

The future of acute care

Andy Black



The voice of NHS leadership

The NHS Confederation brings together the organisations that make up the modern NHS across the UK. We help our members deliver better health and healthcare by:

- influencing policy and the wider public debate on the full range of health and health service issues
- supporting health leaders through information sharing and networking
- working for employers to improve the working lives of staff and, through them, to provide better care for patients.

For more information on our work, please contact:

NHS Confederation
29 Bressenden Place
London SW1E 5DD

Tel 020 7074 3200 Fax 020 7074 3201

E-mail enquiries@nhsconfed.org

www.nhsconfed.org

Disclaimer

All views and opinions in this publication are those of the author and are not the authorised views or opinions of the NHS Confederation. The NHS Confederation shall not be liable for any indirect, special, consequential, or incidental damages or defamation arising from any views, opinions or information contained within this publication.

Registered Charity no. 1090329

Published by the NHS Confederation

© NHS Confederation 2006

ISBN 1 85947 121 8

Ref: BOK56001

Contents

Foreword	2
The traditional segmentation of the market	3
If you knew your history...	5
Back door blocked, front hall crowded	10
Towards a restructured acute hospital?	12
Alternatives to hospital admission	15
The undervalued CAM market	17
Conclusion	18
A worked example: the community medical centre	19

Foreword

The imminent demise of the hospital has been a recurring theme for decades, yet hospitals are still thriving. There are, however, some major challenges that hospitals will have to face in coming years. While many of these stem from developments in medicine, there are also significant pressures from changes in society.

The launch of *Your health, your care, your say*, a major consultation on the future of community health and social care services in England, also begs some important questions about what needs to be inside a hospital. Over the course of the past century, the UK's hospitals have accumulated control over many services that are typically found outside hospitals in other countries. 'New' visions for hospitals have tended to be quite rigidly constrained by historical or professional divisions that have no relationship with what patients actually require. In particular, it is time to question the apparently inexorable trend towards centralisation and specialisation, if there is to be any chance of giving reality to the rhetoric about shifting services closer to home.

Andy Black is a leading thinker about the future shape of services and, in my view, one of the most interesting. His ideas are challenging and require a re-evaluation of many of the assumptions we make. His ideas present some exciting ways in which all our services could adapt to meet shifting expectations, new technology and other changes in medicine and society.

Although its focus is on hospital care, his model effectively removes the distinction between in-hospital and out-of-hospital care. In this vision the hospital is part of a series of integrated components embedded in their community, rather than the hyper-specialised, distant and isolated 'cathedral of illness' sometimes envisaged in forecasts about the future of the hospital.

Andy Black had a management career in the NHS between 1973 and 1994. During this time, he held a number of positions, including running a large metropolitan region, being a senior Government adviser in Whitehall, and chief executive of a London teaching hospital. He now runs his own specialist health services consultancy, Durrow Ltd.

This report does not represent the Confederation's view but we are taking the unusual step of publishing a personal view of this type because, while not all Confederation members may be comfortable with these ideas, they need to be discussed and thought about. This is a strong call to action that deserves our serious attention.

Nigel Edwards
Policy Director
The NHS Confederation

The traditional segmentation of the health market

The health sector in England can be divided into four segments, as shown in Figure 1. The top two quadrants represent the private sector units and the bottom two the public sector. The left side represents private funding and the right side public funding.

Figure 1. The private/public divide

Private patient in a private unit	NHS patient in a private unit
Private patient in an NHS unit	NHS patient in an NHS unit

In practice, the market has been dominated from the bottom right quadrant: publicly funded patients in publicly funded units. This domination has been so absolute and endured for such an extended period that it has become ingrained in the thinking of many managers, clinicians and politicians. Even this Government, which has gone as far as any other in pushing the development of the top right quadrant (publicly funded patients in private units), began with a period in which the private sector was seen as a port of last resort.

The migration of services from publicly provided to privately provided is a current preoccupation because it is now having an impact on mainstream NHS acute elective services. However, the pattern of migration is not new. Since the formation of the NHS, parts of the service have moved from the hospital or the clinic to the high street. Examples include the provision of spectacles and most aspects of vision-correction, most of dentistry and, most important of all, the provision of long-term care of the elderly. This last aspect is looked at in further detail on page 7.

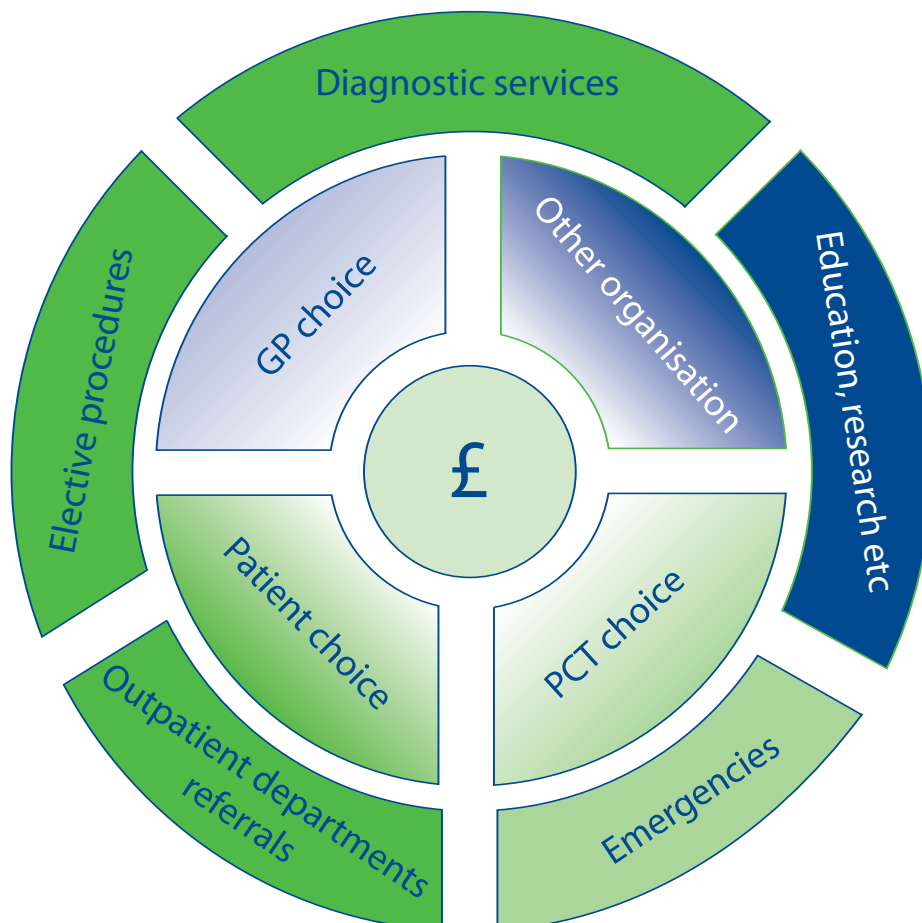
It is not this migration to the private sector that makes the current juncture unique in the history of the NHS, but the combination of two factors:

- that acute hospital care is undoubtedly closer to the voting public's central nervous system than care of the elderly
- the introduction of universal patient choice.

Figure 2 shows the five traditional markets for the NHS acute unit. The three green arcs cover scheduled services, the pale green denotes emergency care and blue denotes other (research, education and training). In the inner circle I have speculated about where the locus of choice will reside. In the green zone it will be interesting to see whether the individual patient takes over or if it will be GP-guided choice. For emergency care it looks likely that the PCT or some similar body will define access points. Education and research will remain a specialist contracted market, but independent providers will move into it.

What does seem obvious is that politicians' views that 'X per cent' of the NHS elective cases will go into private supply cannot survive genuine choice. A GP in Stratford-upon-Avon recently told me that if he were to give every patient a choice of elective care centres, he thought that 'about 100 per cent' would choose the private alternative. One can already faintly feel the ground shaking as the thundering herd of unintended consequences approaches.

Figure 2. Classic markets for NHS acute unit



If you knew your history ...

'If you knew your history, you wouldn't have to ask where you are coming from.'

Bob Marley

Before looking at how future NHS providers might seek success in the new order, it is first necessary to look backwards. It is the vogue to list current 'drivers of change' – reports to NHS boards are rife with them. The list (summarised below) is taken from the Royal College of Surgeons (RCS) of London, circulated to their Reconfiguration of Health Services committee. I find the fact that the RCS can publish this list and the fact that they have a committee looking at the reconfiguration of health services almost more interesting than its contents.

For four decades after its formation, the service the NHS gave was overwhelmingly provided by NHS employees from publicly funded and publicly owned assets. Funding was largely a cascade of funds from Parliament to the point of delivery through some form of regional, district or local budgeting process. The allocation and spending of the money was an internal NHS family affair. Broadly speaking, the same family decided what services would be available and where they would be placed.

It was perhaps in the 1980s that these fundamentals began to show the first signs of breaking up. This decade saw the introduction of the concepts of general management and compulsory competitive tendering. The first marked the germination of the managerial control mechanism that has now achieved hegemony over the professions; the second led (through the private finance initiative (PFI) and the growth of the commercial staffing agencies) to the 'plural market'. It also saw the emergence of the private sector as a significant provider of NHS elective services. In 2005 it is no great shock to think that a so-called NHS

Drivers of change

Primary drivers of change

- Payment by Results (producing very different contracting arrangements)
- patient choice 'choose and book' and potential loss of strategic control)
- modernising medical careers (streamlined training and future role of consultants)
- European Working Time Directive
- pharmaceutical and technological advancement
- deomography and epidemiology of disease
- independent sector procurement.

Secondary drivers of change

- foundation hospitals
- new consultants' and GPs' contracts
- changes in private healthcare sector
- provision of services in smaller surgical specialties
- increasing influence of clinical networks
- increasing specialisation and centralisation
- documents from the National Institute for Health and Clinical Excellence and Clinical Outcomes Group
- treatment centres (NHS and independent)
- desire of new doctors for work-life balance
- more female doctors
- more doctors working flexibly
- introduction of non-medically qualified surgical care practitioners.

hospital is effectively owned by a bank and is dependent on a percentage of nursing staff registered with a private agency that may rise to double figures, not to mention the PFI facilities management subcontractors and other private sector staff.

It is sometimes hard to remember the psychological map of the NHS in the 1980s. Consider two widely held beliefs among NHS staff (and a sizeable proportion of the general public) of the time:

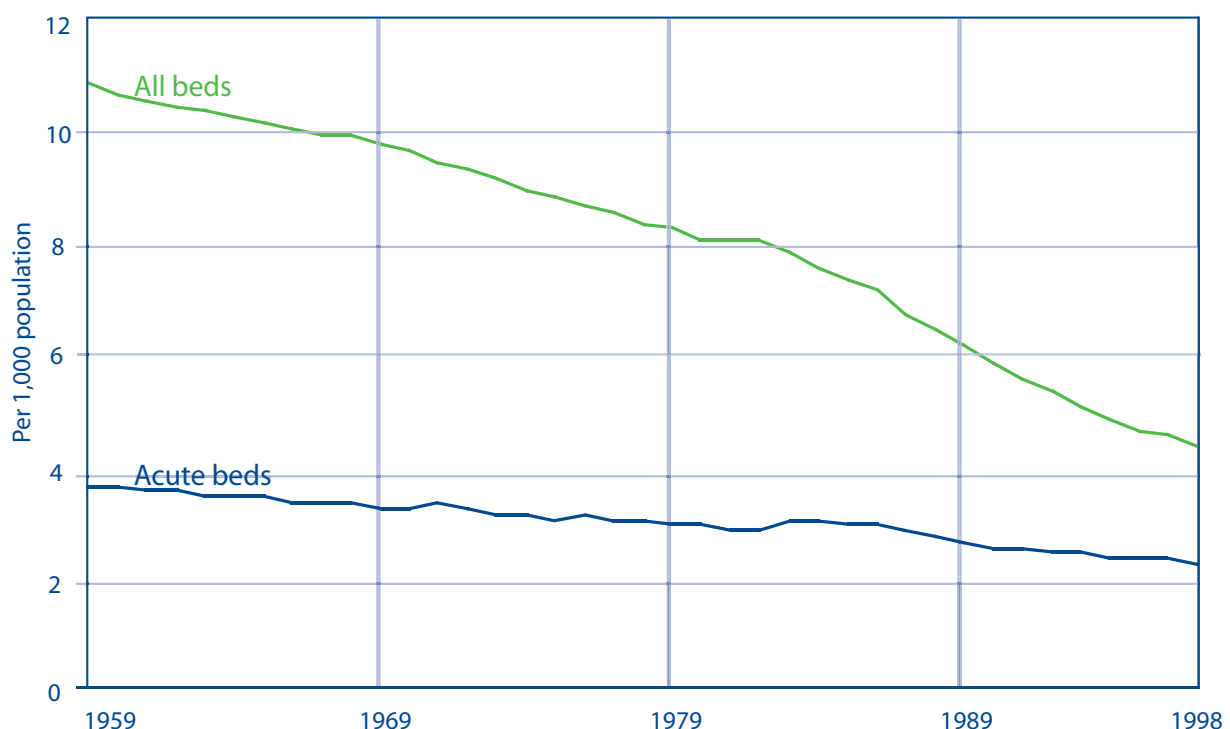
- if the people who cooked the meals or cleaned the hospital corridors were not NHS employees but employed by a private company, then the NHS as we (and the patients) knew it was finished
- many consultants felt that they should not in any way consider the financial costs of their clinical actions and should not be accountable to anyone for the way that they practised medicine.

On the second belief, Dr Martin McNicol, an early pioneer of evidence-based practice and President of the British Thoracic Society, described to me the battles they had there as they sought to build a consensus on guidelines for the basic treatment of asthma.

Inpatients and bed availability

Throughout these decades, the dominance of the inpatient model of care was steadily declining. Figure 3 shows the steady reduction over 50 years in the number of available beds per 1,000 population. Even in 1973, when I started watching the figures, I was surprised at the willingness of NHS managers and clinicians alike to believe that the reduction had, or would soon, 'bottom out'. By the turn of the millennium the NHS bed count had reduced to approximately 2.2 acute beds per 1,000 population.

Figure 3. Average daily available NHS beds 1959 to 1998 (England)



It was around this time that the *British Medical Journal* article comparing the NHS and Kaiser Permanente health systems appeared.

NHS/Kaiser comparison		
	NHS	Kaiser
Average number of primary care doctors per office	3–5	20–40
Percentage with on-site lab, imaging, pharmacy	25	95
Average acute length of stay (days)	5	3.9
Adjusted for age profiles	644	327

from *BMJ* Vol 24, 19 Jan 2002 p138, Table 3
Letters 2002; 324: 1332; 1 June

Even correcting for error, when all the smoke and noise is filtered out it seems obvious that California gets by with fewer beds than the NHS does today at the end of the long march downwards since 1945. If you visit southern California it will be very easy for you to see why. They do (as opposed to talking about doing) more things in community settings.

Care for the elderly and blocks to discharge

While acute inpatient beds were reducing, things were also changing in care for the elderly. In the 1990s, the total number of residential places peaked at around 500,000, with the private sector increasing its share of the market. (see the bottom two bands in Figure 4a.) Looking more closely at the public sector share of the residential/nursing home sector, it is apparent that during this decade the NHS and local authorities shed around 100,000 beds/places. Figure 4b shows these two bands alone, to make the trend more visible.

Figure 4a. Elderly care market by provider, 1990–2000

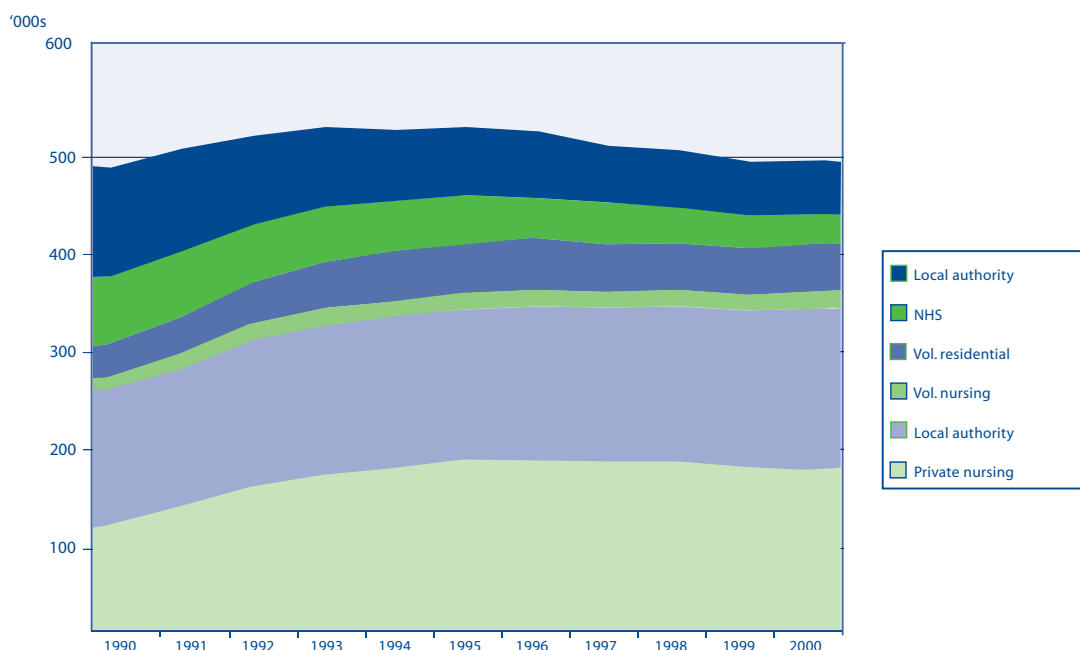
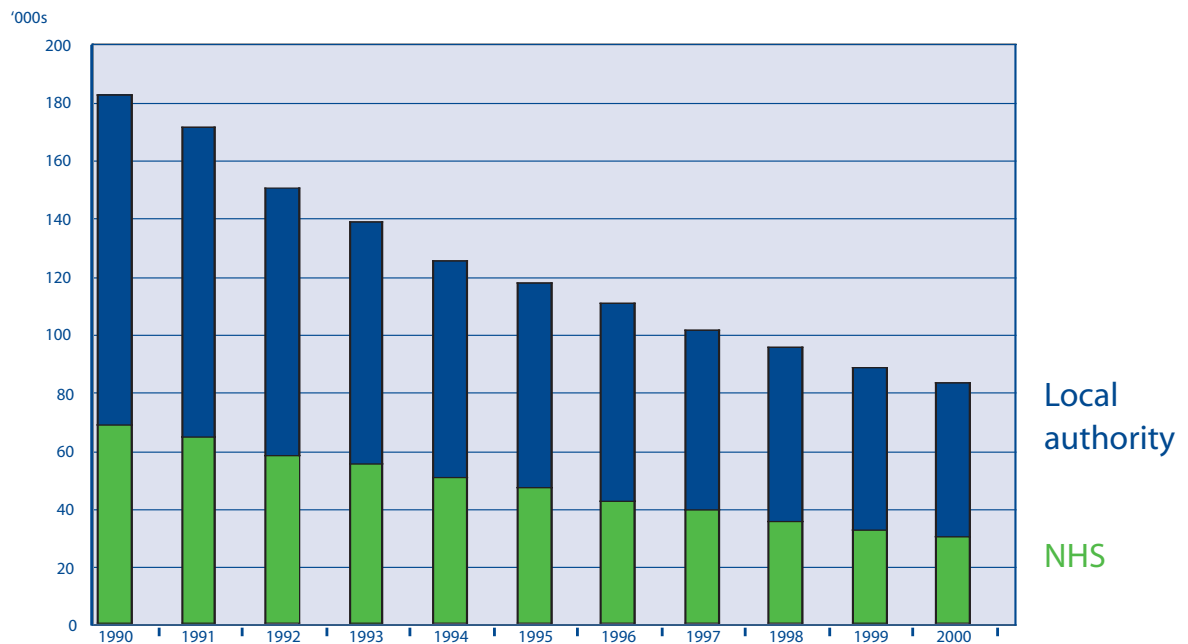


Figure 4b. NHS local authority elderly care provision, 1990–2000



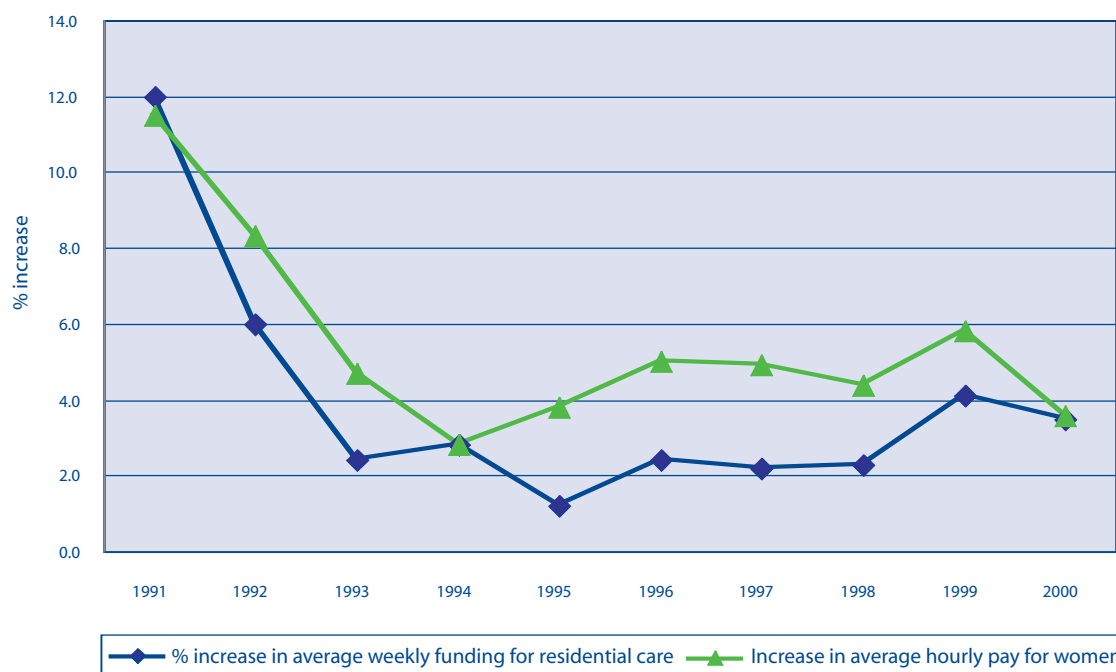
The 1990s saw the beginning of the longest period of sustained economic growth in England. Significant parts of the country began to experience full employment. It also became

increasingly unprofitable to run a private residential care home for the elderly (and any other part of the economy that relied on poorly-paid women.)

In Figure 5, the green line traces the year-on-year increase in hourly pay for women, the blue line shows the year-on-year increase in what the public sector (mainly local authorities) would pay for a

week's residential care. The area between the two shows the gap between what proprietors had to pay in wages and what they received in fees.

Figure 5. Average pay levels outstripped funding growth for residential care



These are averages. In the south of England the differential was particularly sharp. Some local authorities in high wage areas faced the prospect of having to export contracts for residential care to 'low wage' parts of the country. I remember working with two acute hospitals in the same week: one in Lancashire and one in Surrey. The Surrey hospital had over 70 patients classified as 'delayed discharge'; in Lancashire they had three.

These issues have undoubtedly constrained the traditional NHS discharge routes for hospital inpatients who are in acute beds but no longer require acute care. Against this background, the NHS needs to be particularly careful that it does not, by using a hospital-centric model, over-convert the frail elderly into candidates for long-term care. We can see from the many recent studies by chronic disease management providers that there is major potential to reduce inpatient demand by substituting community-based programmes.

Back door blocked, front hall crowded

If the reduction in capacity and the commercialisation of the elderly care sector made it more difficult to move NHS inpatients out of the 'back door' of the hospital, there was also trouble brewing in the front hall. I am grateful to Dr Derek Bell of Edinburgh Royal Infirmary for the following analysis. Although it relates to the hospital scene in Scotland, it certainly fits the observations we have made in England.

The graph in Figure 6 shows the number of (and reasons for) emergency admission to hospital in Scotland over nearly 20 years. Two clusters emerge. Those in the upper cluster, which represents the more common reasons, not only begin higher but have accelerated faster than the lower cluster. And the two reasons showing the fastest increase of all are the nebulous 'signs and symptoms' and 'other causes'. Underlying population morbidity is not increasing, but more patients are presenting as emergencies.

Figure 6. Emergency admissions by groups of diagnoses Scotland 1981 to 1999

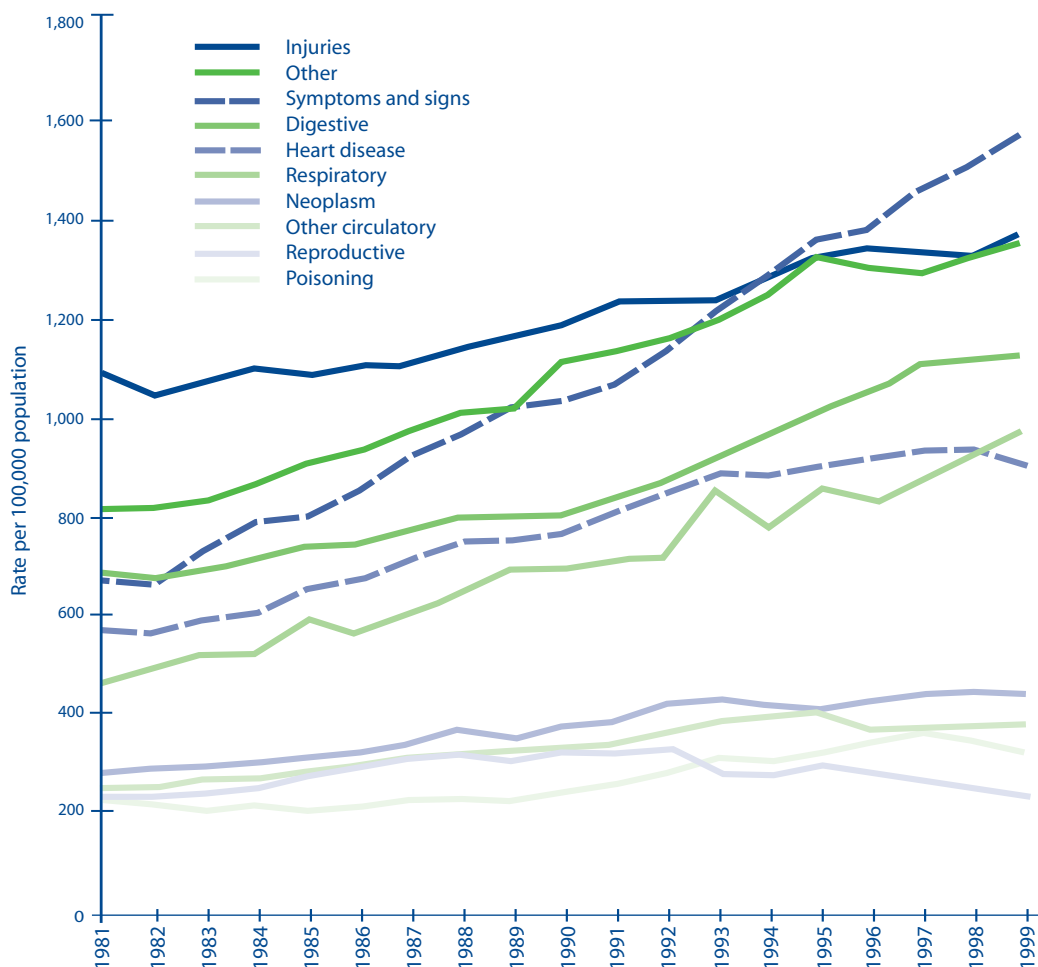
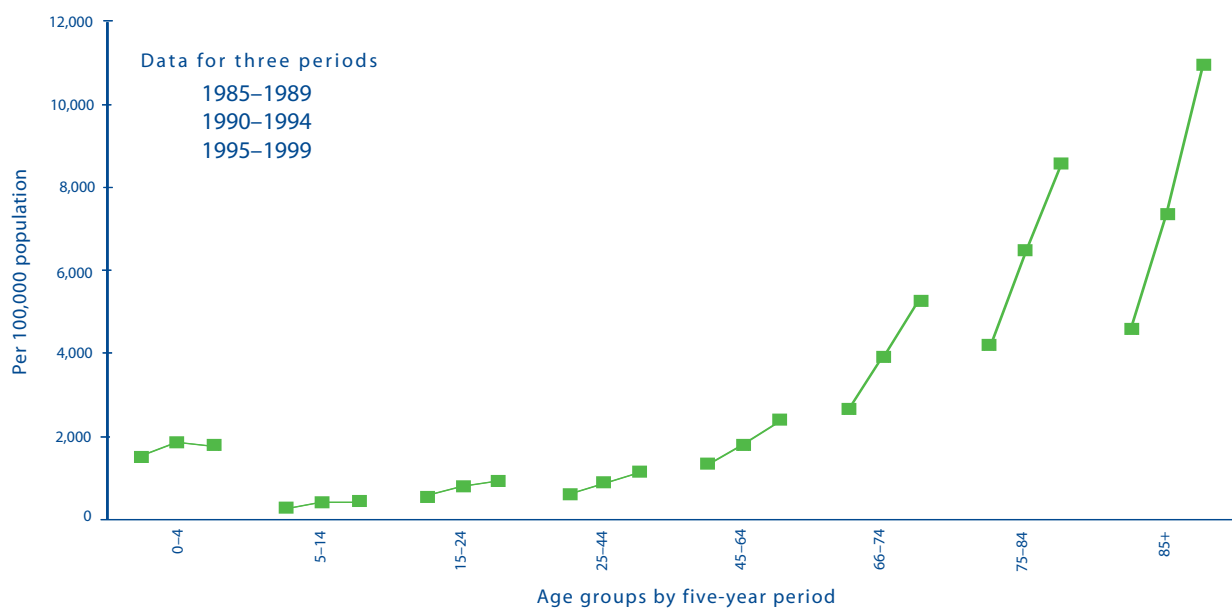


Figure 7 shows patients in eight age groups who have had four or more admissions to hospital in three time periods: 1985–89, 1990–94 and 1995–99. If the rate of admission within each age group were constant for these three periods, the three ‘year-period’

points per group would form a horizontal line. This is nearly true for the 5 to 14 age group and there is not a great deal of change before middle age. However, the pattern shows the elderly being repeatedly admitted with increasing frequency.

Figure 7. Patients with four or more emergency admissions as proportion of age group in population (Scotland)



Information and Statistics Division, NHS Scotland, January 2001

True emergency or tactical manoeuvres?

My personal conclusion is that the acute hospital emergency department is increasingly being used as an instrument to manage chronic disease. How long would it take any hospital to find an elderly patient registered as an ‘emergency’ but who was really referred to hospital as a safety measure?

Not long ago I came across a woman who had been admitted by her GP as an emergency because that GP cynically (and accurately) guessed that this would both prevent a fall and result in her broken

walking aid being replaced more quickly than any other way. My own mother was surprised to find that, after ringing her GP for some advice on juggling her treatments for breathing difficulties, she was whisked off to hospital in an ambulance. She was then told that she would be in for a week while they waited to ‘get her a scan’. She discharged herself without the scan.

The ultra-aggressive policing of the four-hour A&E target must be making things worse. With more patients presenting as emergencies, more are being converted to admissions. Among these, more are subsequently becoming delayed-discharge problems.

Towards a restructured acute hospital?

Many NHS acute hospitals are working under great pressure. Bed management and target monitoring have become very process-intensive and are absorbing large amounts of management and clinical resources. Not too long ago a famous teaching hospital with which I was working conducted a survey of exactly who was in the hospital and why. The result showed that of about 500 inpatients on that day about 100 were queuing for access to diagnostics and were not acutely ill.

My first conclusion is that most NHS hospitals are trying to retune the traditional hospital model – one hears a great deal about the ‘patient pathway’ and ‘modernisation agenda’. I have to say I have become sceptical. At best, this is a coping strategy; at worst, it is just not working. I am unconvinced that enforcing micro-guidance will have any lasting impact. I am more interested in a root and branch re-examination of the way the acute hospital is structured.

It may help to analyse in a little more detail why people are at an acute hospital.

Who is in this hospital and why?

Put simply, all emergency patients can be divided into three groups:

Group one

These people have just arrived. They were not invited, they just turned up: they are patients in need of assessment and a plan. These patients arrived today or maybe last night.

Group two

These patients have been assessed and found to be in need of acute medical care. This is the group with the most potential for therapeutic gain from acute medical care and management. These patients will be in their first week of stay.

Group three

These are patients who have been in the hospital for more than a week. They may have been acutely ill and recovered or they may have been admitted for other reasons. These patients are less and less likely to need or benefit from acute medical care, and they are more and more likely to benefit from a rehabilitative regime. There is a real danger for some that their continued stay could have a negative therapeutic value. The following would not be a fanciful scenario: a crisis in social support met by admitting into hospital a frail but coping elderly lady results in her disorientation, further collapse of social support systems and a hospital-acquired infection.

Durrow Ltd have analysed the clinical activity of more than a dozen large NHS hospitals in the last couple of years, and the data fall into a clear pattern. If there were 600 inpatients, about 100 would be ‘in assessment’, about 200 would be receiving acute care and the remaining 300 would be in recovery/rehabilitation or awaiting discharge. This last sector would include patients who were never acutely ill but were admitted anyway.

So, what can be done?

A radical remix

Imagine taking all the patients (and staff) out into the car park one sunny day and then putting them all back in a different structure.

One new approach would be to move away completely from the organisation of a hospital’s facilities by specialty – I see the grouping of patients by specialty as a weakness and a constraint, and not as a desirable objective.

Reassessing assessment

I would put all the assessment cases together and create a unified medical and surgical assessment team, led by a senior physician. I have never been a fan of separate surgical and medical assessment.

If there are separate teams for emergency surgery and emergency medical assessment there will always be the potential for mismatching patients. Recourse to historical statistics will be little help – assessment of a patient with abdominal pain, for example, is often recorded as ‘surgical’ if seen by a surgeon and ‘medical’ if seen by a physician.

One of the main objectives of this assessment unit should be to treat the least ill patients as quickly as possible and return them home without admission. This was Dr Derek Bell’s great contribution to the art in Edinburgh. Although it might seem counter-intuitive to treat the least ill quickest, there is logic to it – the only avoidable admission is an avoidable admission. Dr Bell’s unit in Edinburgh was doing in two or three hours what many NHS hospitals were taking two or three days to do. Nor were his very ill patients dying from neglect.

A very small number of emergency admissions actually have emergency surgery (I believe the figure is about 1 in 200). A leading physician has said to me, ‘If a patient really, really needs urgent surgery then the most important thing is that they see an emergency physician straight away. I would like a cupboard in the assessment unit that says Emergency Surgery, so that I could get them out and say: “Do that one!”’

The acutely ill

The next large group in our selection is the 200 or so patients who are acutely ill. Why divide these patients by specialty? Why not group them by dependency? We already do this for ‘intensively’ ill patients.

The truth is that many patients have always fitted awkwardly into specialty pigeon-holes. Many of these patients will be elderly and will have multiple problems. If you analyse who is in what bed you will find that force of circumstance has resulted in patients consistently being put in the ‘wrong’ beds. I recently visited a relative who had had a stroke and found her in the spinal injuries unit: both she and

the nursing staff had a tangible feeling that ‘she shouldn’t be here’, although physically the stroke ward was an exact mirror image of the spinal injuries unit in an identical ward block not far away. Labels count. The NHS loves labels.

I will not pursue here all the arguments about grouping patients of one specialty together, but believe me I have heard them all. It is not grouping patients that provides the therapeutic gain of expert care – it is grouping and managing the skill sets of the staff. Community psychiatric nursing teams do not try to get all their patients living in the same street.

The rest

What about the 300 patients in our sample who are not acutely ill?

We have known since the 1970s that if you compare all the elderly receiving care in some form – hospital, residential and nursing home or living at home with support – that clinical need is not tightly matched to their place of treatment.

Frankly, acute hospitals accommodate a lot of inpatients who are not acutely ill. So why use an acute model of medical management? Habit. Deeply ingrained custom and habit.

My suggestion is that, after two weeks, all patients in acute care should be automatically transferred to care focused on rehabilitation. Many could go much sooner, after just a few days, and some should go directly there. Everyone in healthcare, and others, have seen the massive impact that a dynamic clinical team dedicated to active rehabilitation can have on throughput and recovery rates. Unfortunately, most will also have seen cheap copies that can amount to little more than ‘warehousing’ the elderly.

I would physically separate these patients from the acutely ill patients and create a very different physical environment, one that emphasises recovery and wellness rather than sickness. Again,

we have known of the concept of the 'therapeutic environment' since at least the 1970s but for complex reasons our clinical staff do not specify such an environment in new facilities – they continually emphasise the 'acute treatment' environment. This is a physical environment that says to the patient: 'You are (very) ill!'

Of course, acute hospitals will say that patients who are not acutely ill should not be in acute beds and I agree with them. The logical continuation is to move them and halve the size of the acute hospital. The issue of chronic disease management (see page 16) reinforces this point.

In the shorter term...

Since, in the short and medium term, non-acute patients will be in our traditional acute hospitals, the practical approach is to recognise this and restructure accordingly. The physical separation of non-acute patients allows the creation of a non-medical environment. There is also no point in providing these patients with acute medical cover and placing them under medical management. There is no need to provide ward rounds and night medical cover to these patient areas. If a patient's condition worsens, then it is more logical to move them back into the acutely ill environment than to try to extend an acute umbrella over the whole unit, ward or area.

There is a deeper and longer advantage to this restructuring. Over time, if the chronic disease management programmes begin to reshape chronic disease care, we will have a pattern of acute hospitals more suited and more appropriately sized to deal with patients who are actually acutely ill, and the cost of this acute care will be transparent and directly funded. This contrasts with the concealment (and under-registration) of these costs in the general bundle of outpatients, elective care and chronic disease inpatient care.

Alternatives to hospital admission

My first point was that acute hospitals needed to consider fundamental restructuring. My second is that those commissioning healthcare badly want to promote alternatives to hospital admission. History shows that alternatives to hospital care are very difficult to promote, but they highlight four main strategies:

- finding alternatives to outpatient department consultation
- developing diagnostic capacity within primary care
- accelerating development of stand-alone ambulatory care centres
- introducing chronic disease management programmes.

Alternatives to the outpatient department

Each year there are about 70 million hospital outpatient attendances nationally and about 300 million visits to GPs. The current average time per GP consultation is around seven minutes, which doctors in some other countries (and many GPs here) would think is too short. With the rise of consumerism, patients are taking a more active role in the discussion of their health and treatment decisions. This means more time, not less, is going to be needed. Communicating across different languages and cultures also requires more time.

My point here is that GPs with special interests will not, logistically, provide a realistic alternative to consultant outpatient department referral. They may, in particular places and specialties, make a significant contribution, but nationally the numbers do not stack up. I would argue that the movement should be the other way – that specialists should migrate to primary care and become full partners in primary care practices.

Diagnostic capacity in primary care

Increasing this is a surefire winner. About 40 to 45 per cent of all hospital diagnostic activity is for GPs. There are high transaction costs in referring and reporting the results of referral, in addition to the core costs of the work itself. Additionally, patients pay a high price in travel, inconvenience and stress in waiting for answers. My GP friend often needs a large gin and tonic on getting home after an afternoon chasing results from the hospital.

We have been brainwashed into thinking that our diagnostic ironmongery should be working flat out, 'sweating assets' and all that. I like the idea of MRI and CT scanners lying around all over the country with no patients in them – to me they say: 'You can have a scan today ... or tomorrow.' The NHS is one of the least capital-intensive industries imaginable. Most of its money goes on staff wages.

The new wave of primary care centres financed by local improvement finance trusts (LIFTs) should make a strong contribution to increased diagnostic capacity. These 'super-surgeries' will prevent patients who need scheduled diagnostic imaging or other tests getting mixed up with the emergency patients at the hospital. Let us hope that this will also reduce the widespread practice of admitting patients to hospital to gain access to diagnostics.

Independent sector treatment centres (ISTCs)

Stand-alone ISTCs have proliferated in recent years and if numbers are anything to go by, this initiative has certainly 'succeeded'. This is not surprising. If you offer the private sector a chance to invest in an enterprise with no price or volume risks and with a guaranteed return and exit, you can certainly expect a response. It may be the price you have to

pay to create a market quickly. Some will say the NHS got stiffed (again). Just about nobody is being detached and objective. I am generally in favour of ISTCs but think that the unintended consequences for the legacy NHS hospitals will be more awkward politically than is currently imagined.

Chronic disease management (CDM) programmes

This is surely the hot ticket for 2006. If those commissioning healthcare push millions of pounds into this area you can be sure that NHS trusts, GPs and the many US-based CDM companies will enter the arena.

I have been working with American clients in this area since the mid-1990s and was involved in the early NHS studies; indeed UnitedHealth were briefly subcontractors on the early application of predictive software to UK GP data. That there is a kernel of great value here is clear to me. What is not so clear is how it can be introduced to the UK for a lasting and constructive effect.

Leading US health policy expert Victor Villagra wrote a short and insightful objective review of CDM in *Health affairs*.¹ In a nutshell, he says that disease management in the US provided an operational framework to manage chronic disease but did so in parallel with the legacy healthcare delivery systems. He strongly advocates the integration of CDM with primary care clinics. I think that the NHS is in danger of making the same mistake and seeing CDM as a 'bolt-on' additional activity.

The dichotomy between primary and secondary care has become so habitual that we fall into the trap of thinking that we have to work with it as a given. In my summing up (page 18), I suggest that we explore hybrid formations. CDM would be one enterprise where the contributions of individual caseworkers, family doctors and specialists could combine to great therapeutic and financial effect.

For the moment, there seem to be some unrealistic aspirations among PCT executives about the speed and extent to which CDM will empty hospital beds. Their optimism is counterbalanced by layers of cynicism and denial among acute trust executives. This is going to be a long-term game.

¹'Integrating disease management into the outpatient delivery system during and after managed care,' *Health affairs*, W4-283, 2004

The undervalued CAM market

The complementary and alternative medicine (CAM) market in the US was estimated at around US\$27 billion in 1997. That year there were in the US an estimated 629 million visits to CAM practitioners, more than the number of visits to primary care physicians. An *Economist* Intelligence Unit report on the UK CAM market in the mid 1980s estimated that total turnover at that time was about equivalent to the annual budget of one NHS region – about 7 or 8 per cent of the NHS operational spend at that time. Extrapolating from these figures, the value of the current UK market may be more than £5 billion.

In 2004 I ran a check on a small market town in England to see what the scale of the CAM market was; the results are summarised below. There were about 40 CAM practitioners, about double the number of GPs. At a very crude estimate, about £2.5 million of turnover was completely bypassing the local NHS, which was predictably strapped for cash.

Drivers of change

Complementary and alternative medical practitioners in one small English town

Acupuncture	3
Alexander technique	2
Aromatherapy	3
Chinese medicine	1
Chiropractic	3
Cranial reflexology	1
Herbalism	2
Hypnotherapy	4
Meditation	2
Osteopathy	3
Relaxation therapy	4
Shiatsu	5
Aerobics venues	8
Pilates venues	5
Swiss ball venues	1
Tai chi venues	2
Thai kickboxing venues	1
Yoga venues	16

The most interesting things to me about the CAM market are its steady growth and resilience and the fact that it is almost completely funded from discretionary payments by individuals from disposable income.

What is the significance of this?

Consider this information in the context of the NHS choice agenda. There is an assumption among politicians that people will make choices along the lines suggested by their NHS 'guides'. But choice is not given, it is taken. To my mind, there is overwhelming evidence that if people are allowed to decide where they will go for what treatment, there will be a significant vote for CAM to be brought into the frame – another variation of the 'public pay/private provider' segment of the market. This will result in more millions of pounds that used to circulate inside the 'NHS family' moving off into the private sector.

Conclusion

Future success for healthcare providers in the UK may not be a matter of manipulating the existing NHS formations, and now is a good time to explore some new possibilities that exploit the opportunities opened up by choice and Payment by Results.

In looking at the traditional segmentation of UK healthcare (see page 3), I have indicated that the domination of the scene by the public pay/public provider, while clearly not about to vanish overnight, faces the prospect of some shrinkage as public pay services are provided by private providers of many kinds. The domination of public pay/public provider will lose a little ground and, unfortunately, few organisations in this sector have any financial slack at all; indeed a number are at the limits of financial viability already. Those lost millions of pounds will be missed.

Here would be my list of points of departure for NHS trusts looking for a successful approach to the future:

- **hybridisation of primary and secondary care services.** This would certainly include specialists migrating to join partnerships of primary care physicians, and the result would not be either primary or secondary care but a true hybrid
- **new approaches to emergency assessment.** This means the unification of medical and surgical teams in a single emergency team
- **the use of advanced technics.** Technology can supplant the use of increasingly expensive and difficult to source skilled humans to perform simple tasks often associated with communications or information management
- **inclusion of commercial partners.** Don't let the money walk out of the NHS sector: join up with private partners and co-venture!
- **inclusion of the non-NHS 'health economy'.** The CAM sector, for example, is much bigger than we think and it is popular with the public (see page 17)
- **inclusion of 'wellness' facilities not just 'illness' services.** The gym, sport, spa, beauty treatments and a host of other activities on the borders of health and leisure represent other sources of cash flow. They can also help to integrate health services into the local community.
- **civic integration.** This picks up the previous point. The NHS loves to build discrete facilities with no crossover to the other social agencies, let alone the high street. In one major northern city where the NHS is shaping up to spend over £1 billion on hospital projects, there is vague irritation that the city council is poking its oar in and trying to assert the importance of integrated town planning. Healthcare should be part of overall planning.

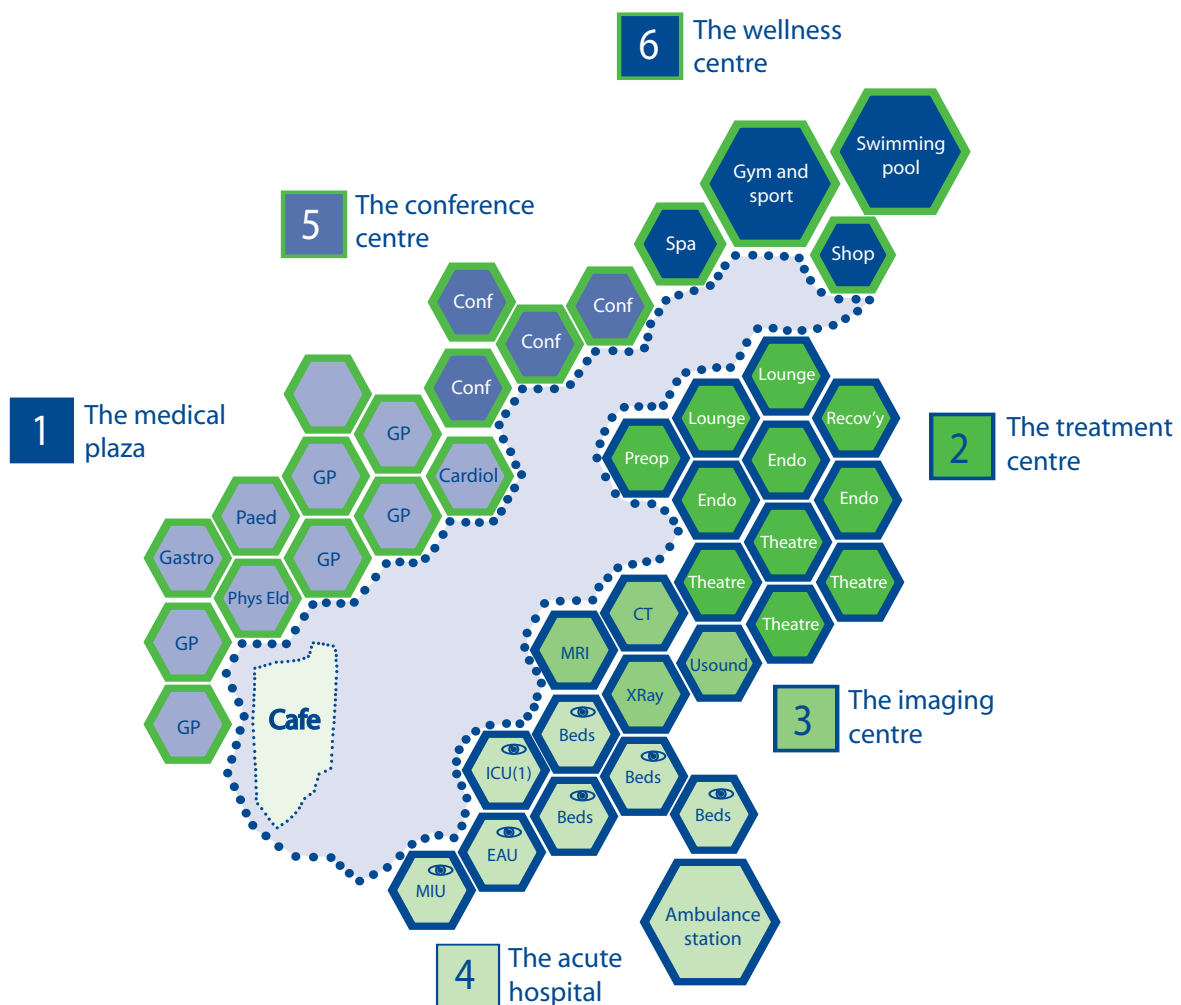
A worked example: the community medical centre

This is not a template, it is an extended planning doodle – an experiment in the way the new elements I've described could be arranged.

The new community medical centre seeks to

provide a hub which can bring together the health and wellness services of a typical UK town. From the health service perspective it specifically blurs the line between hospital and primary care – it is neither and it is both.

Figure 8. How illness and wellness might be integrated in a new-style community medical centre



Some features of this model to note are:

- A full-service 24-hour/seven-day emergency assessment and treatment unit is provided, capable of assessing patients to district general hospital (DGH) standards. The local ambulance service is anchored here.
- The medical plaza provides a facility from which a wide range of clinicians can practice. This includes the functions of GPs, dentists, hospital outpatients department, as well as therapies and services normally provided in private and alternative practice.
- DGH-level diagnostics are available on-site, along with theatre and endoscopy intervention facilities.
- The centre also accentuates wellness. The gym, swimming pool and sports facilities bring in the healthy as well as those recovering, to pursue their activities side by side. Facilities are shared between the personal trainer for the healthy and the therapist working with the cardiac rehab patients.

The centre is a major economic and social fixture in the community. The NHS is part of it but it is not a public institution in feel and tempo. Many of the clinicians will be operating in private practice. The leisure, retail and catering facilities can be provided by diverse commercial providers. Civic integration is important – the centre should become an important element in the town, an impressive and uplifting space.

Further information

A more detailed paper explaining the elements of this concept is available on request at andy@durrow.org.uk

For more information about the Confederation's work in this area, please contact Nigel Edwards, Policy Director, at nigel.edwards@nhsconfed.org

The future of acute care

The imminent demise of the hospital has been a recurring theme for decades, yet hospitals are still thriving. There are, however, some major challenges that hospitals will have to face in coming years. While many of these stem from developments in medicine, there are also significant pressures from changes in society.

The future of acute care has been written by Andy Black, one of the leading thinkers about the future shape of services. His ideas are very challenging and require a re-evaluation of many of the assumptions we make.

This report does not represent the Confederation's view but we are publishing a personal view of this type because it needs to be discussed and thought about. The issues covered here are of considerable relevance to all those involved and interested in the acute sector, and for those who care about what the future holds for the hospital.

The NHS Confederation's *Leading edge* publications are designed to stimulate debate.

The future of acute care is the first in a series of *Leading edge* reports commissioned by the NHS Confederation, offering leading thinkers the opportunity to voice their views on major issues affecting the NHS.

Further copies can be obtained from:

NHS Confederation Distribution

Tel 0870 444 5841 Fax 0870 444 5842

E-mail publications@nhsconfed.org

Or visit www.nhsconfed.org/publications

£15

BOK 56001

THE NHS CONFEDERATION

The voice of NHS leadership



The NHS Confederation
29 Bressenden Place, London SW1E 5DD

Tel 020 7074 3200 Fax 020 7074 3201

E-mail enquiries@nhsconfed.org

www.nhsconfed.org

Registered Charity no: 1090329