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Repositioning the hospital

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HOSPITALS: TO THE NEXT MILLENNIUM

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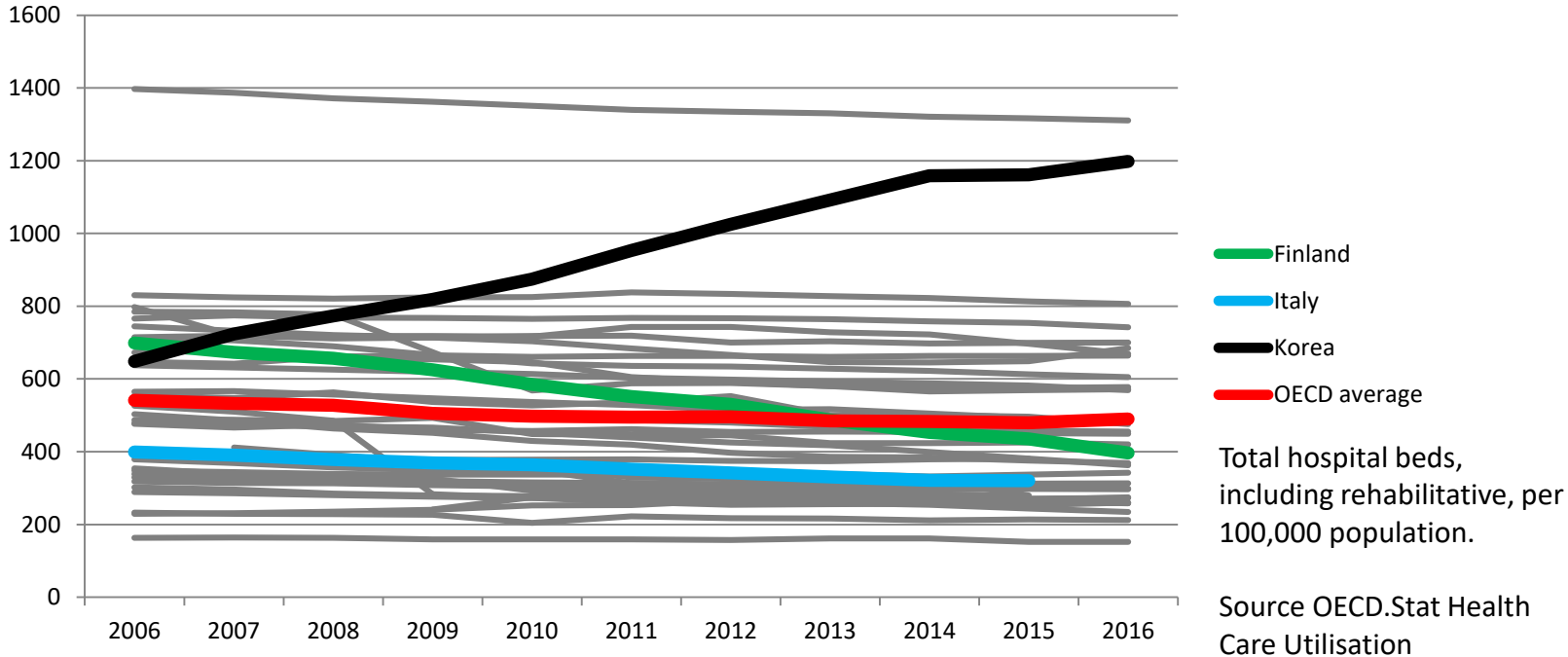
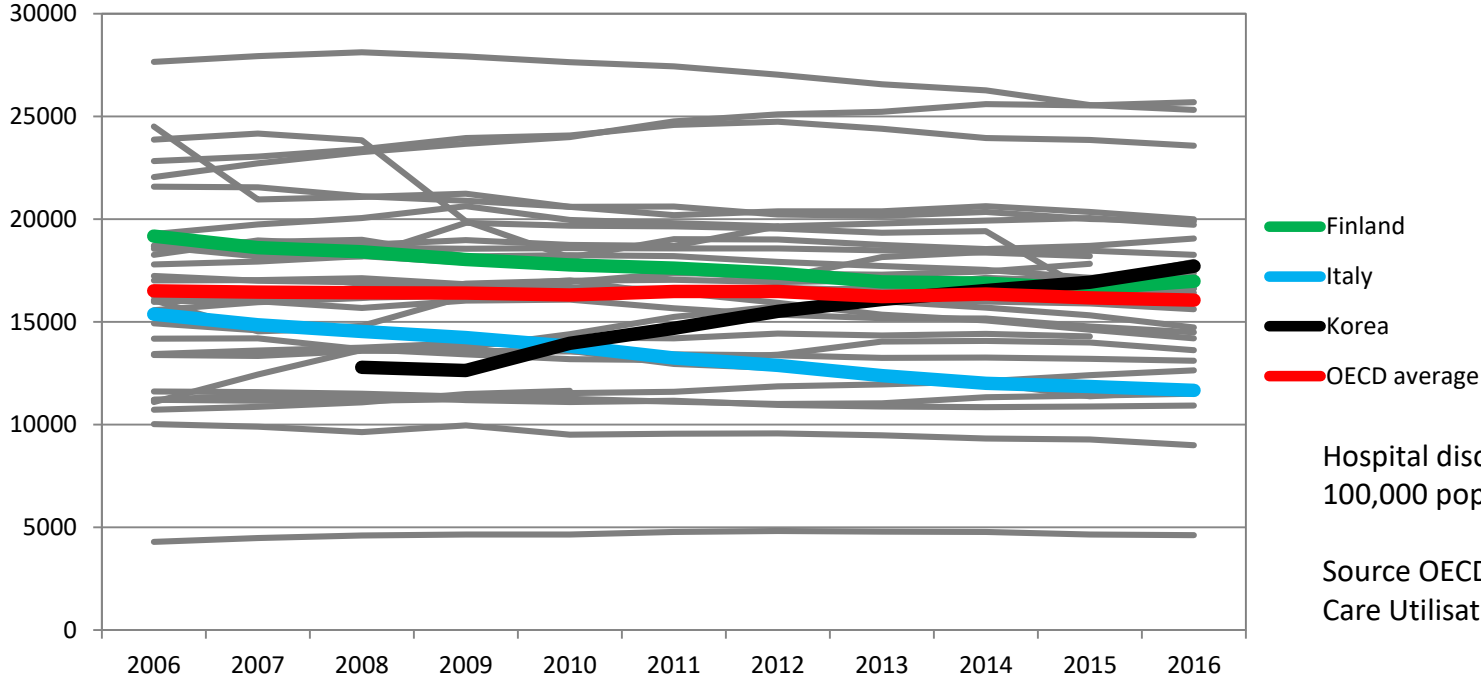
The number of OECD hospital beds has fallen by an average of 10%



Total hospital beds, including rehabilitative, per 100,000 population.

Source OECD.Stat Health Care Utilisation

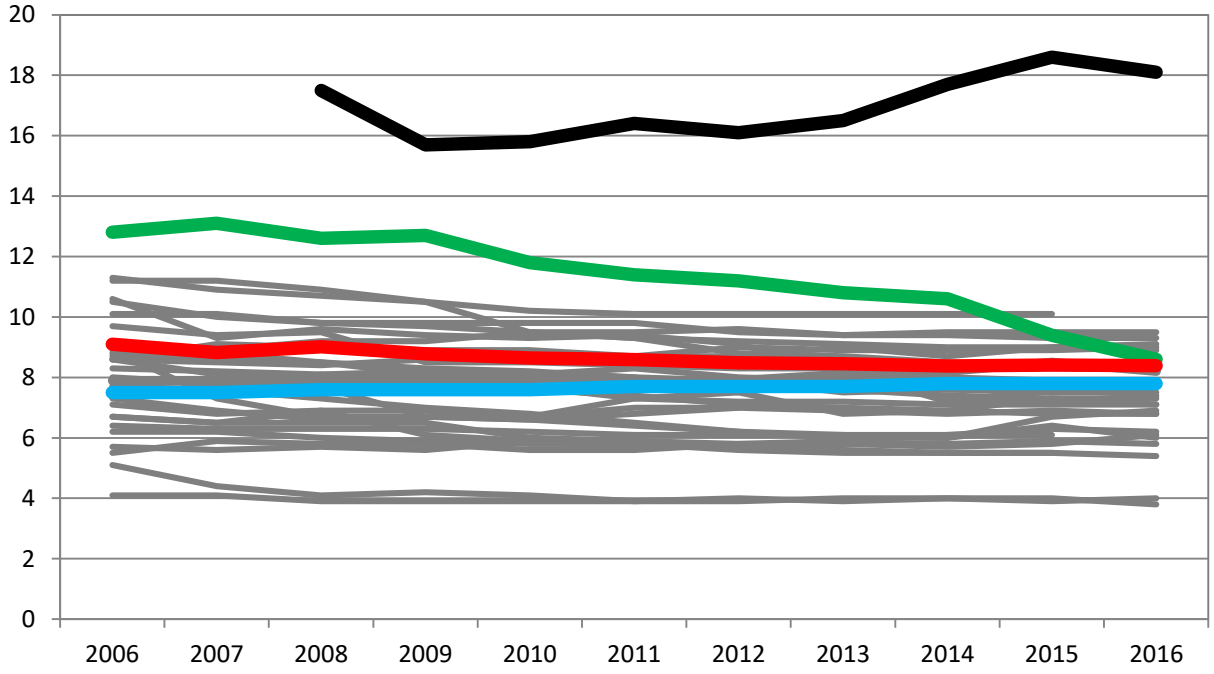
Hospitalization rates have fallen by 3%



Hospital discharges per 100,000 population.

Source OECD.Stat Health Care Utilisation

Average length of stay has fallen by 8%



Average length of stay for all inpatients in days.

Source OECD.Stat Health Care Resources. Japan not shown with LOS around 30 days.

Well known challenges and some opportunities

Growing expectations
More regulation and transparency
Pressure from payers and governments to contain costs
Workforce shortages & burnout
New technology
Anti-microbial resistance
The volume to value transition
Population aging
Etc…….

Multimorbidity

UK: 2015 - 2035 the proportion of people with 4+ diseases will almost double

- 2015: 9.8%
- 2035: 17.0%

Two-thirds will have mental ill-health

One in three patients admitted to hospital in England as an emergency in 2016 had five or more health conditions - this is up from one in ten in 2006.

Medical staffing model not matching patient need

This means hospitals often have the wrong types of staff to deal with the patients they are seeing

Too many narrow specialists – not enough general physicians and geriatricians

Growth in integrated, person centred healthcare

Effectiveness argument

- Fragmented care produces poor results for patients

Economic argument

- Avoidable hospital stays and associated morbidity wastes money

Recognition of the importance of social factors

- Care can be improved by addressing social determinants

Personalisation

- Single disease pathways don’t work for multiple conditions or meet the patient’s goals

Specialisation & regionalisation

Hospital are finding it difficult to maintain the full range of specialisms

Strong evidence for quality from higher volumes in some types of work

- Learning effects
- Development of critical mass of intensive care support
- Ability to have a senior doctor on site

A problem with along tail of low volume procedures

Scale is not so important in general medical specialties but a critical mass of staff is needed

Many very small hospitals cannot provide these specialist services well

Response 1: Operational improvement

- Efficiency improvement
- Length of stay reduction
- Purchasing and procurement savings
- Lean or other redesign
- Standardization and removing variation
- Etc.

These are well understood

This is not a strategy, just the price of staying in business

Repositioning the hospital

The hospital is not a stand alone organisation

It is not the right focus for planning services

The key question is what is the best way of meeting the needs of our patients and the wider population

- What is within the capability of the hospital
- What is core to its functioning
- What are the workforce, digital, capital and delivery models to answer this

Strategy 1: Develop wider networks

Various types of horizonal networks
Focus scarce expertise
Share this using technology
Be clear about who does what
Standardize care across systems

Hub and spoke

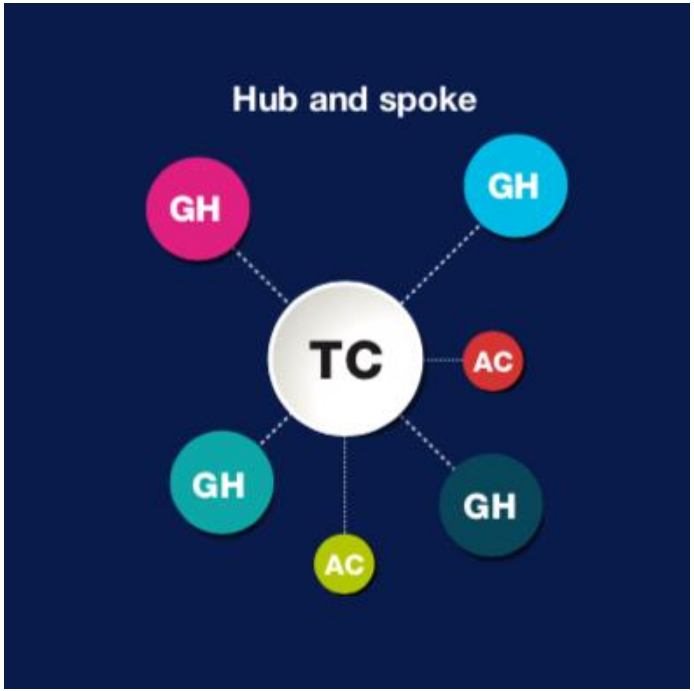
Division of labor between hub and spokes – e.g. Colorectal Cancer

Hub

- Major surgery, radiotherapy, histopathology, and manage complex, metastatic disease, research, leading standards development

Spokes

- Screening, scoping, imaging, biopsy, surveillance, chemotherapy, rehabilitation and co- ordinating end of life care

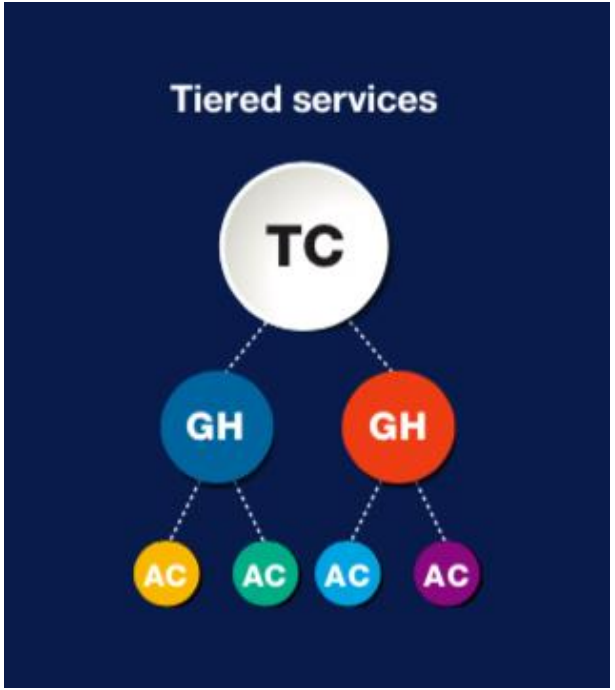


TC = Tertiary Centre
GH = General Hospital
AC = Ambulatory care

Tiered networks

For example:

- Obstetrics with tiers described by clinical risk & need
- Trauma networks
- Stroke



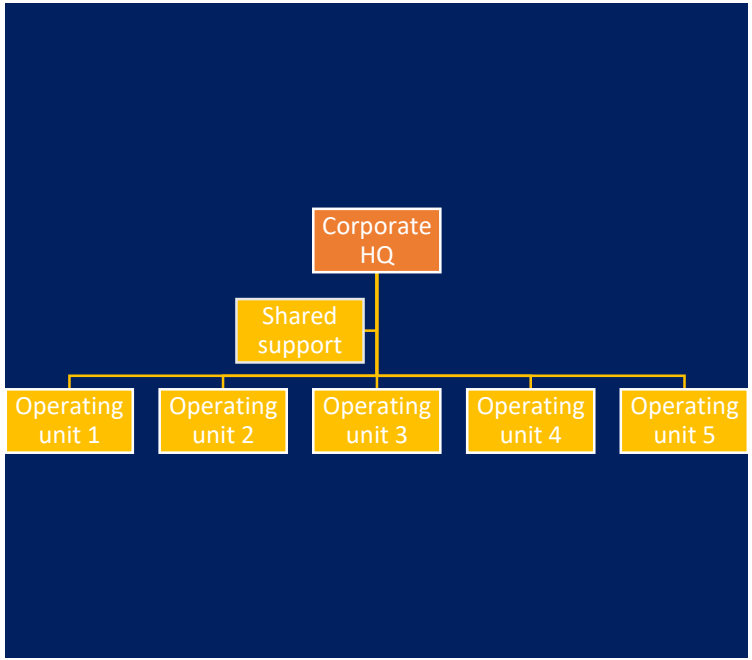
Hospital groups

Shared back office functions, QI, policy development & usually purchasing

Operating units have a high level of autonomy on business choices

Different management skills needed at the centre than in operating units

Growing rapidly in some places

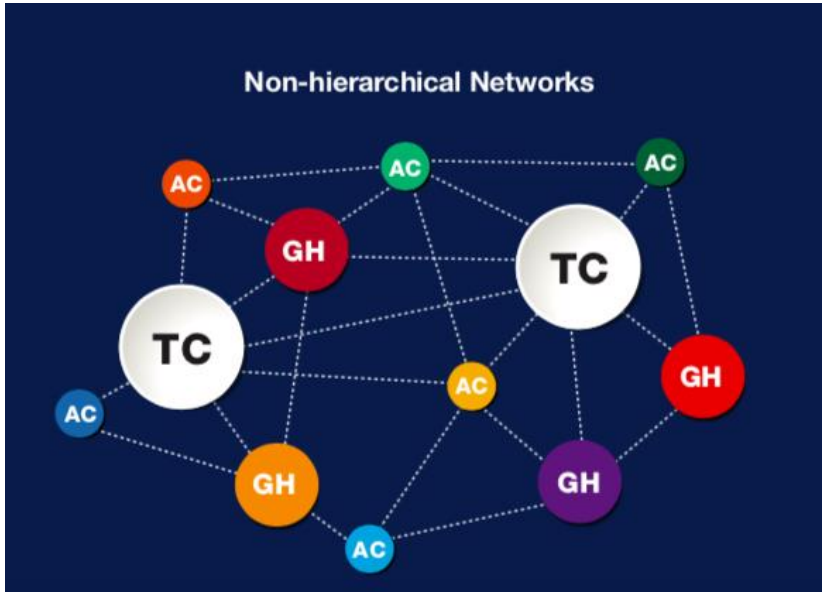


Non-hierarchial networks

Rather rare at present

ParkinsonNet in the Netherlands

- Shared pathways
- Accredited providers with defined roles
- Patients chose their route through the system



Strategy 2: Create integrated care systems

Hospitals integrating with primary care and home care services

The hospital becomes a component and seen as a cost to the system rather than a revenue generator

Challenges to restructure business models & payment systems

Changes in the role of specialists

New role for specialists dealing with chronic disease

- Co-producer of pathways and guidelines with patients and primary care
- Educator and advisor - Keeping the system up to date with the science
- Support to specialist nurses and care coordinators and dealing with the most complex and difficult patients
- Taking a population health view
  - Developing and running registries
  - Identifying the highest risk patients
  - Developing population health interventions
  - Understanding the context & social environment

Other changes flow from these strategies

New outpatient models

- Advice and guidance to primary care rather than referral
- Virtual clinics and telemedicine
- Multidisciplinary clinics for symptoms, one stop diagnosis & treatment

Hospital services reach out and boundaries blur

- Rapid discharge and step down
- End of life care
- Support for or even ownership of care homes
- Home care and rehabilitation

Primary care has to change too

Scaling up
Standardization of care pathways
Different staffing mix
Increased availability of diagnostics and treatments
Shift from face to face to phone and web

In many countries this means major changes in the funding and business model

Other changes

In the organisation of planned care and especially surgery

- Stand alone units
- ‘Factory models’

Supporting strategies

Redesign of the staffing mix

- Extended roles and top of license working
- More generalists
- More mental health input
- New ways of training doctors

Digital capability

- To support proactive care
- Creating opportunities for patient self management
- To drive improvement

Words of warning

Vertical integration is hard work – major culture change and care redesign and creating a proactive population health focus is hard

There are major governance challenges

It is unlikely to work without strong primary care at its heart

It may not save money quickly - If you do reduce admissions hospitals may find it very difficult to release cash

Thinking bigger: Hospitals and their communities

Hospitals are important part of their local communities
They can use this power to:

- Link to the social care system
- Build the local economy and community development
- Train and develop staff locally to fill the many workforce gaps
- Improve the lives of local citizens, patients and staff

Final thoughts

Low and middle income countries might want to think about their strategies

Significant implications from this for the leadership of hospitals

- Change management skills and relationship management
- Rethinking and redesigning the workforce is the most significant imperative for for which most systems are least well equipped
- Ability to mobilize community resources
- An understanding of the wider system beyond the walls of the hospital

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