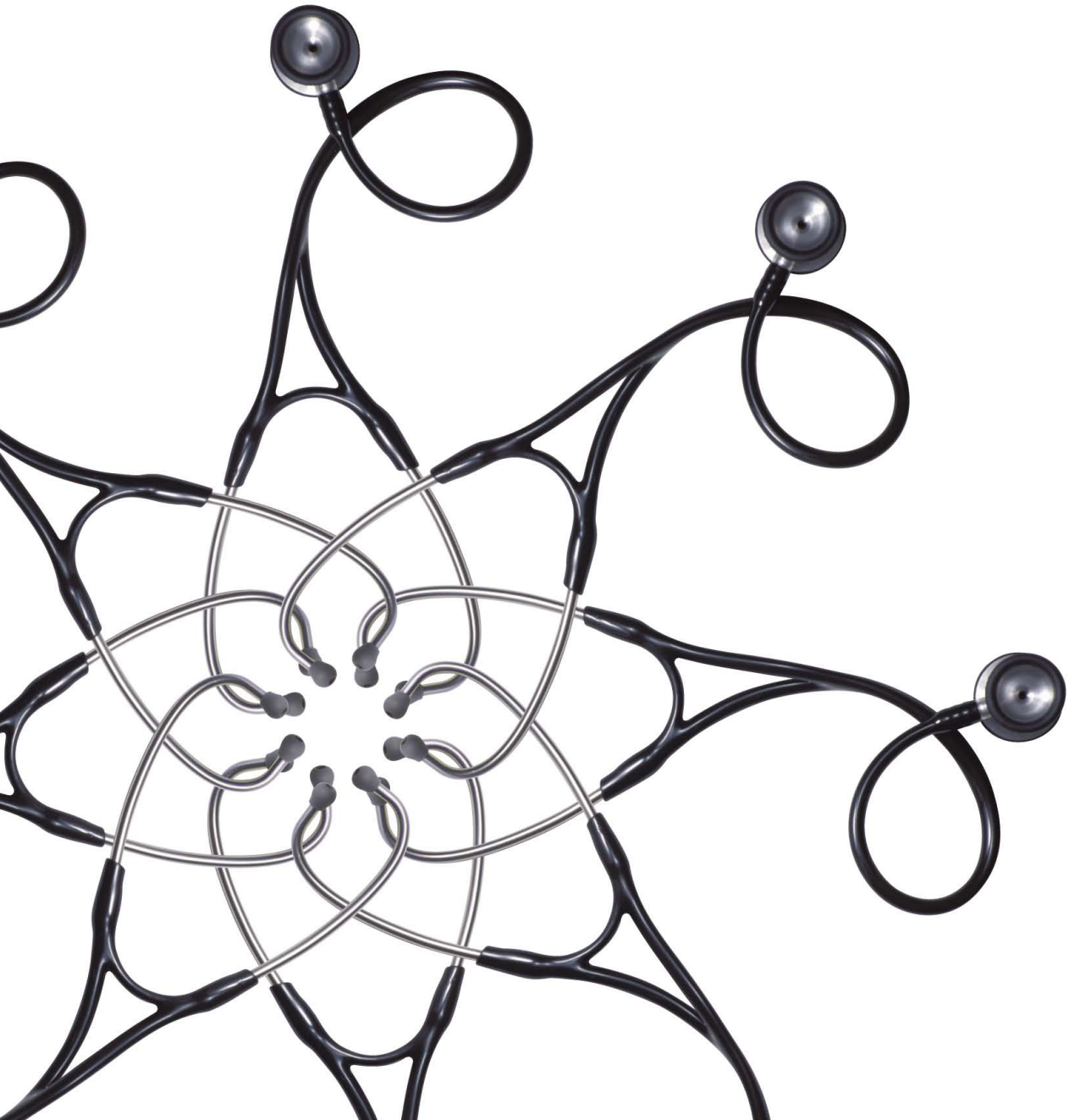
TRIBAL

Intensive care for acute hospitals: surviving the forthcoming recession



Intensive care for acute hospitals: surviving the forthcoming recession

For most people the hospital is the physical manifestation of healthcare, and in the UK, the concrete representation of the NHS. Although the modern British hospital remains a sometimes comforting, if artificial, construct the rationale for their current form and function is increasingly being undermined. The primary argument for hospitals is based on the benefits of consolidating technology, skills and assets on shared sites, coupled with the specific requirement to isolate infectious diseases and socially unacceptable conditions. And, at the founding of the NHS, there was also an imperative to provide an alternative to inadequate and often insanitary home conditions.

These foundations for the concept of the hospital are progressively being subverted. Firstly, by the growing pressure to further consolidate key skills, technologies and expertise into evermore specialist centres, undermining the traditional local, general hospital. Secondly, by the mutually supportive impact of rising wealth and new technologies, which mean that many treatments can now be delivered in non-traditional settings; from the home to the retail shop. Whilst we can be fairly sure that there will always be some hospitals, in the sense of technologically intensive clinical locations, which hospitals and what their service models and portfolios are is more questionable.

Pressures such as these have transformed virtually every other major industry, yet political sensitivity, amply demonstrated by the hospital building programme of the last ten years, has left the hospital sector largely immune to change. However, this immunity is now threatened by the coming financial squeeze on healthcare. The 'brittle' economics of hospitals, with their apparently high, fixed and seemingly built-in cost inflation, makes them particularly vulnerable to rapid and unpredictable change.

The purpose of this paper is to look at the pressures that are bearing down on hospitals and to explore possible responses, both operational and strategic. This paper is the latest in a tradition of Newchurch papers stretching back over 20 years, many of which have plotted the evolution in acute services. This tradition has now passed to Tribal, which Newchurch joined in January 2009.

For further information about Tribal or about the issues raised in this paper please contact:

Matthew Swindells
matthew.swindells@tribalgroup.com
+44 (0)7825 060 102

Kingsley Manning
kingsley.manning@tribalgroup.com
+44 (0)7802 302 437

The gathering gloom

By comparison to the gloom that has pervaded most of the economy, the current position for many NHS hospital providers is still very good. Buoyed by nearly 20 years of growth in NHS spending, by the pursuit of the 18 weeks objective, by local PCT surpluses, continuing growth in demand and by the beneficial impact of HRG4, many have achieved at least a degree of financial stability. The Foundation Trust process, following on from the formation of NHS Trusts in the1990s, has also encouraged real improvements in performance. As a result, the majority of hospital providers have been reporting financial surpluses and even building up cash reserves.

This benign position could not last and the 2010/2011 Operating Framework, along with the Pre-Budget Report, marks a watershed in NHS and acute hospital funding. The NHS budget in England will at best only increase after 2011/2012, in cash terms enough to keep pace with inflation, and after the forthcoming General Election, even that position may not be maintained.

Therefore, it is now common currency that the NHS will need to deliver between £15 billion and £20 billion of productivity improvements on a recurring basis by 2013/2014 to meet the inherent pressures within the system. And although the uplift in NHS resources in 2010/2011 has been confirmed, the Operating Framework introduces a number of measures which will impose financial pressure across the system in anticipation of worse to come.

A more extensive discussion of the scale and nature of the NHS deficit is set out in our recent paper on the industrial transformation of the NHS[1]. In that paper we identified how commissioners could deliver more than 10% savings in their expenditure, whilst simultaneously improving the health of their population through rigorously implementing best practice drawn from healthcare systems around the world. However, this leaves the remaining half of the savings to be delivered through unit cost improvements by providers.

1. Tribal Newchurch, Industrial transformation in the NHS, June 2009, ISBN: 978-0-9559143-1-7

The pressures

NHS spending on hospital-based acute service providers accounts for more than 50% of the total budget. Therefore, hospitals can expect to be the focal point for any constraint on spending growth, bearing a disproportionate share of the pain to come, with mounting pressures from both rising costs and falling revenues squeezing their margins. For a significant number of hospital providers this squeeze will threaten their continuing viability, at least as independent institutions.

Ever-rising costs

Hospitals suffer from built-in levels of inflation in their input costs. Whilst these have generally run ahead of increases in the prices for their services, their track-record of improving their use of resources has been modest. Although varying significantly between providers, the growth in hospital costs has been running ahead of inflation in the wider economy for a number of years. Indeed the sector seems to be locked into a process of cost escalation which we estimate to be about 5% a year, even when inflation in the wider economy has turned negative. Tackling these cost pressures has consistently been a second order issue for hospital managers, by comparison to capacity expansion and the achievement of ubiquitous performance targets.

Staff

The inexorable rise in staff costs is the largest component in hospital inflation and has accounted for the bulk of the additional NHS spending over the last decade. Hospital managers might well argue that their staff costs have been largely driven by national agreements where they have little influence. The Government has now announced that whilst the 2010/2011 pay rise for the NHS will go ahead – except for senior managers and consultants – they will aim to restrict rises in the subsequent year to 1% a year, except for the lowest paid. This will provide a modest breathing space, but even a 1% real increase in pay would leave hospitals with about 3% annual wage inflation driven by the automatic increments for service, let alone any impact from continuing 'grade drift'.

In the medium-term, a pay freeze will inevitably thaw and there will be pressure to regain lost ground. Hospitals may gain greater freedom to negotiate pay locally, but historically they have lacked the resources, skills and confidence to engage in effective negotiations. As a result, the track record of hospitals controlling pay in the previous era of local pay bargaining was poor. Indeed, few hospitals have demonstrated much determination in a process which, through pay uplifts and grade drift, has resulted for many in an annual inflation in the pay bill of over 5%. Whilst Agenda for Change has certainly not helped, few hospital providers have taken action to manage its impact through taking a strategic approach to workforce management, in order to mitigate both grade and skill-mix drift.

Technology

In most industries the impact of technology is ultimately to reduce operating costs. This is not an assumption shared by the hospital industry where the inevitable advance in technology means not only that hospitals can do more for patients, but almost invariably at a higher cost. Hospital drug costs provide a good example, rising at above inflation for many years and driven by prices, usage levels and the introduction of new drugs.

Standards

The last decade has seen a determined effort to improve standards across the NHS; the Department of Health has issued National Service Frameworks, the Royal Colleges have acted to improve the quality of training, NICE has encouraged greater consistency in medication and even Europe has contributed through limiting working hours. But all of these improvements come at a cost, contributing significantly to hospital inflation.

Expectations

Finally, hospitals are being dragged into the consumer world. Increasing transparency and well-publicised failures have raised the public's awareness of service quality and therefore user expectations. Quite rightly, hospitals have to respond to these pressures by delivering cleaner hospitals, smarter facilities and a more patient sensitive service – but all this comes at a cost.

The triple threat to revenues

As costs have continued to rise over the last few years, prices, at least those set through tariffs, have not kept pace. However, hospital providers have been able to cope because overall revenues, driven by activity, have been rising even faster. Indeed, hospitals have been able to assume and even plan on seemingly ever-rising demand, and with it growing revenues. Now however, the commissioners, the hospital's payors, are intent on reducing activity growth and if possible actually cutting hospital revenues, through a combination of tariff reforms and increasingly effective measures to shrink the demand for hospital based services.

As a result, not only will prices fall but also the apparently inextricable rise in activity, and therefore revenue could be slowed if not reversed. This pressure on revenues applied by commissioners is likely to be intensified by the promotion of greater local competition. Whilst the systemic rise in demand for healthcare services, powered by demographic shifts and patient expectations, will continue, the revenue benefits will not automatically flow to hospital providers.

Hospital revenues are therefore under pressure from three directions:

- Price cuts
- Reductions in activity
- Rising over-capacity, increasing competition and greater choice.

Price cuts

The most immediate manifestation of increasing pressure on revenues will come through changes in the tariff and payment system announced in the Operating Framework 2010/2011. From April 2010, the maximum uplift in tariffs for the next three years will be 0% and as they shift to a 'best practice' basis they could even fall in cash terms. The expectation is that the same price constraints will also apply to non-tariff prices. But, with the shift to tariffs becoming the 'maximum' rather than the mandated price, there will be increasing downward pressure on locally negotiated prices.

The impact on revenues of these real terms price cuts will be reinforced by a move to marginal pricing for over-plan emergency activity. Payments of 30% of tariff for emergency activity that exceeds the aggregate 2008/2009 activity (at 2010/2011 tariffs) will be punitive for

hospitals that are unable to rein in activity. The shift in the payment mechanism severely curtails the ability of hospitals to offset the impact of price reductions through increased activity.

Taking these developments together, our own modelling suggests that it is reasonable to expect that over the next five years acute hospital prices could fall by more than 20% in real terms. And the impact of such tariff reforms will be reinforced by the adoption of invoice validation systems by commissioners. In our experience these systems, combined with effective enforcement of the national contract, can lead to a reduction in hospital revenues in their first year of 1.5% to 2%.

Reductions in activity

The current operating regime, notably the combination of tariffs and Payment by Results (PbR), was intended to encourage expansion, with hospitals incentivised to admit patients and push up activity. By 2010/2011 this approach will no longer be continued, with the balance of risk for inappropriate admissions and treatments passing back to the hospital provider.

At the same time, managing demand is becoming the key priority for commissioners, and specifically diverting referrals away from hospitals. Although many hospital providers will be highly sceptical, a combination of better, up-to-date data and more powerful tools is likely to mean that commissioners become increasingly effective at referral management. Our experience of applying tools such as ACG[2], MCAP™[3] and InterQual[4], which provide a powerful and rational basis for both qualifying admissions and managing patients through the hospital, suggests that in a typical health economy, hospital referral and admissions could be reduced substantially over time, with a resulting cut in revenues of some 15% to 20%.

Increasing over-capacity, increasing competition and greater choice

The commissioners' efforts to manage demand for hospital services are likely to have an impact of reducing the numbers of patients, particularly in medical specialties. This, aided by marginal pricing for emergency activity, is likely to extend to all areas of unplanned care and surgical services. By themselves these techniques, if successful, are likely to result in increasing spare capacity within the hospital sector.

This is in addition to the surplus capacity generated over the last few years through initiatives such as ISTCs, 18 weeks and the considerable expansion in the clinical workforce. The impact of the increasing excess capacity will be translated through the sector by intensified competition between NHS providers seeking to sustain revenues, by cutting prices to gain volume.

Whilst the current administration appears to have lost much of its enthusiasm for explicit competition and even any incoming government may be tentative in its approach, this is probably only a temporary halt on the road to greater supplier plurality. Along this road the greatest threat to NHS hospitals will not come from the conventional independent hospital sector but from new forms of suppliers with very different clinical and business models, and a very different cost base.

2. ACG: http://www.acg.jhsph.edu/html/AboutACGs.htm
3. MCAP: http://www.theoakgroup.co.uk/mcapsystem.html
4. InterQual: http://www.mckesson.co.uk/?section=page&p=/primary/commissioning/demandmanagement

From surplus to deficit

Competition will of course only have an effect, if individuals are willing to change their traditional patterns of behaviour. To date, the impact of patient choice has been muted but there is evidence that people are beginning to be more active in making their decisions. The numbers choosing to use independent sector suppliers through the Extended Choice Network are rising, with volumes now running at more than £300 million a year; a process intriguingly given impetus by the Secretary of State's promise to patients that the NHS cannot treat within 18 weeks. And where there is evidence of comparatively poorer outcomes between relatively accessible local providers, individuals appear to be making active choices. For example, one London District General Hospital has seen a relative reduction of over 10% in referrals in 12 months since information about its poor clinical performance received local publicity.

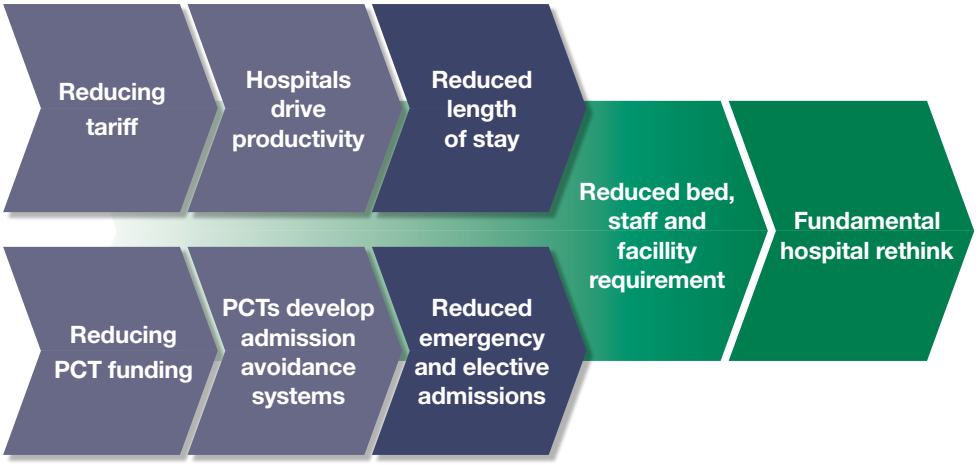
Taking these revenue pressures together, the best case for NHS hospital providers is that the fall in average cash prices every year is offset by activity growing sufficiently to maintain current revenues at their 2009/2010 cash levels. By 2015 this would result in the sector delivering about 15% more activity with no increase in cash revenues. On the cost side, a best case scenario, which assumes a 1% annual pay rise for 2011/2012 owed by minimal further increases, is probably that input costs for 2010/2011 would rise by about 4%, falling thereafter to around 3% a year by 2015. With cash revenues remaining at their present level, this level of cost inflation would turn a current surplus for the sector of some £1.5 billion a year into a deficit of about £7.5 billion a year by 2015, and a cumulative deficit of over £20 billion.

Even under this relatively favourable scenario of cash revenues being maintained by rising activity coupled with falling cost inflation, the sector would have to deliver a 15% to 20% improvement in productivity by 2015 to break-even. But it could be much more difficult.

Average prices might fall by more like 5% a year in real terms and commissioners might rise to the challenge of holding activity at its current level or even reducing it. Under these circumstances hospitals would find themselves in the grip of an uncomfortable pincer movement; having to drive down costs as activity declines, with overheads having to be absorbed across smaller and smaller volumes.

Where there is local over-capacity and competition, the position could be significantly more difficult with prices and volumes both falling more quickly over time, so reducing revenues even further.

As cash revenues decline the productivity improvements required to stay afloat begin to increase sharply, suggesting that the improvement required could be much closer to 25% to 30%.



Surviving the crunch

The prospects for the hospital sector as a whole are therefore pretty bleak. Many will argue that given the constraints they operate under and the requirement of recent years for a rapid expansion in capacity, this swift reversal in fortunes is unreasonable. Some will also doubtless see new opportunities, but in a contracting market one provider's successful expansion will inevitably be at the expense of another.

A few may feel, some with good reason, that their position is impregnable, perhaps because of location or because they have a well diversified mix of revenues from education and research. But even the relatively benign base scenario described above will require a significant reduction in capacity across the sector, both in terms of the number of staff employed and the assets used. The majority of hospital service suppliers therefore face threats to the continued operation of some of their sites, to the maintenance of some of their services and in some cases to their very survival as independent organisations.

The silver lining to this particular black cloud is that the opportunities for delivering a very substantial level of performance improvement have never been better. The rapid expansion in hospital capacity – in both buildings and staff – provides substantial opportunities for both operational and strategic improvement in productivity.

To make that level of performance improvement, hospitals need to respond to these challenges at three levels:

- **Operational** – significantly improving the productivity of the current business and clinical model
- **Tactical** – flexing the business and clinical model to improve the underlying economics
- **Strategic** – redesigning the business and clinical model to adopt a new model of care for the system as a whole.

OPERATIONAL EFFECTIVENESS
'Doing things that we do now, better'

1. Improving the flow of patients through the hospital process – looking both at the hospital as a whole and focusing on the key areas (A&E, Acute Medicine, Non Elective Surgery, Care of the Elderly and Elective Surgery)
2. Minimising clinical errors – looking at theatres, admissions and medicines
3. Reducing the cost of inputs to the patient flow focusing on key areas; workforce, medicines management, supply chain and diagnostics
4. Reducing the wider cost base – looking at overheads, facilities management and support services.

TACTICAL ARRANGEMENTS
'Changing the way that we do things'

1. Auditing the use of current resources using tools such as MCAP™
2. Improving the utilisation of assets by reducing the estate or repatriating activity
3. Rebalancing the case mix to improve the average revenue to cost ratio
4. Shifting the service portfolio towards high volume or high margin services
5. Reducing cost through the use of technology
6. Minimising risk by assessing the market and developing a response to likely commissioner intentions.

SERVICE STRATEGY
'Changing what we do'

1. Reviewing the clinical, financial and operational viability of services and constructing the most appropriate portfolio
2. Considering horizontal and vertical integration opportunities to achieve economies of scale
3. Redesigning the business model – the ultimate purpose and being of the organisation.

Whilst the returns for operational improvements can be relatively rapid and are largely within the decision-making scope of the hospital's management team, the benefits from tactical changes tend to be longer term, invariably involve third parties and usually carry with them greater risk of failure. No organisation would willingly engage in strategic change, where the risks are always high and the timetable indeterminate, unless they had concluded that without taking such a step the organisation's very survival was in doubt.

The first and crucial step is therefore to understand the magnitude of the challenge; what is the scale of the change that the organisation needs to make to be competitive and to survive? Given current market conditions the board of any hospital provider needs to be assured that the plans for the organisation's development are equal to the challenges.

Knowing the starting point

Without knowing the starting point it is difficult to understand the scale of the task and the path to follow. In our experience even using a relatively small number of key indicators casts considerable light on the strengths of hospital providers within their local markets. What is surprising is how few hospitals review their own indicators on a regular basis or have undertaken a detailed assessment of the financial viability of their local health economy.

Simple comparative benchmarking typically used by hospitals is not enough for this task; this invariably tells the organisation that it is not doing too badly by comparison to hospitals that are themselves not doing very well at all. What is needed is to look at a set of core indicators that provide a picture of performance in absolutes as well as comparative terms. The core set of indicators we use are set out in the accompanying box. These look at the hospital's position along three dimensions:

- **Financial**, for example revenues relative to cost base
- **Clinical**, for example admission rates for first time attendees at A&E
- **Market**, for example the relative competitive intensity of the local healthcare economy.

Tribal's twelve indicators of hospital performance

Financial Indicators

- Income per whole time equivalents (WTE)
- Income per £ spent on fixed assets
- Income per £ spent on staff costs
- Cost per WTE
- Financial contribution of 40 high volume health resource groups (HRG)

Clinical Indicators

Demand/income risk

- Avoidable admissions, for example, Ambulatory Care Sensitive (ACS) conditions, Procedures of Limited Clinical Value etc., improved efficiency / cost savings
- Best practice length of stay (LOS), for example, variation in LOS due to day of discharge etc.
- Medical WTE per 1000 admissions
- Qualified nursing WTE per 1000 admissions

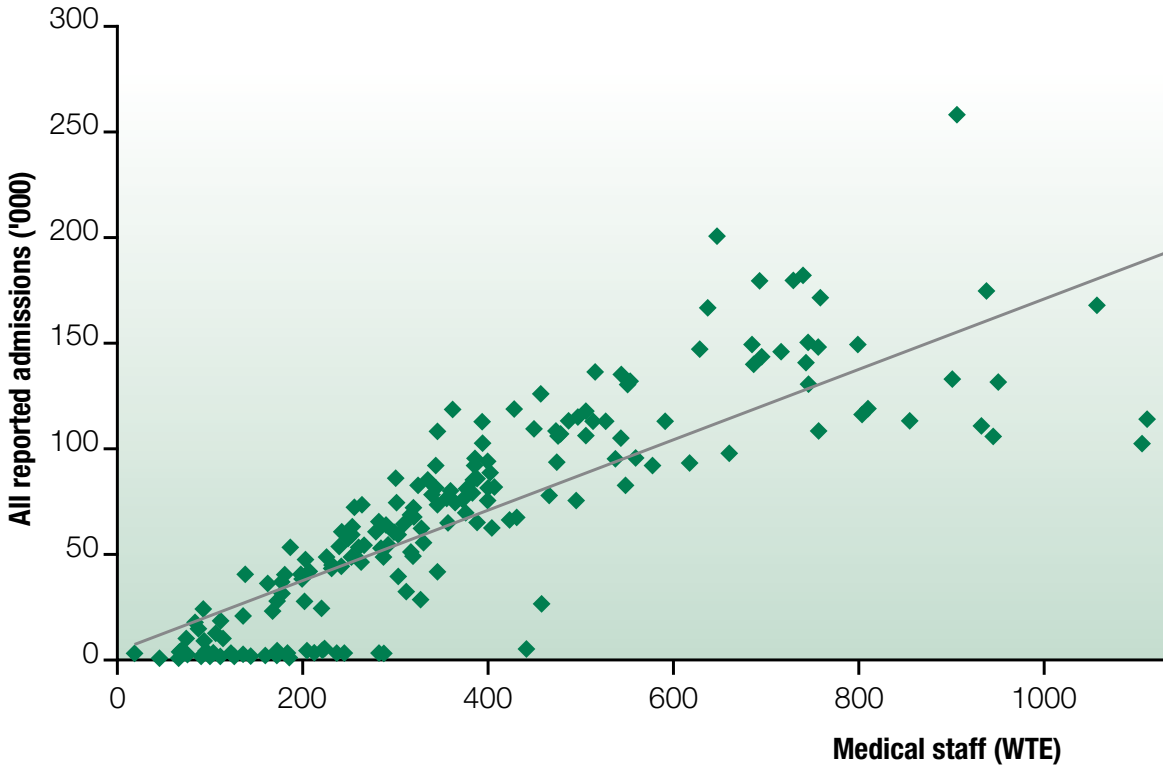
Market Indicators

- Market share (all admissions)
- Acute hospital accessibility
- Competitor price differentials - 2011/2012.

Each of these is a high-level indicator driven by a variety of factors, but taken together they provide a robust measure of current hospital performance and future success. Where they are clearly out of line, the underlying drivers can be analysed in greater depth.

Example of a performance indicator

All reported admissions per reported medical WTE 2008/2009



Data Sources: HES 08/09, DOH Workforces Census September 2008

The hospital's performance then needs to be set in the context of its local health economy, through undertaking a five to ten year modelling exercise to determine the likely scale of resource reductions and shifts across market participants. With a monopoly purchaser, the viability and spending power of the local commissioners, whatever organisational form they take in the future, is the key determinant for any hospital.

Having established a starting point, the scale of the task and the feasibility of bridging the gap can be assessed. To get a sense of the extent of the action required, the feasibility and the timescale, the hospital can undertake a bridge analysis (please see example on the following page), based on the achievement of best-in-class outcomes for similar hospitals.

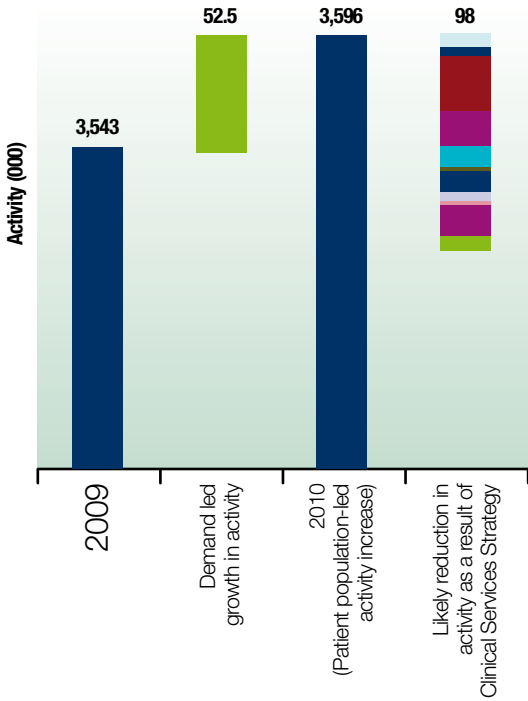
Given the scenario described above, there will be very few hospitals that will not need to improve their operational performance and many will need to take significant tactical action to achieve economic viability. For some, the bridge analysis will show that operational and tactical action will simply not be enough and for these the only option will be to consider the strategic alternatives.

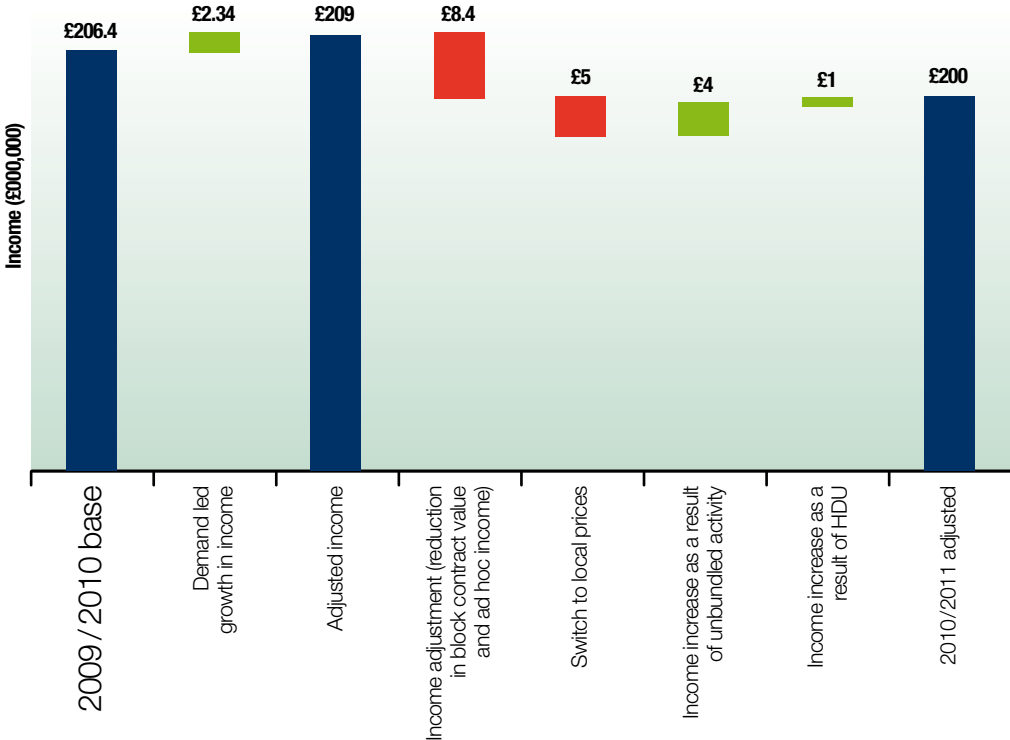
Example of bridge analysis

Assumptions

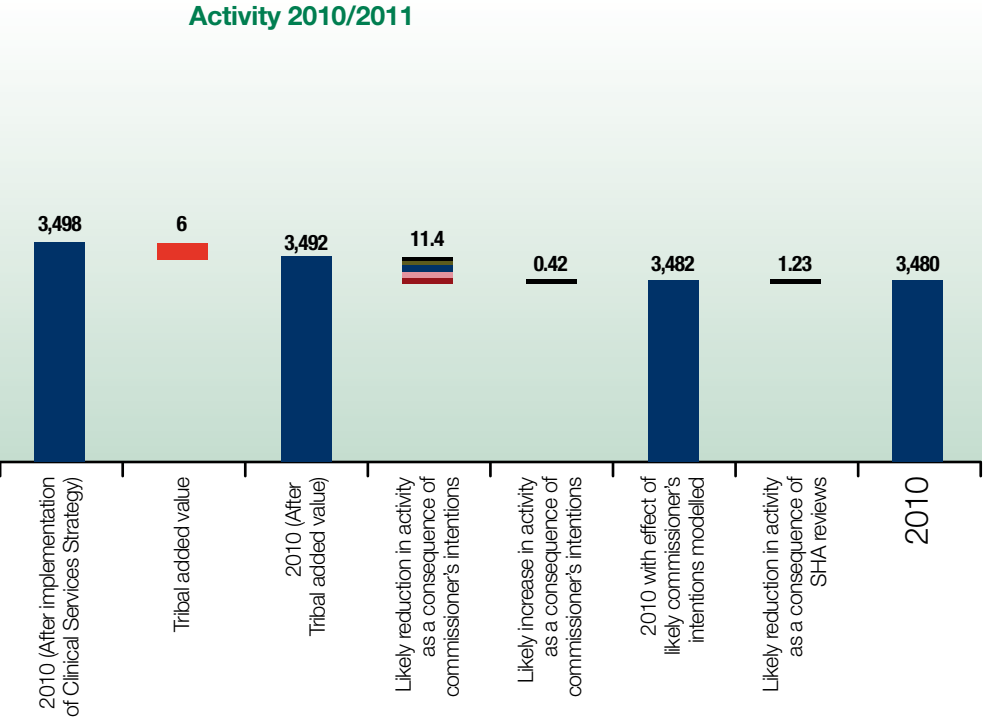
The bridging charts were compiled using the following assumptions:

- Planned activity and income are broadly representative of actual income and activity
- Demand for acute services is largely determined by demography
- Price inflation has not been modelled
- A block contract to be agreed with the PCT for 10/11 onwards
- Ad hoc income will reduce ~ in 10/11 relative to 09/10
- The PCT's commissioning intentions will reflect a need for significant reductions in expenditure
- Strategic changes i.e. SHA reviews will take three years to fully implement
- The commissioner will tender out selected services

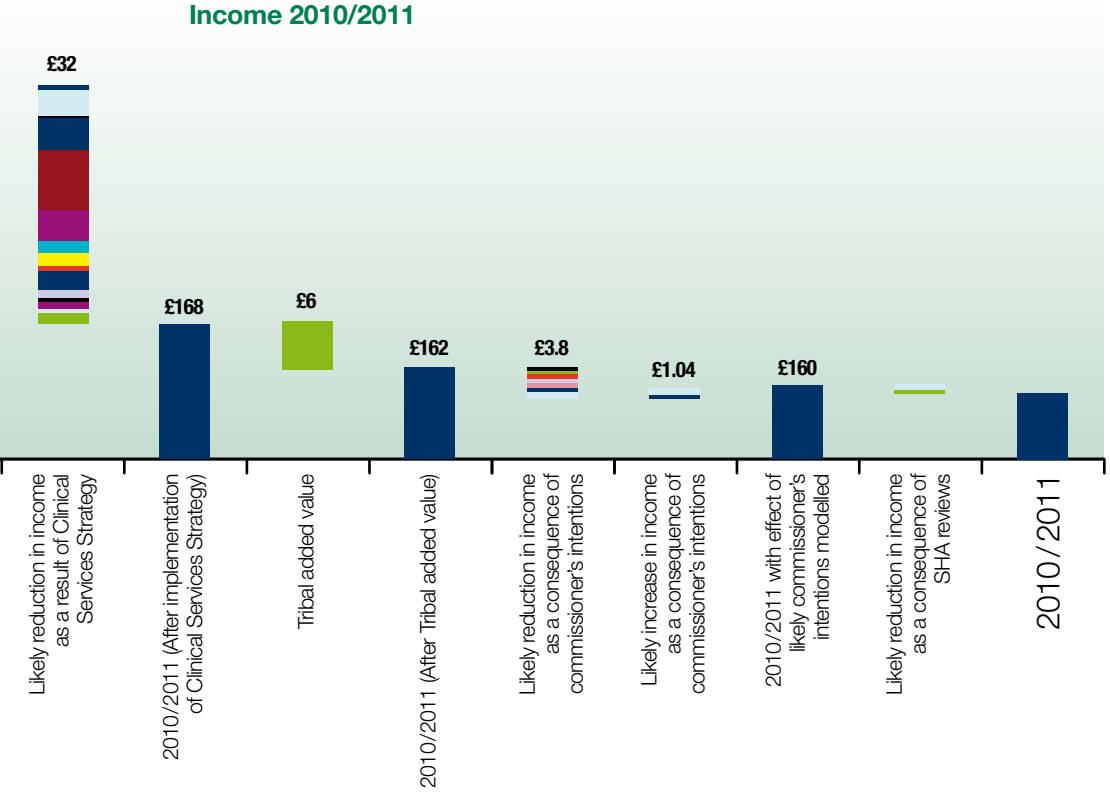




Activity 2010/2011



Income 2010/2011



Improving operational performance

However brilliant an organisation's tactical and strategic plans, they will come to little fruition in the absence of competition beating operational performance. Improving operational performance lies largely within the organisation's own decision-making scope and can deliver returns in a relatively short timescale.

Operational performance, overwhelmingly reflected in clinical performance, is a function of six components:

- The way patients flow into and through the hospital, from door-to-door
- The cost of the inputs used as patients flow through the hospital
- The cost of assets facilities and support services
- The cost of failure
- The organisational mindset
- The information flows for operational management.

The objective, which is ultimately the key management task of the hospital, primarily for the clinicians, is to maximise compliance with the optimal pathway for the patient whilst reducing as far as possible the input cost. This way the ratio of revenues to costs can be improved and with it the operating margins; the critical driver of financial stability. To achieve this goal, improving quality is a prerequisite not a desirable option.

Optimising patient flows

One of the most intriguing aspects of hospitals is that we know how to manage them well. Literature abounds with freely available information of best practice, the optimal design of clinical pathways, and safe and cost effective outcomes.

Yet the uptake of this free advice is both patchy and invariably very slow; the mean time for the NHS to adopt a new innovation has been calculated as some 17 years!

Given the homogeneity of the population, the preponderance of a relatively small number of common processes, the abundance of research and the willingness to share knowledge, the establishment of best practice for clinical interventions is not surprising. The failure of hospitals and clinicians to willingly adopt best practice is however a common experience; even though it is rather akin to airline pilots deciding on their own variations for landing procedures at Heathrow. As tariffs move to be based on best practice rather than on average costs, and patients become increasingly concerned about what is done to them rather than by whom and where, hospitals and clinicians will increasingly have to justify adopting their own local variations.

The starting point for any hospital is therefore to audit their performance against international standards of best practice using an appropriate, recognised audit tool, such as MCAP™ or InterQual. These tools provide a clinically accepted basis for judging the appropriateness of the original referral and of the setting, nature and process of the care provided within the hospital itself. Typically, such audits find that at any point in time in the UK, between 13% and 49% of patients are receiving inappropriate care and should either have never been admitted or should have already been discharged.

This audit provides the basis for reviewing and redesigning the individual pathways and patient flows. This can be undertaken using a number of proven methodologies, such as LEAN and comparison to examples of Optimal Clinical Practice.

These types of reviews will invariably identify substantial opportunities to improve operational performance and with it the quality of services. Improving flows can cut unnecessary admissions and appointments for patients, and reduce irritating duplications and waiting times. Also, operational efficiency is always positively associated with improved safety and outcomes.

Reducing input costs

In parallel to improving the process design, which aims to reduce the quantum of resources used, the challenge is to reduce the cost of all resource inputs. The dominant input costs are:

- Workforce
- Diagnostics
- Medicines management
- Overheads, back-office and estates.

Workforce

Staff costs for an NHS hospital are typically 60% of total costs; reducing staff costs makes a direct and immediate contribution to improving margins.
The starting point is to match current staff resources on the basis of best practice – numbers, grades and costs – against the current and the redesigned work flows. This will identify short-term gains.
The next step is to optimise the total workforce cost, primarily through focusing on working practices and skill-mix.

Diagnostics

Not only are the costs of diagnostics high but the knock-on impact of their operational effectiveness is considerable. In many hospitals there is paradoxical mismatch between potential capacity – often considerably more than required, with actual available capacity – often disappointingly low. The result is unnecessarily high operating costs and collateral inefficiencies rippling through the rest of the hospital. Matching capacity to need reduces assets and maintenance costs, whilst adopting best practice working methods will reduce staff driven operating costs.

Medicines management

Where drug costs are embedded within tariffs, any failure to control them will have an immediate impact on margins and may have a negative impact on patient interventions. In most hospitals there is the potential for reducing costs, both through improved procurement and through strengthening the review and management of prescribing and usage.

Overheads, back office and estates

Overheads and support costs are typically 10% to15% of total costs but rarely attract the attention they justify. Effective management of hotel services, the supply chain, clinical records, space utilisation and so forth not only save money but invariably enhance the quality of services for patients and the work experience of staff. A comparative and absolute analysis of current expenditure will identify where action can be taken.

Reducing the cost of failure

The cost of clinical failure is enormous. The greatest cost is of course to the patient and their carers but the cost to the organisation is also huge.
Invariably the cost of dealing with clinical errors, in terms of clinical resources, drugs and bed days is a multiple of the cost of getting the intervention right in the first place.

The starting point is to have a regular and robust audit, preferably with an independent element, of the key indicators of clinical performance.
These will include comparative, risk adjusted clinical outcomes, the rate of emergency readmissions, return-to-theatre rates, infection rates and medication errors. It will help if the board gives clear leadership by putting quality reporting at the top of its monthly agenda. It will also help if the organisation as a whole adopts a common cultural approach to quality.

Changing the mindset

However good the tools are and however comprehensive the plan, any substantial improvement in operational and quality performance has to be based on changing the corporate mindset; for all staff to recognise that improving productivity and quality is part of their job. The preconditions for such a change are threefold.
First is leadership from the top, from the board, from the management team and critically from the senior clinicians, crucially this means moving away from a victim mentality. Second, the organisation has to believe that high levels of productivity are inevitably associated with high quality, safe and effective clinical interventions; there is no contradiction between saving money and improving services. Finally, staff have to recognise that being busy is not the same as being efficient. Indeed, the reasons why many may feel stretched and overworked may well be due to poor work processes and system design.

Any attempt to improve productivity and quality without a comprehensive approach to organisational change will be doomed to fail. Many NHS organisations habitually fail to make the necessary investment in organisational development; seeing communications programmes, skills development and training for change as being desirable luxuries rather than necessities, only to pay the cost later.

Operational information

The absence of effective operational information systems in many hospitals cannot be due to a lack of data or a shortage of suitable systems – perhaps it's more fun to run a large complex organisation by the seat of the pants.
Or perhaps investing in technology to support management processes is too often seen as unimportant by comparison to buying another piece of clinical kit.
Yet a good management information system is not only the basis for effective operational management, but fundamental to clinical safety and quality. Provided of course, that alongside an investment in, a management dashboard which sits on a comprehensive data warehouse, the hospital makes an equal investment in improving and sustaining data quality.

Finally, the key task is to ensure that the hospital gets paid for what it does. Much of the benefit of operational improvements can be lost if the clinical coding is inaccurate and the invoicing processes weak.

Improving the economics – tactical changes

The objective of tactical action is to improve the core economics of the hospital within the bounds of its current business model, for example by spreading fixed costs over greater volumes. Within the NHS, with its obsession with size, the knee jerk reaction of many is to focus on consolidation through vertical and horizontal mergers.

However, the overwhelming evidence from other industrial sectors is that the faith placed in these structural responses is often misplaced. In the absence of a radical improvement in operational efficiency, greater scale will rarely bring with it improvements in cost performance and revenue security. The NHS evidence over the years, of merging smaller failing hospitals to make larger failing hospitals, rather supports this proposition.
Even given these uncertainties, the NHS often seems more comfortable embarking on controversial and, in all probability, undeliverable mergers and site closures than it is in confronting outdated workforce productivity or clinical practice.

Whilst consolidation is therefore the predominant tactical response, there are a range of other actions available to hospital providers, some of which may well prove more effective than vertical or horizontal integration. These include:

- **Rebalancing the case mix**, to improve the average revenue to cost ratio
- **Rationalising the service portfolio**, moving towards higher margin services
- **Cost shifting**, through technology, site rationalisation and outsourcing.

All tactical actions usually take longer than straightforward operational improvements and almost always have consequences for third parties, for example patients, commissioners and competitors.
The success of tactical action may therefore be less predictable and not entirely in the hands of the hospital.

Rebalancing the case mix

Whilst the current surge in activity for most acute hospitals brings with it welcome revenues, it is at a price; for as a result, many are operating significantly beyond their optimal capacity. The marginal cost of delivering the excess activity may well be sufficiently high to reduce overall margins; this will certainly be the case where marginal pricing is introduced.
For many hospitals there is therefore a mutuality of interest with local commissioners to cooperate in managing demand; reducing both inappropriate attendances at A&E and outpatients and inpatient admissions.

Agreeing and introducing referral and admission protocols with the commissioners is the starting point for this process. Its success, of course, may well depend on commissioners generating alternative patterns of supply, which may in itself present a development opportunity for the hospital provider.

Rebalancing the case mix so that it accurately reflects the hospital's optimum operating model will have the effect of reducing average unit costs faster than the reduction in revenues. A managed reduction in activity and revenues may be counterintuitive for many organisations, but it is a relatively painless way to improve margins and productivity.

Rationalising the service portfolio

The service portfolio, the mix of specialties and sub-specialties of many hospitals is invariably an historical accident. It is rarely optimal, either for the needs of the local population or the scale of the hospital. Rationalising the portfolio is not easy and can take time, particularly when undertaken in isolation.

However, networking, franchising and trading with other providers can provide a faster route to improving performance; a bit of cooperation, even with 'competitors', can often deliver mutual benefits for all concerned. To make these approaches work, clinicians would have to accept a greater degree of flexibility in their working arrangements but with the benefit of a more appropriate and richer case mix.

Cost shifting

By comparison to most industries, many hospitals remain remarkably old-fashioned in their approach to managing their resources and assets. Their adoption of new cost saving technologies is often slow, they hang on to sites and buildings seeing them as assets rather than the liabilities they so often are, and continue to undertake activities where they have little expertise and no economies of scale.

As complex, multi-dimensional organisations, the scope for outsourcing within hospitals is considerable. Whilst to date this has been restricted largely to hotel services and maintenance functions, there is considerable scope to explore outsourcing a wide range of back-office functions such as elements of finance, personnel, informatics, clinical coding, medical records and so on.

As activity levels begin to fall, the burden of fixed assets will rise. Multiple sites bring with them not just the direct costs of the buildings but they act as magnets for a wide-range of other support, administrative and operating costs. Even where hospitals are compact, the scope for better utilisation of the built estate is often considerable. Hospital managers and clinicians often have a strong attachment to buildings, but the resulting costs are far from sentimental.

Horizontal integration

Horizontal integration is all about trying to improve the underlying economies of scale, through shifting the ratio of revenues to fixed costs by spreading overheads and by increasing purchasing power. Taking over the neighbouring trust, closing some sites, losing some managers, and reducing competition is terribly seductive. It is particularly attractive to hospitals facing reduced activity and with it the risk of volumes falling below critical mass.

However, hospitals can redesign their services much more quickly through creating networks or franchise arrangements rather than through mergers and acquisition. And as already noted the general success of mergers is very much in doubt.

At least in part, this is because the benefits of horizontal integration can all too often be offset by its diversionary effect and the transaction costs; a recent simulation of a proposed merger suggested that it would be difficult to complete a merger in less than 18 months[5]. At the same time, horizontal integration almost inevitably results in increased organisational complexity. And even if location risk is reduced through horizontal integration,

5. Tribal, NHS Transactions – Can the Process Work?, 2010, ISBN: 978-0-9559143-5-5

by diversifying the markets served, sector risk is inevitably intensified; putting more eggs in the same acute services basket.

The difficulties of making horizontal integration work should serve as a warning rather than as an absolute deterrent. In some circumstances it will be the right answer, but only with first-class transaction management and an experienced management team that can handle the post-transaction challenges.

Vertical integration

Vertical integration is often tantalisingly attractive. Most organisations from time to time believe that they could do a better job than their colleagues, either before or after them in the value chain, particularly if this reduces competition and increases control over referral patterns. Consequently, many acute hospitals are looking at the prospect of extending their range of services by taking over community providers (whilst at the same time community providers are looking at taking on social care and even primary care!).

However, the evidence as to the benefits of this type of integration are sparse; our recent research of 207 published papers on service integration produced little or no concrete evidence of either significant financial or clinical benefits from vertical integration. This is probably because whilst up or down stream community and primary care services may be part of a single pathway for a patient, the delivery of these services may require very different skills and assets. There is no doubt of the challenge of managing a complex hospital and employing thousands of staff on two or three sites. But, it is equally challenging to manage a couple of thousand staff making thousands of visits to people's homes each week.

Whilst service integration may produce improvements in the quality of the patient's service experience through reducing organisational boundaries, this is always at the expense of choice. Inevitably, being tied in to an integrated service supplier will limit some consumers to accessing average or even poor services. In every day experience, consumers have a tendency to reject the entirely logical attraction of fully integrated services – whether from financial institutions or supermarkets – preferring to construct their own highly personal and individually specific service portfolios sourced from a range of suppliers.

As with horizontal mergers, the weaknesses in the argument for vertical integration should serve as a warning rather than a prohibition. In some cases it will work but probably because it will result in a strategic shift in the way the whole organisation works, shifting both the business model and the model of care.

Strategic possibilities

Very wisely few organisations embrace strategic change unless they have no alternative. Strategic change invariably requires altering a number of key dimensions at the same time; a risky and sometimes traumatic process. However, as the sector and individual hospitals come under pressure, boards and their managements – having exhausted the possibility of operational and tactical improvements – may have to explore the strategic alternatives.

The current strategies of NHS hospitals are remarkably uniform. There are of course exceptions; a small number of small specialist hospitals that have survived remarkably well. At the other end of the scale, there is a group with medical schools that seek to differentiate themselves, but most are really just larger general hospitals though there are a few genuine power-houses of research and education.

For the rest, the great majority, the model is very similar. All are building based, operating from a limited number of sites and serving a well defined local population with management and ownership coterminous with the sites and buildings. The range of services varies but only at the margin, with a high degree of commonality around the core services delivering largely episodic care. Overwhelmingly, revenues are based on activity and the size range is small; with the exception of a few outliers, the largest is only four or five times larger than the smallest.

Each of these dimensions could be flexed. The management and ownership could be decoupled from sites and building. In many parts of the world smaller hospitals are managed as parts of chains or networks, combining the benefits of organisational and management scale with local, focussed delivery. Given the density of the English population the creation of such chains would pose few practical difficulties; though even if each hospital retained its local identity the loss of local ownership might prove a barrier.

Episodic service delivery was certainly appropriate to the requirements and clinical technology of previous decades, but the growth area of the future is the continuing care of chronic conditions. This will lead some to reduce the scope of their service portfolio, focusing on a more limited range of conditions, whilst at the same time extending the breadth of their service offering along the value chain of the patient pathway. Inevitably this will lead to the detachment of service delivery from traditional locations, and the exploitation of new service and clinical technologies.

The specialist hospital of the future may rarely actually ‘see’ a patient and so shrink its asset base accordingly, whilst expanding the addressable population. This could lead some to become virtual hospitals of specialisms, with the core skill being able to manage remote and geographically distributed patient communities.

These types of development would reinforce the move away from output and activity based payments, with a shift to payments based on outcomes and risk. This could be attractive to suppliers, giving greater certainty of committed income, extended scale and the possibility of enhanced margins. But it would require a much more sophisticated business model and a substantially bigger balance sheet.

These types of strategic development on the part of 'acute' hospitals would of course have a profound impact on every other part of the health system; outdating the distinction between acute, community and primary care and even questioning the distinction between commissioner and provider. These interesting possibilities will be the subject of forthcoming Tribal papers.

The outlook for hospitals is extremely challenging. The current experience of rising activity and revenues flatters performance but also obscures the deep seated and systematic failure to improve productivity. A rapid reduction in the growth of resources will be translated to hospitals, initially in a curtailment of expansionary expectations and for many a progressive reduction in revenues.

Given the hard-wired operating models of the typical hospital, the juddering halt of the growth in resources could result rapidly in financial difficulties. Yet, the very scale of the last decade's expansion offers the possibility of making deep and rapid improvements in productivity, with no loss in service or clinical quality.

Very few hospitals cannot make significant improvements in their operational performance. Most will need to look at their underlying economics, questioning their service portfolio, specialty mix and use of assets. For some, these improvements will not be enough and they will need to consider both their viability as an independent organisation and the sustainability of their current business model and model of care.

About Tribal

In today's complex world, effective and efficient public services depend on the collaborative effort of people working across the public, private and voluntary sectors.

Tribal's distinctive offering combines professional, commercial and public service expertise. We work in partnership with our clients to help shape policy and improve the quality and value for money of public services.

We work with 2,500 public sector organisations in health, education, central and local government, housing and regeneration. Whether we are raising standards in schools and colleges, regenerating communities or improving hospitals, our focus is on delivering outcomes that enrich lives.

TRIBAL

www.tribalgroup.com
info.health@tribalgroup.com

ISBN: 978-0-9559143-4-8