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Health & Life Sciences

POINT OF VIEW

INNOVATE, RENEW, THRIVE

HOW DISTRICT GENERAL HOSPITALS CAN BE POSITIONED TO PROSPER

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INTRODUCTION

Since the founding of the NHS in 1948, District General Hospitals (DGHs) have been its bedrock. They account for 60% of the National Health System (NHS) hospital budget, and their efforts in delivering local healthcare to communities across the nation are a crucial component of the NHS's success.

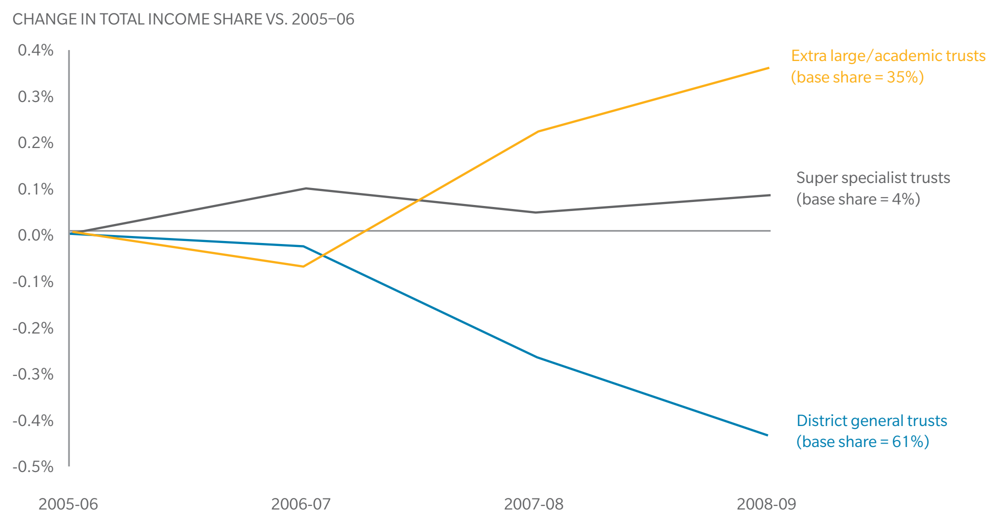
Over the last decade, the health system has changed substantially, and much-needed funding increases have brought UK healthcare spending in line with the European average. DGHs benefited from this rising tide, growing strongly over the period. The *next* few years, however, will be challenging. Trends have started to emerge that may have fundamental implications for DGHs and their role within the health system. NHS reconfiguration exercises could cause DGHs to lose activities (and revenue) in areas where they lack scale. They will also find it economically difficult to comply with other initiatives such as those to reduce clinical variability through more robust consultant coverage.

MARSH & McLENNAN COMPANIES

Recent history illustrates some of the challenges faced. Exhibit 1 shows that even as the overall hospital budget was rising, DGHs in fact received an ever decreasing share of the pot.

But the DGHs' challenge goes far beyond these initiatives, and smaller institutions are not the only ones affected. Given their crucial role as local deliverers of care, it is imperative for these institutions to find solutions that result in a sustainable, vibrant DGH sector. We believe all DGHs need to rethink their role, their potential, and how they address the varying needs of patients and commissioners. In this article, we will look at what we consider the most significant trends and suggest how DGHs can respond to them, protecting revenue while staying true to their mission.

EXHIBIT 1: CHANGE IN SHARE OF TOTAL INCOME 2005–09, BY TRUST ARCHETYPE



Source: Hospital Episodes Statistics (HES) database Copyright © 2010. Re-used with the permission of the Health and Social Care Information Centre. All rights reserved; NHS Trust income and expenditure accounts; Oliver Wyman analysis. Note: Cohort of trusts operating in 2005 and 2009 used.

CONTEXT: HEALTH SYSTEM EVOLUTION

In the past few years, a process of substantial change has begun as the health system responds to shifts in patient and commissioner needs. Exhibit 2 illustrates the direction of travel for hospitals within the NHS between 2005 and 2009. The chart shows change in total revenue and revenue per admission (a good surrogate for specialisation) at NHS acute trusts.

Some observations:

- **Breakout specialist trusts are becoming more specialised.** Total income per admitted episode has risen, with small increases in overall income. These trusts are attracting patients for more specialised, higher-acuity admissions. For example, The Clatterbridge Cancer Centre's movement reflects the centre's commitment to cancer treatment and the heightened acuity it brings.

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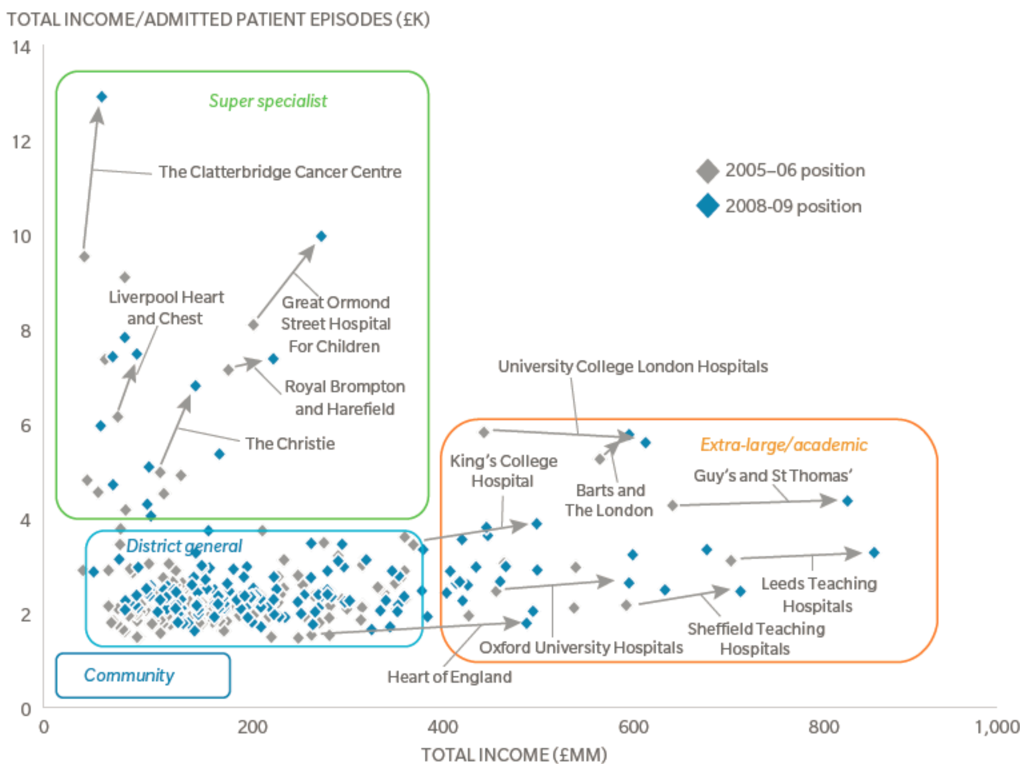
- **At breakout extra-large/academic trusts, income is growing—but not average admission value.** These institutions—for example Guy's and St. Thomas' and Kings College—have attracted significant additional need, but without becoming more specialised. We attribute the additional volume to patients who choose the institution because they are well known and have a reputation for higher quality, plus any consolidation.
- **Some district general trusts are growing rapidly.** Typically these are trusts that have broken away from the DGH archetype. Some have made a strategic decision to become more specialised, moving away from their generalist roots and delivering services that address more acute or severe patient needs. Others have successfully executed strategies to attract additional patients for existing and new services.

It is clear that hospital institutions are working to very different strategies and some are achieving "break-away" growth in the services they deliver. However, a core group of DGHs is apparent in the left lower corner of Exhibit 2—stable in degree of specialisation throughout the period, but not growing.

EXHIBIT 2: NHS ACUTE TRUSTS: TOTAL INCOME VS. TOTAL INCOME/ADMITTED PATIENT EPISODE



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FUTURE CHALLENGES: A CALL TO ACTION

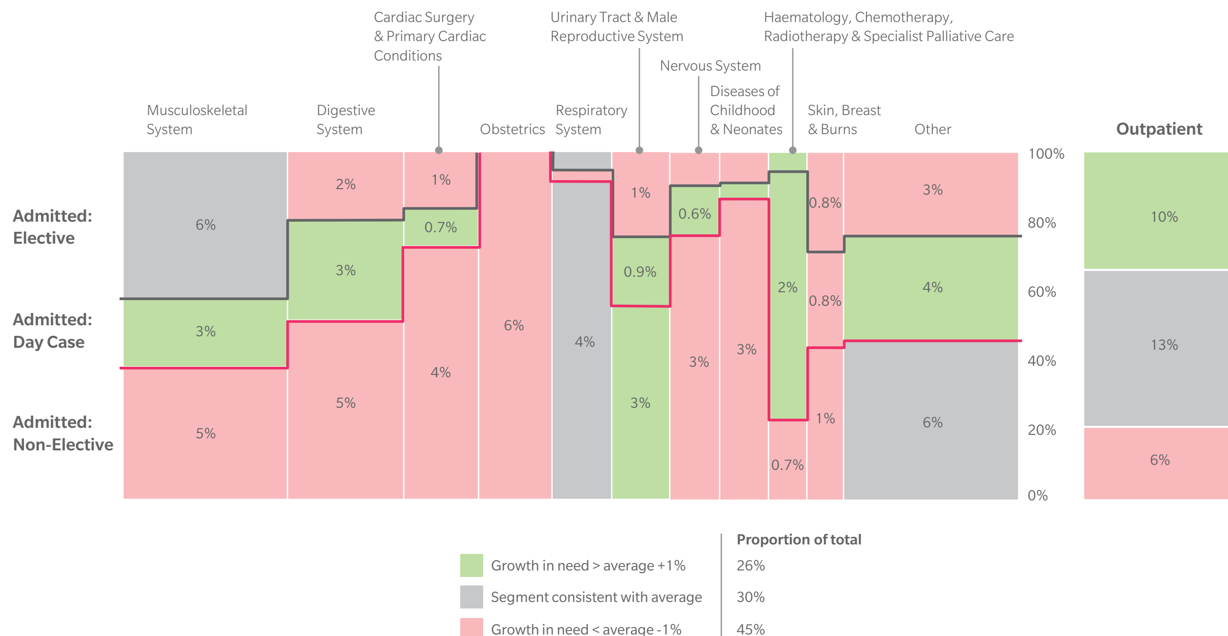
The next decade seems likely to be even more challenging. As funding remains at best flat in real terms, the "breakaway" institutions described in the last section are likely to continue to gain resources and funding, this time not from a growing pot, but a shrinking one.

Part of the challenge for DGHs is rooted in their activity mix. Exhibit 3 categorises the services delivered by an "average" DGH in terms of growth in need between 2005 and 2009; green represents high need/fast growth, while red is low need/low growth. Clearly, the focus is disproportionately on areas of declining relative need, which, given the funding constraints, is likely to be an ever declining pool.

It is also apparent that substantial proportions of DGH activity could be subject to sudden change. As the Clinical Commissioning Groups (CCGs) gather momentum they will aim to shift care to the community and contract with new entrant "qualified providers" who may implement new care models. In many cases, these new care models may be more efficient and higher quality than existing DGH services. For example, at high-throughput "systematised" ambulatory centres some new entrants have estimated efficiency benefits of 20%-40% versus the NHS average.

Non-elective (emergency) admissions are another example. Today, DGHs derive more than 40% of their PbR (payment by

EXHIBIT 3: DISTRICT GENERAL TRUST PBR INCOME BY SEGMENT AND GROWTH, 2009



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Note: Analysis uses 2012-13 PbR methodology and tariffs; Growth based upon 2005 vs. 2009 income levels; Outpatient specialities not present in 2005 shown in grey; Relative size of outpatient and total admitted income (28% and 72% of total income respectively) is not representative; Totals do not equal 100% due to rounding.

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EXHIBIT 4A: ACUTE TRUST INCOME SOURCES, 2008–09

DGHS ARE MOST RELIANT ON INCOME FROM PRIMARY CARE TRUSTS

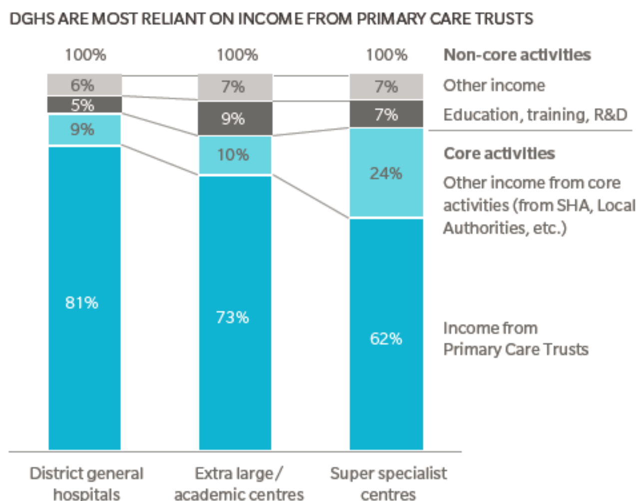
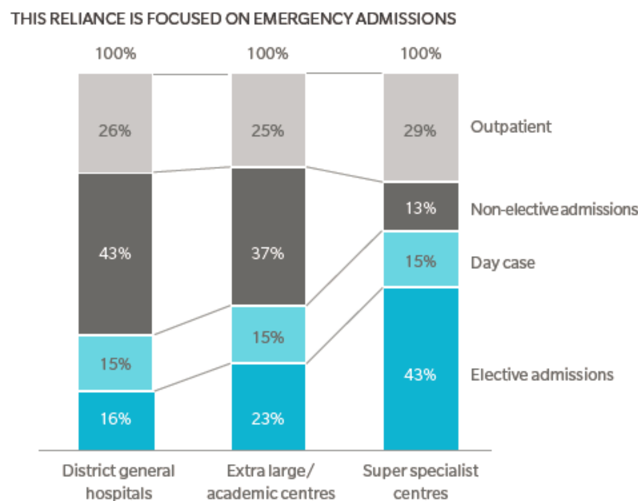


EXHIBIT 4B: TRUST PAYMENT BY RESULTS INCOME, 2008–09

THIS RELIANCE IS FOCUSED ON EMERGENCY ADMISSIONS



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results) income from non-elective work—a higher percentage than at other kinds of hospitals. See Exhibits 4a and 4b, showing that DGHs are more highly reliant on this source of income. Non-elective admissions are facing pressure as authorities aim to incentivise preventative care. On top of this, some integrated care pilots for the elderly are expected to reduce non-elective admissions by half. If these pilots succeed and are rolled out nationally, the impact on DGH income would be very large indeed.

INVEST AND INNOVATE TO PROSPER

It is not easy to address the challenges of the new NHS environment. DGH staff are burdened with an enormous range of initiatives and obligations. They need to deliver cost savings as part of the QIPP initiative; ensure delivery of high-quality care with great outcomes and low complication rates; achieve the highest standards of cleanliness and low infection rates; deliver in-year financial surpluses; source effectively; identify and fund investments to keep pace with technological innovation; attract and retain the best clinical and management talent; meet national targets, e.g. waiting times; negotiate terms with demanding commissioners; prepare for the new NHS landscape; and operate efficiently across a wide range of functions.

Despite many challenges, the changing NHS landscape offers DGHs many opportunities. By addressing and exploiting opportunities presented by the changing environment, DGHs can realise significant rewards. In the future, successful DGHs could continue to occupy an ever more important function within the healthcare system. New areas of growing local need will require the development of innovative services. Advances in clinical technology mean that much of what used to be performed in

highly specialised institutions can now be performed locally. New local, community-based models of care, if successfully deployed, have the potential to deliver higher quality and improved efficiency. Given that approximately 60% of the UK population lives within 10 minutes of a DGH, DGHs are well placed to deliver these new local services (despite the preconceptions of some commentators, they are already in the community). While there is no simple solution and delivering new services will require a mind-set shift, we believe it is a strategic transition that DGHs will have to make, or face extreme financial pressures. Key elements of the strategy include:

- **Invest to ensure services are superior, where the DGH is best positioned to meet existing needs:** DGHs will continue to be exposed to segments in which need is growing slowly. In order to defend their position, they must deliver improvements to these services and build a reputation for excellence that attracts patients, commissioners, and referrals. Trusts need to identify segments of existing need in which they are well placed to deliver excellent local services and can differentiate themselves. This will likely include episodic care where being local is essential, e.g. maternity, accident and emergency, some specific orthopaedic work and day case procedures. Differentiating will require significant investment in supporting infrastructure and assets, such as: the best doctors and equipment; service-specific quality assurance systems and continuous improvement programmes; superior, reportable outcomes; department-specific informatics capabilities to monitor operational efficiency and ensure the system is functioning effectively; disease-specific support programmes (e.g. patient navigators in cancer treatment); service-focused patient satisfaction surveys with immediate follow-up on issues highlighted; and defined best-practice patient pathways with compliance monitoring systems.

- **Adopt innovative, often community–based, care models:** Through the Oliver Wyman Health Innovation Center[1], we have documented how leading health organisations have developed new care models with the potential to deliver greater efficiency, a more patient-centric experience, and higher quality. The concepts will be familiar to NHS stakeholders, and range from high-efficiency ambulatory clinics focusing on single conditions, through to broader disease-based models addressing areas of high need such as diabetes. They also include highly complex models for the management of poly-chronic populations such as the frail elderly. All are characterised by very focused and defined care processes, documented integrated care pathways, and structured informatics and IT support systems, including quality and outcome metrics. Many also include specifically tailored facility plans designed to optimise patient flow, and reduce nurse and clinician workload. By taking a leading role in the adoption of these novel care models, DGHs can ensure they realise the benefits from innovation, rather than being negatively impacted.

1 The Oliver Wyman Health Innovation Center is a cross-industry advisory panel of CEOs, senior executives and thought leaders formed to serve as a forum where leaders can share innovative ideas, connect with other market leaders, drive innovation, and shape the evolution of healthcare.

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- **Ensuring the DGH is a fully integrated member of the regional care network, including the re-localisation of services:** As mentioned earlier, many elements of the care currently carried out in specialist institutions can now be delivered locally, either on the DGH campus or in nearby community sites. For example, many complex cancer services can be carried out locally, including ambulatory medical oncology (chemotherapy) and clinical oncology (radiotherapy). In some international markets, the only cancer service not delivered locally (for the four major tumour sites) is complex surgery. Moreover, the increasing ability to integrate care will mean that the lower acuity segments of some pathways can also be localised. For example, some of the post-operative pathway elements of Blood and Marrow Transplant (BMT) are candidates for more localised care, e.g. transferring patients from specialist institutions to closer-to-home DGHs to convalesce. Of course, implementing these changes requires coordinated planning with all stakeholders in the commissioning and delivery system, and strong protocols to identify patients that are appropriate candidates. The requirements to implement this level of coordination vary: in some areas improved communications and joint planning will be sufficient; in others, formation of Integrated Care Organisations (ICOs) may be the best way to ensure sufficient alignment.

* * *

Renewing the role of DGHs will, at times, require the sort of vision and innovative spirit that drove the original founders of the NHS. In places there will be a role for the private sector, but hopefully where it will bring truly accretive capabilities such as care model blueprints or the ability to deliver demonstrated rapid operational efficiencies, rather than vague assertions of "better management". It may also call for a flexible mind-set in terms of traditional boundaries, especially to deliver integrated care. Successfully driving these shifts and renewing the role of DGHs will help to ensure the future of one of the bedrocks of the NHS.

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