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Beyond the edge: the future hospital

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ABSTRACT

This paper outlines the challenges facing the NHS particularly over the next decade and outlines some potential solutions. A better policy cocktail to encourage more coordinated care outside hospital plus improvement methods to accelerate local solutions to improve fragmented hospital care. Clinicians have a lead responsibility to develop this agenda.

KEYWORDS: Future, NHS, sustainable, improvement

Demand and funding challenge

Demand for health care is rising in almost every area. In England visits to A&E departments are up by more than two million over the last decade. Calls received by the ambulance service over the same period have gone up from 4.9 million to 9.1 million. The average number of consultations in general practice per patient rose from 4.1 to 5.5 per year between 1999 and 2008. Emergency admissions to hospitals in England went up 31 per cent between 2002/03 to 2012/13; many of these were for short stay admissions, and for older people with multiple co-morbid conditions, but in recent analysis less than half of the rise explained by population aging alone.[1]

Set against this, total spending on health care almost doubled between 1997 and 2009 across the UK. Since 2010 there has been a funding squeeze with near zero percent real growth and an actual decline in spending on GP services. There have been significant increases in staff – the number of doctors up by 40% in the last decade, nurses up a relatively lower 14%. The number of (overnight) beds have reduced by half in under 30 years (to 140,000) but the number of day-only beds increased sixfold over the same period (to nearly 12,000). International comparisons suggest that the NHS is not overbedded and relatively high occupancy levels mean hospitals are running hot.

The financial squeeze means the NHS must make at least 4% efficiency savings per year if it is to manage increased demand. Recent evidence shows strong productivity growth of 3.2% for the two years from 2009/10, driven mainly by a slowdown in staffing, and holding down wages, while activity levels were maintained.[2] Quality of care has improved significantly over the last decade in many areas.[3] And more recently, as a basket of 150 indicators show, across England the quality of care has at least been maintained[4] despite practically no increase in real-terms resources. Yet this is just the start of what may well be a longer period (to 2021) of austerity to make the needed 4% efficiency savings per year, an unprecedented challenge for the NHS.

So the picture above is mixed. A rise in activity but accompanied by a huge injection of resources. An overall rise in the number of staff, but shortages in some key areas such as in A&E. A rise in demand from older frailer people, but not just from these groups. Good labour productivity, in recent years at least, but this following on from a longer period of what can (at best) be described as modest growth. But of most concern must be the likely prolonged period of austerity ahead. While we in the UK are currently in a period of belt-tightening across the public sector to help make up the government's budget deficit, other OECD countries are watching health spending rise faster than GDP, and wondering how to put outlays for health care on a sustainable footing for the longer term. This is regardless of how the health systems are financed.

It no surprise then that on almost every conference platform on the future of the NHS the message is 'we now have to do things radically differently'. The acceptance of the need for 'radical' change stems not just from the need to make efficiency savings, but to improve quality of care, not least following the scandalous lapses in care exemplified at Mid Staffordshire NHS Trust[5,6] and the Government's response.[7]

Fragmented hospital care

There are now a great number of initiatives going on around the country on both objectives. But until the RCP's report *Hospitals on the edge*,[8] and The Future Hospital Commission's report which followed,[9] there has been no recent analysis of the organisation and flow of medical care within acute hospitals. *Hospitals on the edge* identified some stark problems: fragmented care (patients moved around the hospital 'like parcels'); markedly lower quality out of hours; and growing and unmanageable clinician workloads. The impression was that patients were at the mercy of a barely managed system of medical care, in what should be a sanctuary, that the situation was worsening, and that it was as dangerous as it was avoidable. That the Royal College of Physicians should report this was notable indeed.

The RCP went on to convene an independent group – The Future Hospital Commission – to discuss potential remedies. The resulting report was solution-oriented, suggesting a bold blueprint for the redesign of care. At its heart was a diagnosis that

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specialty driven medicine was ultimately failing patients because it was uncoordinated. The solution proposed was effectively that care oriented around the patients' needs should be achieved by increasing proportion of generalists, pulling in specialists as appropriate. The report went further to suggest how acute care might be coordinated better beyond the hospital walls, in part using teams from within.

The solutions proposed may or may not be exactly right, and they may not be a blueprint for every acute hospital across the UK. But the principles seem hard to argue with, and the report is a welcome display of medical leadership addressing issues about the design of services, not just the standards of bedside medicine. Of course while specialists may come and go in the course of a patient's stay in hospital, patients will give ample testimony of poor design if they are asked and listened to. There is welcome acknowledgment of this in the Commission's Report – absolutely right especially given the deafness to patients and carers of Mid Staffordshire NHS Foundation Trust.

The task is now how to encourage appropriate action on the back of the Report. The RCP can push only so far, but what else might help?

Responsibility and improvement

The impetus must be on the Boards and the executive leadership (clinical and managerial) of acute NHS Trusts to review the flow of acutely ill patients throughout the hospital. Given the turnover of senior executive and non-executive staff in NHS hospitals, the clinical leaders must take the key responsibility for making progress. Useful examples of how to improve quality of care in the pathway could come from ongoing work in the NHS to improve flow, for example in Sheffield and Warwick,[10] in the recently set up collaborative in Wales[11] and as is beginning in Scotland. These are using well-tested techniques to map the pathways of patients, and using the skills of frontline staff and patients to design and test improvements in care. Some of these techniques, such as the theory of constraints and other formal quality improvement methods,[12] are mostly far from the curricula of medical students or postgraduates, yet can have a considerable impact on clinical outcomes. They may also be beneficial because they lead to adaptive bottom-up incremental change in service design, informed by patients and staff, rather than a top-down blueprint, and thus may make it easier to identify and secure necessary changes. Organisations such as the Health Foundation have over 10 years been slowly building capacity in the NHS in these areas, yet still the number of doctors who have the needed skills is vanishingly small.

Even if the design and quality of care inside hospitals is vastly improved, as the Future Hospital Commission recognises, this is not enough. The question is also how to coordinate care and support of patients in the community (pre admission and post discharge) so that the 'value' of care is increased, or more specifically the risk of acute hospitalisation is reduced.

This is probably the biggest question policymakers and practitioners are asking in health care across OECD nations. Here, health systems have grown organically and are now top-heavy with increasingly sub-specialised hospital care. But the greatest need (and costs) in the future will be from increasing numbers of older people with multiple co-morbidities and dependencies, as well as from a growing population of people whose risk factors (obesity, poor diet and exercise) have not been managed early enough to ward off early illness. Meeting these challenges effectively in future will mean a different and more managed orientation of care to that which has developed to date. The ingredients include integrated care across different settings (health, social care, community, home), a greater emphasis on self-care, and much more effective population and targeted cohort-based preventive public health.

Policymakers have a big role here, to recognise where the NHS is in its state of development, and craft a cocktail of policies which work to encourage the right path ahead. The cocktail includes: payment incentives; pricing; commissioning and risk-based contracting; regulation; developing information and performance reporting; allowing local networks of providers freedoms to develop; determining the extent of competition; and, yes, a few targets with performance management. Initiatives in England such as the recently announced integrated care 'pioneers'[13] and the Better Care Fund[14] are examples, but there are many more. Many countries across the OECD are trying a similar set of initiatives,[15] albeit in very different contexts. As yet, there evidence of impact of 'integrated care' to improve quality, but mixed and weak evidence of impact on costs.

But ultimately it is not the nature of the policy environment in which providers of care sit that will lead to desired progress – for example towards integrated care, or to the model outlined in the Future Hospital Commission's report – but the nature of the providers themselves. One or two physician leaders, however talented and heroic, just won't do the trick. Creating a collaborative learning culture over time amongst larger groups of staff, and listening to patients, is the way to lead hospitals to a place beyond the edge. To achieve that, how and who we train in medicine will need a transformation. ■

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