising the massive variations in care that existed within the system.

Ms Imison found cause for optimism in the greater role that patients were taking in hospitals and potentially in primary care, "Many CCGs have patient groups attached to practices, which they are now building up," she said, adding this was a connection with patients that PCTs did not have.

And she confessed to being extremely optimistic about the role of new technology, including social media and patient access to records. This was echoed by Dr Goldman, who said that, despite the many problems and disappointments, the NHS was slowly progressing towards electronic medical records. IT systems would offer the opportunity to move more quickly. Ms Wearne also stressed the acceptance and use of technology by people of all ages, who were increasingly using it to find solutions to their own problems.

'Many CCGs have patient groups attached to practices, which they are now building up'

The NHS's workforce was another cause for optimism. Mr Watson spoke of Circle's experience in engaging and motivating staff. He said: "We are finding that ... [when] we engage people in sensible debate about what needs to change at all levels of the organisation and in terms of longer term change ... I'm amazed at how much we are able to tackle these issues."

People were willing to give up something for the greater good, Mr Watson argued.

Dr Coutts agreed, saying there was a huge amount of goodwill and innovation from staff in the sector. "We are starting to see strong clinical leaders coming through and make some of the hard decisions," he said.

Dr Patterson said that being in such a challenging environment was encouraging people to think of solutions. In some challenging areas, outcomes were improving and specialist input was being brought into different settings.

Moving on from the grounds for optimism, Mr McLellan asked what would be the one realistic change over the next three years that would avoid problems or realise opportunities for change in the healthcare system.

Dr Alessi felt the narrative being discussed in the NHS needed to change but there was still a need to "walk the walk". "We have heard a lot of people talking about this but little physical manifestation," he said.

Sir Len spoke of the importance of a "golden thread" of seamless care for patients that went across different settings. But he said the position of GPs, as self-employed contractors who were not completely part of the NHS, also needed to be understood. He would like to see a more consistent offer from primary care. "You have a situation where your primary care services are not 24/7 – out of hours and at weekends it's an agency. I think the public still hanker for the family doctor service." GPs used to understand the social and family conditions that patients – especially the old – were in.

Mr Griffiths argued that revalidation of doctors had the potential to be "phenomenally transformative" in linking doctors' performance to outcomes. It would require the General Medical Council and employers in healthcare to work together to make it a success.

Dr Dash called for more innovation – in particular what she called "20 by 20 by 20".

"I would find 20 sites in the country, I would run them for 20 months and they would be based around groups of GPs. Each one

would have a different sort of hospital," she said. Staff from health and social care would work together with a GP leading with specialist input.

"I think we would see them working for about 20 per cent lower unit costs and reducing admissions by about 20 per cent. We could do that tomorrow."

The capacity of data to open up discussions about care was highlighted by Ms Imison. "I would love us to have a data mining capacity to genuinely understand how our population use services," she said.

Understanding how costs move around the system would also be helpful.

Dr Goldman quipped: "If you had asked me a couple of weeks ago what needed to change I would have said the secretary of state. I'm not certain I would have said the current secretary of state but the jury is out."

But, more seriously, he added: "I would like everyone to start to think about some new funding approaches to healthcare." It would be extraordinarily difficult to sustain healthcare on the back of what was a flat settlement from the Treasury, he said

Mr Watson urged: "The more people who get the chance to show a different way to run a hospital – we can all learn from each other."

The right attitude

But Ms Wearne felt that attitude was important – the NHS needed to recruit people with the right attitude to work in the NHS. Mr McLellan said it would be interesting to see what the Francis report had to say about attitudes.

Dr Patterson highlighted staffing issues at night, where a medical registrar was sometimes the sole person providing cover in an area of a hospital. She would change the NHS to make it a more 24/7 service, where patients could be discharged on Saturdays and Sundays, and services such as radiology and diagnostics were available outside normal hours.

"It should not all stop on a Friday at 4 o'clock," she added, but she stressed this was not just an acute sector problem.

Dr Coutts stressed the importance of having positive and negative consequences for actions. "Something that makes it worthwhile to do the extra stuff," he said. Competition did make people up their game, he said. But he added: "We can do more medically than we can afford. We just keep trying to squeeze it in."

"I would focus on urgent care and I think we should develop an agreed set of performance levels so we could see if we have a successful healthcare system or not." The tariff and payment by results simply did not work in urgent care because the incentives were all wrong, he said.

But were there a key set of principles for the hospital system of the future that the participants could unite around?

Sir Len suggested there was a need for command and control to help the system develop in a way which was needed. "We really need to go up 30,000 feet and look down, look at the infrastructure that is there. Some of it is locked into PFI and we have to address that legacy. There will be further specialisation," he said.

But patients needed support outside hospital and primary and community care needed to provide a bridge for them. Sir Len's trust was considering building a new health centre in the west end of Newcastle that would offer very-short-stay recliner chairs for elderly patients who were "off their feet" to enable them to be assessed and have tests done outside the acute sector.

Mr McLellan asked Sir Len what patients would notice about the changes he was proposing. That they were not passed from pillar to post and did not encounter delays to see a specialist, Sir Len said. Staff could be confident that returning patients to their homes was the best solution in the circumstances, and would be much more aware of the social and domestic circumstances affecting the patient.

Mr Griffiths proposed principles should include more emphasis on good outcomes; good access and coverage; and good access to information for patients and staff.

Ms Dash outlined a future with three types of hospital. The first would be a major acute hospital working 24/7, where there would be no difference

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A predicted model of the future – comprising major acute hospitals, more specialist 'boutique' hospitals providing elective procedures, and small hospitals in every market town replacing community health centres and GP services – sparked lively discussion, including concerns over 'second-rate services' and patients needing surgery who might 'fall into a grey area'

between "three in the morning and three in the afternoon".

All the evidence suggested that these should serve a population of between 400,000 and 500,000, which would represent between 50 and 70 per cent of the acute hospitals we currently have.

A second type of hospital would be more specialist or "boutique" – for example, dealing with only elective procedures. These may need limited physical space.

And the third would be small hospitals, found in every market town, operating 16 hours a day with possibly some beds for elderly people. They would provide urgent care and would replace community health centres and GP services.

Patients would have smartcards which they could update themselves, there would be tight performance management around quality and productivity, and there would be no national workforce constraints such as the number of births per midwife.

But this model of a local hospital caused some qualms for Ms Imison. The question of whether or not it would have beds was key, she said. And, for urgent care, there was always the issue of medical patients who might need surgery and fell into a grey area. They might not be able to be treated in a local hospital with limited input.

Dr Goldman said: "I'm not going to tolerate second-rate services in a small hospital. I think there will be a consolidation of acute services in larger centres linked to the requirement to get more involved in research."

'A lot of people feel they can't give quality care because of the chaos in the system'

Mr Watson pointed out that, however defined, hospitals needed to be within a well thought out system. There would be room for small specialist hospitals. "I think there should be consequences for poor performance in hospitals," he said. "I think the hospital needs to be designed around the patient, not the staff."

He suggested technology would be part of this but it might be used in different ways, such as pulling information around the system.

Dr Patterson said it would be important to have a system where people were given a proper assessment at the right time, and that it felt less chaotic for staff on the ground than it did at the moment. But she questioned whether sending acute patients into community hospitals was the right thing to do. "People go into hospital and get admitted because they are sick."

But Dr Dash said: "The reality of what is happening is that around 10, 20, 30 or 40 per cent of people in our hospitals at the moment are not acutely unwell. It's that great group of patients that people are questioning, whether we need to ship them all to a snazzy 24/7 acute hospital."

She questioned whether they could be treated elsewhere – for example, in day beds – but Dr Patterson argued that proper assessment of people was vital.

Dr Coutts foresaw a world when consultants did provide 24/7 cover, expensive equipment was used for 16 hours a day, and patients were happy to travel for the best care when they were presented with outcomes data. Acute hospitals in this system would be £500m a year businesses, he pointed out.

See-through culture

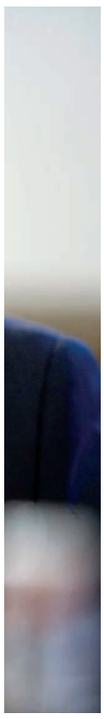
Transparency would be an important driver in all of this, suggested Dr Newbold. Hospitals needed to be extremely open to public, patients and staff.

"They should be very clear about how they make decisions, where they spend money and what their performance is," he said. "We need to get used to operating in a much more transparent way."

But Mr McLellan raised the issue of how such plans could be "sold" to public, staff and politicians.

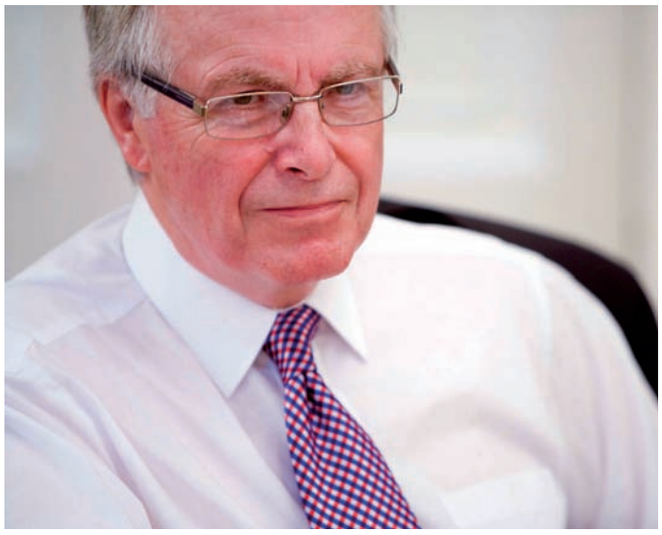
Several panellists felt that good information was key to this. Mr Griffiths said: "The only way this vision can be built is by articulating the benefits to patients and the benefits to staff."

The four tests for reconfigurations laid down by Andrew Lansley when he came into office had to some extent









incorporated this, he said. But managers in the NHS were hopeless at articulating the benefits of change. "The medical profession does not get off its proverbial. The royal colleges and the GMC all hide," Mr Griffiths said. There was a need to align behind changes.

But he added that it was also important that the public understood that hospital care was risky and they should not go into them without good reason.

Dr Dash said she had been involved in analysing stroke data from different sites, putting it into green and red to demonstrate outcomes, and had then found that when audiences were presented with this evidence, there was very little opposition to making changes.

Good data also makes poor performance hard to hide: she said she had encountered a council of governors that was convinced its trust was a top performer on cardiac care because that was what it was being told. The data showed the governors otherwise.

And the NHS needed to find more doctors willing to stand up and support change while also avoiding scoring own goals, such as referring to A&E closures rather than emphasising the importance of other components of urgent care.

Ms Imison agreed the NHS was "appalling at articulating the case for change". "All too often people jump to a



conclusion and have not worked out how this will deliver the benefits." But it was possible to make progress providing people were properly engaged and understood the process. And it was also necessary to be clear about what changes would mean for the workforce – for example, regarding 24/7 care.

Dr Goldman said that professional groups were capable of irrational behaviour in the face of cogent arguments and it was important to move people away from emotion towards arguments based on outcomes. "Less Dr McCoy and more Mr Spock," he said.

Mr Watson called for clarity around measurement of outcomes and patient experience and suggested money almost needed to be taken out of the equation.

Ms Wearne said it needed to be acknowledged that engagement was hard work and needed repeated cycles of involvement rather than the "grand gesture". She said: "It is Mr Spock and Dr McCoy. It's telling the story for those who need the logic but you also need to tell the story in a passionate way."

Dr Patterson stressed the messages about change needed to be around quality and outcomes but supported by the clinical leadership. "If you have not got senior professionals on board you won't convince the public," she said,

"It's a great privilege to be a doctor. It is not a privilege to give poor quality care. A lot of people feel they can't give quality care because of the chaos in the system."

And she added that talking about what was being taken away did not help.

Dr Alessi also pointed out the importance of language around reconfiguration, with processes set up that created "winners" and "losers". "Talking about closing A&E is completely illogical. We don't need to close them, we need to set up networks of care, hubs and spokes," he said.

Mr Griffiths pointed out that, with the advent of revalidation, doctors would want to see changes if they allowed them to get good results.

Dr Coutts pointed out the issues for politicians often focused on what was and was not going to be provided in their constituency.

Dr Newbold said he had personal and painful experience of leading consultations. While the public might accept that their local service was not safe, they could not see why it should then be closed or moved away, and tended to blame it on money. "Before you can sell difficult area you need trust and engagement," he said. "That needs a different sort of management in the NHS." He would like to see doctors taking a more positive stance towards change rather than "sniping from the sidelines"; however, this would need time.

And Sir Len pointed out that over the timescale the panel was examining – up to 2020 – there would not be a continuity of message and people would be "set off here, there and everywhere". Messages would become confused and conflated.

He predicted that some areas currently doing well would continue doing so, but there would be "pretty challenging" areas.

"It has taken seven or eight years and half of our trusts can't make foundation trust status – and we tolerate this," he said. The right response would have been for people to "have been called into the centre and told three months' unemployment beckons, sort it." ●

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