Going with change: 
Allowing new models of healthcare to be provided for NHS patients

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Mike Parish

June 2014 #goingwithchange
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Reform

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Executive summary

The NHS is in the grip of two crises. The first crisis is the financial challenge. With the parlous state of the public finances and rising demand, the NHS is facing an “affordability gap” of £30 billion by the end of the decade. The second is a crisis of quality. While many patients require high quality and coordinated services, nearly all experience care that is fragmented and of variable quality.

Many in the health service agree that meeting these challenges requires tough choices and radical reform to existing services. However, the major challenge facing the NHS is a crisis of inaction. While many agree that something must be done, too often change is judged to be “too difficult” and is deferred. But tinkering with existing services and putting off radical change is only storing up trouble for the future.

Alongside a crisis of inaction is a false loyalty to the existing models of healthcare delivery. The vast majority of healthcare is delivered in organisations that have changed very little in the last 50 years. Primary care is largely provided through a cottage industry of small GP practices. Too many patients with long term conditions receive their care in acute hospitals. Specialist services are often provided in hospitals that are too small to achieve the volumes of scale that are needed to ensure patient safety and consistently good quality outcomes.

The NHS has so far struggled to embrace modern technology to transform the way patients receive their care. These traditional organisations are both out of step with the new healthcare needs and are also bankrupting the service. High fixed costs, such as labour and estates, also mean that these organisations are not agile enough to develop new ways of providing services. There is a tendency to put the interests of organisations ahead of the interests of patients. In the absence of a market, the onus for change and progress is on managers and politicians who effect change as late as necessary rather than as early as possible. There is limited scope for disruptive innovation as the system is more geared to perpetuating and protecting the status quo.

Rather than relying on extra funding to deliver more patient care the
NHS now needs to harness new sources of value. In other sectors of the economy similar challenges of cost and quality have often been resolved by new business models that have been able to create value in new ways. This report presents case studies from diverse industry sectors:

- **Grocery retail:** Grocery retail has moved from high cost, fragmented, high street-based shops to larger retail outlets that offer greater value, choice and convenience for consumers and which harness the shopper’s own labour capacity. In recent years retail chains have introduced their own high street outlets utilising the scale economies established through the large store business and moved online to allow consumers to do their shopping from home or work. Innovations such as loyalty cards have enhanced customer satisfaction and allowed retailers to use consumer insight and feedback to continually improve services and target promotions.

- **High street retail:** Better supply chain management and consumer feedback has allowed many high street brands to develop “fast fashion” – bringing customers the clothes they want quickly. This necessitated the elimination of non-value adding delays and process interventions as well as challenging long established supply partnerships. A consequence has been the decline of established high street giants and the rapid emergence of new retailers more tuned and flexible to consumer preferences.

- **Car manufacturing:** Manufacturers such as Mazda, Volkswagen and BMW have taken a “zero error” approach to quality assurance leading to a dramatic improvement in car reliability, as well as leveraging fixed cost infrastructure investments to be more flexible for multiple product usage.

These case studies from the private sector offer lessons than can be readily applied to healthcare. The “hub and spoke” model of the grocery industry with larger superstores and smaller local outlets is a powerful example for the configuration of specialist and community hospitals. Like supermarket chains, the NHS can learn to harness the contribution of the consumer through membership cards and online
access. If medicine took a “zero error” approach and learnt the lessons of advanced car manufacturing there would be a dramatic improvement in quality.

All these examples demonstrate the importance of new entrants in transforming the sector. While existing organisations can lack the agility to develop new models of care, new entrants can rapidly transform patient care if given access. However, while all industries resist new entrants, the NHS is particularly hostile to competition. Overcoming political resistance to new entrants is a first step, but the policy and structures of the NHS also need to align to the development of new business models.

However, in all these examples change did not happen overnight. While new models of integrated care are starting to emerge, transformation of the NHS could take even longer. The authors therefore predict that in ten years there might be three broad business models in the NHS: the existing model of fragmented care, a new business model of integrated care and a technology-enabled business model that has yet to be developed. Given the NHS resistance to change, the change to the new model will be incomplete. By 2024 the structure of the NHS provider landscape could potentially be broken down by these three different forms of provider:

- The current major pre-2014 fragmented model will cover 30 per cent of patients and service users with 40 per cent of the resources.
- The post-2014 business model of integrated care will cover 50 per cent of the NHS with 45 per cent of the resources.
- The newer post-2018 technologically-integrated model will cover 20 per cent of the population and cost 15 per cent of the resources.
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The narrative of change for the NHS
In 2014 nearly all discussion within and about the NHS features some aspects of crisis. Whilst the day-to-day work of the NHS continues with a million consultations every 36 hours, the discussion at all levels of leadership revolves around a crisis.

As we comment throughout this report, what is interesting is how most of the discussions start off with a description of either a financial or a quality crisis, but usually end up planning very much within the existing model of healthcare. Whilst the description of crisis frames the discussion, that crisis does not drive through to the necessity of very different healthcare activities.

At a system level there are two crises.

The crisis of economics

Firstly, every conversation starts by recognising that the next decade will bring a growing demand for healthcare.\(^1\) This rise in demand comes from the demographic fact that there will be a rise in the number of very old people and it is certain that very old people have a larger number of long term conditions than the rest of the population. This rise in demand is usually placed at between 3 and 4 per cent a year.\(^2\) Whilst this may not seem to presage a crisis, over a ten year period this adds up to an increase of a third in demand for healthcare. This rise in demand has increased slightly on what was happening before, but it is now taking place alongside an unprecedented flat line in resources.

The scale of the challenge has been documented through this Parliament by a range of organisations such as the Institute for Fiscal Studies (IFS), The King’s Fund, the OECD and the Health Select Committee.\(^3\) The IFS recently calculated that even though the NHS been protected from cuts, rising demand means that “real age-adjusted per capita spending on the NHS would be 9.1 per cent lower in 2018–19 than in 2010–11.”\(^4\)

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These conversations usually continue by saying that the NHS will be approximately £30 billion short of funds by the end of this decade.\(^5\) Taken alongside the cuts in public funding for local authority social care, the impact of this funding squeeze is magnified further, with knock on effects for the financial viability of the NHS.\(^6\)

All in all, the conversation around finances usually concludes by saying that, in order to meet the resource crisis, there will have to be some very hard decisions.\(^7\) Other industries in looking at this requirement to deliver significantly better healthcare outcomes for the same resource would recognise that they probably have to develop new models of delivery. By contrast the discussions within the NHS start off recognising a large financial crisis but usually end up with a scale of change which is framed mainly within the existing model and which in no way recognises the level of financial crisis that is driving change.\(^8\)

**The crisis of the organisation of service delivery**

Meanwhile, increasing numbers of patient groups are pointing out that the fragmented nature of health and social care means that too many patients experience very fragmented care.\(^9\) And whilst patients may be receiving individual elements of their care that are very good, the whole pathway of care is disjointed and fragmented. Many complain about the fractured nature of their care experience between not only different providers of health and social care, but also different parts of the same organisation not knowing what each other is doing.\(^10\)

Therefore the second conversation around crisis is all about the necessity, in order to meet this crisis, of developing a new integrated model of care. This often starts with a recognition of just how

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7 NHS Confederation (2013), *Tough times, tough choices: being open and honest about NHS finances.*


9 The King’s Fund (2010), *How to deliver high-quality, patient-centred, cost-effective care: Consensus solutions from the voluntary sector.*

10 Ibid.
fragmented the existing experience is, but it quickly realises that to develop something different will need a radical new model of delivery.\textsuperscript{11}

However the discussion of new models usually stops short of actually deconstructing the old model. Tinkering and linking up existing models is the main outcome of these discussions.

**A crisis of inaction**

The discussions of these two crises are not just taking place at the top of the health and social care systems. They are also being had in the boardrooms and staffrooms of nearly every organisation that provides services. In fact, in 2014 there are very few boardrooms that are not dominated by the challenge of how to meet the demand for healthcare while tackling the impact of fragmented care on the overall patient experience.

Similar discussions are taking place in the biggest hospital trusts, the smallest GP practices, the largest residential social care providers and the smallest domiciliary care providers.

That these twin crises must be addressed is an almost universally held opinion. NHS leaders and NHS boards will all agree that something radical needs to happen if we are going to tackle them successfully.\textsuperscript{12} But in only a few places is anything at all radical or transformative happening. Momentum dissolves, radical strategies are postponed for further discussion in three months’ time while teams are overwhelmed by the need to tackle the latest cost improvement programme, or to provide nurses with extra re-training in care.

But this “let’s try and make the current system work a bit better and put off the radical change until next year” dance is a dangerous one.

\textsuperscript{11} Coulter, A. et al. (2013), *Delivering better services for people with long-term conditions: Building the house of care*, The King’s Fund; Department of Health (2013), *Integrated care and support: Our shared commitment*; Oldham, J. (2014), *One person, one team, one system*.

\textsuperscript{12} Health Select Committee (2012), “Written evidence from the Foundation Trust Network”; NHS Confederation (2014), “Health service is driving change but needs support, survey finds”, 20 March.
In this paper we hope to move discussions on to action. It will explore:

- why this is happening in the NHS,
- how a wide range of other industries that have also experienced similar problems have moved themselves on, and
- how a radical new business model in health and social care might solve current and future problems.

**What can we learn from other industries?**

Of course, the NHS is a unique organisation, but it can learn much from other UK industries. We show how new business models that evolved in a range of industries were able to solve some of the most apparently intransigent problems. We provide various examples of the move from the old model to the new – moves that now seem obvious but at the time felt impossible and inconceivable. Today the new models are considered normal, but, as with any change, the transition from old to new was not without conflict.

**What is the solution?**

The only real way of solving the current economic and quality crises in health and social care is to develop and implement new health and social care models for these care sectors. This is already happening now in early 2014, but as momentum grows it is likely to be met by derision from the supporters of the old ways. What is more, as the new grows to replace the old, there will be sharp conflict between the two.

This will not be an easy process. Old models are very rarely replaced with new ones overnight. In fact, we are not suggesting that there will even be a new model for the care of all NHS patients within a decade. It is unrealistic to assume – given the size of the NHS and social care services, their historically slow speed of change and the special political conditions in which they operate – that the current model of care will disappear within that decade.
Instead, we are likely to see change which starts very small via various NHS commissioners asking providers to deliver integrated health and social care based around the outcomes that patients need.

The struggle between old and new

The politics of change in health and social care ensures that the “old” fragmented care model will be financially and politically subsidised to keep it going against the competition of the new integrated care model. Politicians may say that they want an outcomes-based integrated care service, but the necessary changes to the model are often passionately resisted.¹³

In contrast, national patient organisations provide strong consumer pull for the new business model because they provide patients and service users with the integrated care they want.¹⁴

Provider interest groups will repeatedly argue that the only options possible are trade-offs between funding and quality and accessibility – not that new service models can protect the latter given a squeeze on the former.¹⁵

Consumers of other industries have pulled new models of service into being purely through demand, which we highlight in this paper. We believe that over the next decades an increasingly powerful consumer voice in health and social care provision will come into being. Many patient groups will begin to demand sets of outcomes from health and social care expenditure that their members currently do not get. We suggest that within ten years, a new business model will cover around half of NHS services.

A third business model

In fact things will go further than a battle between two models of care. We suggest that within five years a newer technologically-enabled

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¹⁴ The King’s Fund (2010), How to deliver high-quality, patient-centred, cost-effective care: Consensus solutions from the voluntary sector.

business model for health and social care will start to win commissions and replace some health and NHS care. So by 2024 the structure of the NHS provider landscape could potentially be broken down by these three providers, with:

- The current major pre-2014 fragmented model will cover 30 per cent of patients and service users with 40 per cent of the resources.
- The post-2014 business model of integrated care will cover 50 per cent of the NHS with 45 per cent of the resources.
- The newer post-2018 technologically-integrated model will cover 20 per cent of the population and cost 15 per cent of the resources.

Throughout the rest of the 2020s there will be a succession of new models of healthcare coming onto the scene. We are therefore assuming that, while the old NHS model succeeds in holding up change, it will not succeed in destroying either of these new business models.
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The future of health services
The quality and financial crises are recognised by many who lead and work within the existing model of health and social care. Many agree that something radical needs to be done. However most clinicians and managers within the NHS continue to defend the service models and organisations they have grown up with, believing that the model that they work within is the only way of delivering safe health and social care. Anything different from this norm is hard for them to imagine and they may well feel the unknown may be dangerous for patients. They are inevitably limited to their history and experience. Clinicians are not alone in this.

**Imagining different ways of working**

Most people who have long worked within a well-established methodology or market are themselves defined by their experiences. This can be seen in a host of other industries over the past two or three decades.

- Newspaper journalists once believed that readers would always want the rustle of newspapers.
- Branch bank managers felt that branches would be the way in which we would manage our accounts.
- Salespeople in IBM believed that computers would be the size of rooms and Microsoft believed that we would have boxes on our desks.

All these people were like today’s medical staff – they were good and experienced people who believed and trusted that the parameters of their working model were the only proven and safe way to provide their service.

**The dangers of closed thinking**

Given their belief that we must work within the existing healthcare model, those clinicians who accept the need for cost containment see the only way forward as salami-slicing budgets, rising waiting times and increased rationing of healthcare provision.\(^{16}\)

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This loyalty to existing methods can become inextricably linked with protectionism. Even when hospitals are accepted as failing they are sustained by the system because those within the system consider it their duty to prop them up.

Much of the existing provision of primary care for the second decade of the 21st century is based on small, sometimes one-person, GP practices, largely unchanged from the 1970s and 1980s. Insufficient competition between models of primary care means that this provision endures despite recognition that they are unable to meet the needs of their patients. The response is to argue that to maintain this current model must require an increase in the number of GPs.\(^\text{17}\)

If the existing model continues to dominate primary care it is indeed inevitable that greater demand must lead to more GPs. Without them – if you stay in this model – there must be a reduction in service. If you have more work to do and you continue working in the same way, then of course you need more of the same resource to meet rising demand.

### Will resistance be futile?

Happily there are emerging examples of regulators, GPs and commissioners who refuse to be complicit in sustaining bad quality care and service. Poorly performing hospitals are being put on notice.\(^\text{18}\) New operators of existing hospitals are being sought – not just to have a go at running the current model better but to create something new.\(^\text{19}\) Progressive GP practices are seeking to use different channels to communicate and treat patients and are trying to create scale in primary care to achieve it.\(^\text{20}\)

The issue for the future of the NHS is whether these challengers of poor practice will be allowed to see their challenge through. Will those in the vanguard of new thinking be rewarded for their innovation? Or will resistant forces and politics clamp down on them for the sake of the status quo?

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\(^{17}\) Royal College of General Practitioners (2014), “Majority of public believe GP workloads are threat to the level of patient care”, 23 March.


\(^{19}\) BBC Online (2013), “George Eliot Hospital to be run by private sector?”, 6 September.

Structural changes happen in other industries all the time, but they exist in worlds where progress and reform is not resisted or blocked by protectionism or political conservatism.

**Developing new forms of value in healthcare**

The next chapter will look at the ways in which other industries have successfully developed significantly better outcomes for the same resource by reinventing methods and dropping outdated solutions. Where market entry and exit is the norm, new entrants and methods coexist with traditional ones. The traditional methods have to adapt to the competition or they decline and ultimately disappear.

But there is no avoiding the fact that change is difficult – particularly in markets that provide essential services and where people will be understandably risk averse. If such markets are also closed to new entrants and discourage exit, is it any wonder that they perpetuate proven but unsustainable methodology rather than embrace fundamental change?

**The volume/cost question**

Typically, in nearly every industry more activity through the existing infrastructure inevitably results in lower unit cost. Yet in the NHS increased volume of demand has not resulted in better productivity. The only clear insight is that, like professional football, increased funding has passed directly to the workforce with no productivity gain.\(^\text{21}\)

It is therefore no surprise that the response of many who have only ever worked in this organisation is to believe that rising demand must be matched by increased resource. It is true for clinicians, NHS managers and even politicians. Throughout the Parliament, Health Ministers and the Prime Minister have continually asserted that both NHS spending and the number of doctors are increasing.\(^\text{22}\) In an era of austerity where there is no additional funding available, mindsets must change.

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\(^{21}\) Cawston, T. et al. (2012), *Doctors and nurses, Reform.*

The new sources of value

The experience of other industries indicate that material productivity gain, as well as being possible, is often matched with (and even enabled by) a step change improvement in quality. When there is no more money to buy more of the existing value creators, industries find new forms of value. However, it requires innovation to step outside the restrictions of the current model.

If the NHS is to achieve a step change it will have to locate new sources of value and new locations where efficient healthcare can take place. Current healthcare providers are organised around episodes of health and social care that treat patients and service users as passive recipients of care.23 Challenging this will strike at the very definition of who is a provider and who is a consumer of healthcare. The future providers of healthcare will have to radically change that definition.

If the NHS is to be sustainable in ten years from now it must discover new ways to create value so that it can provide considerably more healthcare outcomes for the same input of traditional value sources. One of the main ways it might do this is by uncovering the capacity of individual patients, their carers, families and local communities as an intrinsic part of the solution – or, in economic terms, a new value source.24

The models we draw on to make this point come from a wide range of other industries where the co-production of value has become the norm. In many cases, the home has become the location where that takes place. For those industries that have encouraged or facilitated the consumer to be capable of being a co-producer they often have agile and highly functional infrastructures.

Putting new forms of value front and centre

Any new model must see this form of value at the core of healthcare and not as a peripheral exception. In ten years from now the effectiveness of clinical and social care will be judged by the extent to

23 Corrigan, P. and C. Mitchell (2012), The hospital is dead, long live the hospital, Reform.
which an interaction has engaged the capacity of the patient, their carers, families and local communities.

New providers will recognise the home as the main site of healthcare and will be looking to find ways of increasing its efficacy as the location where efficient healthcare is delivered.

It is quite realistic to expect such new methods to emerge alongside existing approaches and the old and the new systems will inevitably coexist for a considerable period. However, patients must be able to switch to innovative providers to encourage and reward fresh thinking.

Financial capacity will dictate that the market operates as a “zero sum game”. So as better solutions attract customers, existing supply will lose patients and the resource that goes with them. This will result in rising unit costs for traditional provision and potentially lead to the demise of the providers who do not adapt.

The new models in practice

There are four domains of health services that are currently facing significant pressure: primary care, specialist care, urgent care and services for patients with chronic illness. In each of these, existing services are no longer creating sufficient value to meet demand. For each of these new business models offer solutions to deliver quality at lower cost.

Scenario 1: Primary care

What are the challenges that need addressing?

For the public:

- An increasingly 24/7 society wants access to primary care on the same day, at times that suit their lifestyle, 365 days a year.\(^\text{25}\)

- As with other consumer services, patients want to be able to access primary care in person, by phone, by email, by text and via the internet.\(^\text{26}\)

\(^{25}\) Patients Association (2013), Primary Care Review Vol. II Primary Care: Access Denied?

\(^{26}\) GP Magazine (2009), “Patients want greater email contact with GPs”, 16 October.
Patients want their primary care clinician to have their personal details and medical record to hand whenever they are in contact.

Increasingly well informed patients do not want to travel to a hospital for every medical consultation or procedure. They want diagnostic facilities and routine treatment to be available locally in a consumer-friendly environment.\textsuperscript{27}

Patients with long term conditions want an expert personal clinician as their “go to” contact for any healthcare issues. They will expect that clinician to be able to coordinate all of their care.\textsuperscript{28}

For the NHS:

Primary care is delivered by a fragmented range of typically small and privately owned practices of variable size and resources.\textsuperscript{29}

There is a current and growing shortage of GPs and primary care nurses.\textsuperscript{30}

Attempts to create a single patient record have been fraught with difficulty.\textsuperscript{31}

Many GP practices occupy dated and constrained properties with limited scope to maintain quality standards or expand the range of services.

Whilst there has been some progress in the training of GPs with specialist interest, there are some significant gaps in traditional primary care, particularly mental healthcare.\textsuperscript{32}

There is limited financial capacity to invest in new services or to fund an expansion of existing services to meet demand.\textsuperscript{33}

\textsuperscript{27} Department of Health (2006), \textit{Our health, our care, our say: A new direction for community services}.
\textsuperscript{28} National Voices (2012), “Integrated care: what do patients, service users and carers want?”
\textsuperscript{29} NHS England (2013), “Improving general practice – A call to action”.
\textsuperscript{30} Centre for Workforce Intelligence (2013), \textit{GP in-depth review: Preliminary findings}.
\textsuperscript{31} Public Accounts Committee (2007), \textit{The Electronic Patient Record}.
\textsuperscript{32} Department of Health (2014), \textit{Closing the gap: Priorities for essential change in mental health}.
\textsuperscript{33} NHS England (2013), \textit{Transforming primary care in London}.
Many GPs seem locked into their current method of scheduling and seeing patients. Frustrated primary care patients turn to other routes for immediate access to care – particularly A&E.\(^{34}\)

**How might an “open market” NHS tackle these issues?**

Many health systems have begun to develop advanced primary care services that have used technology, scale and a different skill mix to provide greater patient access.\(^{35}\) Below are some components that could be created as part of a 24/7 customer focused service:

- A customer account system that maintains a patient record.
- A telephone, email and live chat system that is available 24/7 (and the development of out of hours and 111 services means that the infrastructure to support this already exists).
- A personal healthcare advisor who receives alerts of all contacts and who is available as a navigator to the NHS.
- A named lead clinician who is available as support to the personal healthcare advisor and available to each designated patient.
- A web-based system with FAQs for education and support for long term conditions and common ailments.
- A “bricks and mortar” network for those face to face consultations that are necessary or preferred, based on a hub and spoke model with the hubs open 24/7, 365 day a year.
- These hubs include investment in diagnostics equipment and specialist and multi-disciplinary medical practitioners able to deal with all outpatient and ambulatory requirements.

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What existing primary care resources could be combined to offer most of this solution?

- GP practices joining this “integrated society” – sometimes through mergers – but equally as users of support services that enable the model for current practices.
- 111 call centres extended to include personal healthcare advisors and specialist clinical advisors, including mental health.
- NHS Choices developed with interactive patient engagement.

How could new investment be stimulated?

If patients could be empowered as consumers, with specified budgets for primary care list membership and a range of services, and if this were topped up by approved funding for referred treatment, both the NHS and independent organisations would develop investment plans with new and existing consortia. Patients – and the resource that goes with them – would be competed for by these different models of care.

In primary care, incumbents need to be freed up from the economic fetters that are tying them to protecting their investment in their current practices. This restriction of market entry and exit perpetuates existing supply and methodology.

To facilitate investment in change and better solutions, this inertia must be addressed – most obviously through the freedom for GPs to monetise their cumulative investment in their established business. This would enable public and private providers to build on existing solutions with new service models rather than compete to destroy them, or be deterred from investing through “greenfield” solutions by market protectionism and patient inertia.
Scenario 2: A patient with a specialist/rare condition who needs regular treatment and follow up

Over the first two decades of the 21st century medicine will continue to develop new ways of saving lives and relieving distress. Many of these will need ever greater specialisation of training and interventions. This new specialist work will continue to take place at a small number of regional and national centres. Given the small number of interventions that are likely to be carried out, these treatments are likely to take place with heavily subsidised NHS providers.

The problem with super specialism is the distance and discontinuity, both medical and physical, between the specialist intervention and the recovery and follow up care involved.

The former takes place in a very specialist institution at a regional centre whereas most of the latter is provided by generalist providers with insufficient specialist interest or cohesion. Therefore the value potentially created by the specialist intervention in terms of potential healthcare outcomes can be compromised or wasted by the loss of continuity and cohesion.

The answer lies with NHS England specialist commissioners

Commissioners need to start commissioning contracts that include the entire value chain rather than the episodic specialist intervention. For most specialist providers this will need a radical reworking of how they see their interventions. They must recognise that they need to become expert in the delivery of specialist episodic care as well as in the provision of community level health and social care across a wide set of geographies. This can be achieved through generalist community care provision, so long as there is sufficient focus and investment in specialist skills and communication.

36 NHS Confederation, Academy of Medical Royal Colleges and National Voices (2013), Changing care, improving quality: Reframing the debate on reconfiguration.
37 London Cancer (2013), Specialist Services Reconfiguration: A case for change in specialist cancer services; Royal College of Surgeons (2013), Reshaping surgical services: principles for change
They will also recognise that it is not possible for every national hospital, for example, to have a close relationship with 150 local authorities or a greater number of clinical commissioning groups. They must therefore employ some logistical expertise to ensure that value chains of care are created and delivered.

For the patient who has a specialist or rare condition needing regular treatment and follow up, this new form of treatment recognises that their health outcomes depend upon:

- Very high level skills in initial intervention in a specialist hospital,
- very high level community health and social care in their own home, and
- a seamless set of handovers between these two very different forms of care.

Interestingly, those logistical skills which unlocked change in other industries through sophisticated supply chain management are significantly underdeveloped in the NHS. This is one of the key areas where skills from the private sector will add something new and distinctive to NHS management skills.

**Scenario 3: Urgent and emergency care**

What are the problems needing new solutions?

For the public:

- Waiting times for primary care access can be days or even weeks. There is little recognition of the urgency that many patients feel.\(^{39}\)

- Primary care, urgent care centres (UCC) and A&E departments have limited mental healthcare provision and are a confusing patchwork.\(^{40}\)

- There are limited UCCs and walk-in primary care services.\(^{41}\)

- Out of hours primary care has limited access to patient information and records.

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39 Patients Association (2013), *Primary Care Review Vol. II Primary Care: Access Denied?*

40 Department of Health (2014), *Closing the gap: Priorities for essential change in mental health.*

A&E departments often offer poor patient experience and typically long wait times.\textsuperscript{42}

There is no connection with social care or mental health services.

For the NHS:

- Patients access A&E with non-emergency needs.\textsuperscript{43}
- A&E is not organised to deal with mental health needs – these divert it from its designated purpose and it offers poor solutions for those with mental health needs.\textsuperscript{44}
- A&E is not a popular career path for consultants, resulting in a shortage.\textsuperscript{45}
- Out of hours services have few options but to admit vulnerable people, even though their needs could be met by social care.\textsuperscript{46}

What solutions could be developed?

- Emergency and urgent care need to be developed in primary care-led integrated pathways. This must be based on more extensive access to primary care through integrated in-hours and out of hours services, including multi-disciplinary walk-in centres and UCCs. Out of hours services are seen – often unfairly – as being the weakest part of the system. There needs to be renewed integration between in-hours and out of hours primary care services and the out of hospital system should be commissioned with a mind-set of being at its strongest out of hours when other services are less available.

- Rapid response mental health services are needed, by telephone, specialist UCCs and call out.

- Create rapid response domiciliary care teams and capacity in care homes that is specified for urgent requirements. This should also be integrated with out of hours primary care so that

\textsuperscript{42} NHS England (2013), \textit{Improving A&E performance}.
\textsuperscript{43} National Audit Office (2012), \textit{Emergency admissions to hospital: managing the demand}.
\textsuperscript{44} Foley, T. (2013), \textit{Bridging the Gap: The financial case for a reasonable rebalancing health and care resources}, Royal College of Psychiatrists and Centre for Mental Health.
\textsuperscript{45} Public Accounts Committee (2014), \textit{Emergency admissions to hospital}.
\textsuperscript{46} NHS England (2013), \textit{Transforming urgent and emergency care services in England: Urgent and Emergency Care Review}.
vulnerable and older people are supported in their own home to stabilise a crisis and avoid unnecessary hospital admission.

**Scenario 4: A patient who has one or more known longer term conditions with regular care needs**

Given the importance of this group we have developed two examples:

- The first is someone who is already quite ill and needs considerable healthcare input.
- The second is someone who, whilst they have two long term conditions, can still live an independent life.

In 2014 a progressive NHS would recognise that for nearly every person with one or more long term condition, the main site for the provision of health and social care will be the patient’s home. The main people staffing that care in the home will be the patient, their family and their carers. The main infrastructure around that site of care will be their community. The more orthodox health and social care services will be organised around those vital resources.

In a decade’s time the main model that healthcare providers will have developed to provide that infrastructure will be one that recognises the extent to which co-production of health and social care is at the heart of provision for people with long term conditions.

The increasingly inexpensive and existing technologies that enable self and professional monitoring of these patients, as well as assertive support and intervention, need to be mobilised at industrial scale.

**4a: A patient who is quite ill with their co-morbidities, requiring considerable healthcare input to make their home a more effective site for healthcare.**

Over the next ten years there will be an increase in the number of people suffering from co-morbidities with high acuity. The new providers will recognise that the current model of health and social care that works with high acuity is bad for the patients and their carers and bad for the health service. Health and social care services will have recognised that the idea of care closer to home is redundant.

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Our new health and social care model will place care not closer to home but in the home. Unless patients, their carers and medical staff have the confidence that a patient’s home is as safe a site of healthcare as a hospital, patients and their carers will always default to a hospital as the only safe place.

New technology can add considerably to the safety of a home as a location of high acuity care. By 2024 many high acuity patients and their carers will be able to use that new technology to add to the safety of the home. Indeed they will expect that their health and social care will be enabled by it in the same way that many other of their services are.

4b: A patient who has one or more known longer term conditions with regular care needs lower acuity.
The home will also be the site of healthcare for people with co-morbidities that have lower acuity, and they too must be confident that their home provides safety. The many more people with lower acuity long term conditions have an additional source of value which needs to be a core part of their health and social care: their ability to self manage.

It is vital to note the different amounts of care provided by different parts of our new healthcare system. The patient self manages their long term condition for about 5,800 waking hours a year.48 They may well self manage badly during these hours, but they all self manage, often with the active help of family and friends.

Over the next ten years’ time the new form of health and social care will increasingly use this self management (and independence for social care) as the major resource of health and social care. It will invest the annual 10 hours a year of professional time in improving the 5,800 hours of self management. Technology will further improve the capacity of patients and their carers to improve their self management.

The care will be organised by an accountable lead provider for long term conditions who will have an annual contract with the patient

48 Department of Health (2007), Research evidence on the effectiveness of self care support.
which will drive a simple set of outcomes. The lead provider will have a series of sub contracts with different health and social care providers, including the GP. None of the sub-contractors will get paid for their work if the patient is not satisfied with the overall outcomes of the year’s health and social care.

The commissioner will have constructed a single overall contract for the health and social care of 10,000 lower acuity co-morbidity patients.

**Slow progress towards new models**

While new services are needed, existing organisations are not evolving fast enough. One of the main criticisms of existing healthcare organisations is that they are organised around their own needs rather than the needs of the patients. This is the case because healthcare organisations do not feel that they have the agility to provide their services around patient needs.

A key criticism of the current business model of NHS healthcare is the balance between fixed and variable costs. NHS organisations feel that the very high level of fixed costs, especially in hospitals, restricts the agility of providers to radically change. Since these fixed costs are seen as intrinsic to the healthcare industry, this is felt to be an inevitable block to change.

Other industries have developed new business models that break the rules of their industry by changing elements that were seen as unchangeable. In these cases the categories of fixed and variable costs are challenged and become unfixed. So any new business model in the provision of health and social care will have to challenge the list of costs that are traditionally considered “fixed”.

It is interesting to note that many providers of healthcare in the rapidly developing Indian economy are obsessed with being “asset light” so they can avoid being “prisoners” of their fixed costs. The NHS has a history of being most proud of creating its most fixed assets. Again this mindset needs to change – and, ironically, the continued choking off of the supply of public capital is probably accelerating this change.

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Which fixed costs could be challenged in an NHS organisation?

Real estate:
Most acute hospital trusts spend a large amount of their time and a high proportion of their money working in real estate. Unsurprisingly an organisation whose main business is healthcare is rarely very good at issues of real estate. Getting out of this business would help them to develop a new healthcare business model.

For example some hospitals are developing a franchise model of healthcare, including the Royal Marsden at Kingston and Moorfields at a number of places. Developing this franchise model would see them carry out a higher proportion of their business outside of the fixed cost of their own hospital. As the franchise grows as a per cent of the whole business, the importance of the original real estate is reduced.

In our new business model – not least because it recognises the patient’s home as the main location of healthcare – the extent to which buildings are a fixed cost changes.

Staff costs:
Staff costs are seen as fixed in most existing healthcare models, whereas they are seen as variable in other industries. In healthcare, staff costs are negotiated within national pay bargaining, but it is difficult to see how, over the next few years, national pay bargaining can survive as a fixed part of the NHS architecture. Some doctors and nurses may decide to organise themselves in different ways, including through chambers-like arrangements. New pension rules on maximum pension values will result in doctors, relatively early in their careers, finding that their pension pots are “maxed out” and this is likely to open up a far more flexible mindset from those colleagues in where, how and for whom they wish to work.

Enhancing agility
The new business model is based upon the development of a much higher proportion of variable costs, allowing for, and encouraging, an organisation to be much more agile, which will follow through to

52 Cawston, T. et al. (2012), Doctors and nurses, Reform.
healthcare provision. This agility will allow different providers to use the same facilities and to join together in a supply chain organised by accountable lead providers.

It is this agility that will allow the new business model to organise whole person coordinated care around the demands of commissioners and the needs of patients, rather than the needs of organisations. But it needs expertise in the management of those patient pathway supply chains if it is to unleash agility not chaos. This is a new and essential skillset for NHS leaders.
Implementing change: learning lessons from other sectors
Learning from other industries

We have brought together a range of examples from other industries to explain how consumer-based services are provided and to demonstrate how the transformation takes place from the old to the new.

1. Grocery retailing

In the 1970s the grocery industry developed a new business model which transformed the consumer experience of the industry.\(^{53}\) This was carried out by the national retail chains that we know today – Tesco, Sainsbury, and Asda.

Previously, retail outlets were high street based and fragmented, serviced by dominant grocery manufacturers who delivered direct to store. This high cost model was viable because of the power asserted by the manufacturers who passed their distribution cost on to the fragmented retailers, who in turn passed it on to consumers.

The new entrants and some incumbent retailers developed larger retail outlets, increasingly located out of town. Initially this had the impact of improving their buying power, but over time they built sufficient critical mass to create their own dedicated distribution centres and buy from the manufacturers ex works.

This new channel had many benefits that consumers valued:\(^{54}\)

- They could do more of their shopping under one roof.
- They could drive to and from the shop and no longer had to carry heavy shopping on foot or on public transport.
- They were able to buy products all year round that were previously considered exotic as the larger retailers were able to source internationally.
- Quality of product and shelf life also improved as the new dedicated distribution channels invested in temperature control and used “just in time” methods to reduce supply chain storage.

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\(^{54}\) British Retail Consortium (2012), UK retail: Leading globally, serving locally.
Consumers had much greater choice and increasingly benefited financially as the reduced cost of scale and purchasing power was passed on to them.

In terms of learning the lessons for change in health and social care provision, it is important to realise that replacing the old model with the new was not favourable for everyone in the industry.\(^{55}\)

High street based, specialist and small retailers increasingly found that they were unable to compete on price and range and were increasingly forced out of business.\(^ {56}\) Grocery manufacturers found that as the larger retailers bought their product ex works, substantial volumes of product were removed from their own distribution infrastructure. The old model had an infrastructure that carried high levels of fixed cost which had the effect of increasing the unit cost of distribution for their remaining volumes. As they sought to pass the higher unit cost on to the smaller customers this added to retailers’ financial sustainability problems. Ultimately this was not possible and the grocery manufacturers suffered losses and then had to incur restructuring costs as they downsized their infrastructure.\(^ {57}\)

One of the other benefits to the grocery retailer was that because the new large format stores were designed for self-selection, they no longer needed to employ so many staff – instead the shopper found what they needed themselves. This proved to be a win/win situation: the shoppers enjoyed the experience of browsing the aisles; the retailer employed fewer staff and enhanced the shopping experience by redeploying some to keep checkout queues short; but even more valuably for both, the shopper made many more spontaneous purchases.

**The rise of local stores**

When national retailers started to develop local stores, it was assumed that this could only be viable if premium priced. Yet this channel has become increasingly significant and profitable without any premium pricing, simply through supply chain efficiency and marginal cost on the back of existing large scale distribution

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infrastructure.⁵⁸

**The online shopping boom**

Similarly, home shopping was initially considered to be costly and only justified for either small package products or bulky commodity products which could free space in shoppers’ trollies for higher margin smaller products. Widespread opinion was that products that required touch, smell, taste, or fashion would not be popular or profitable for home delivery.

The reality is that shopping for everyday groceries and a wide range of fashion items that need to be tried for fit and taste have led to the “white van” revolution, not to collection points as originally forecast, but to the home.⁵⁹

**Why has this come about?**

- Shoppers trust the quality and consistency of products and retail brands.
- Online shopping sites are convenient and offer product images and descriptions. Good customer service offers returns policies convenient and acceptable to consumers.
- Volumes, density and tight cost control have enabled logistics operations to develop low cost and convenient delivery.
- Retailers have either leveraged the critical scale of their bricks and mortar channel with marginal cost or new retailers have accessed a market with low entry barriers.

**Growing brand loyalty**

In recent years one of the important innovations has been retail loyalty cards such as the Tesco Clubcard. Again this development of new over old took place against a backdrop of conflict. Originally derided as an expensive and unproven substitute for Greenshield Stamps, the Clubcard progressively gave Tesco detailed insight into shopper preferences and behaviour. This enabled them to target promotional activity specifically for individual consumer interests, resulting in greater satisfaction, loyalty and productive use of promotions.⁶⁰

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Beyond this, Tesco has been able to redesign its stores to be more customer friendly. By analysing shoppers’ buying activity it has come up with better product combinations and store configuration. Tesco has been able to use consumer insights, and this channel of communication, to expand into new segments of retail such as electronics and clothing as well as financial services. A truly transformational retail story.

**Important lessons for healthcare**

This retail lesson for healthcare is probably the most important in this paper.

There is broad agreement that new healthcare models depend upon much greater co-production of healthcare value – between commissioners, providers and patients. The new retail model depended upon harnessing and enabling customers’ engagement in their retail experience resulting in better choice, decision making and utilisation of their “labour” in substitution of the retailers’ labour resource.

Healthcare could also learn much from the scale of these transformations. There is already recognition within hospital care that scale is essential for some procedures. We need larger units to carry out the number of procedures that safety demands – so for some procedures local provision may have to close.

However if we look at the development of large supermarkets over the last 15 years, we can see that small local stores and home delivery of the large supermarkets gain from the economies of scale of the superstores. This synergy is available to healthcare specialist provision – to create regional super-specialist centres that can then support local services, either franchised into local health centres or accessible by patients at home, for the convenience of patients.

The information revolution achieved by retailers must resonate with the difficulties that the NHS has experienced in achieving this same goal.

The introduction of club cards was not imposed on customers – they were incentivised by the benefits generated by the availability of data to the retailer. Gradually more and more customers elected to
participate in this information sharing until the retailers ultimately achieved critical mass through willing rather than imposed participation.

Similarly, retailers did not set out to build their information systems in one integrated project – they were pragmatic and built them gradually, using established, flexible and nimble technology rather than over-engineering enterprise-wide systems that either never get finished or create unacceptable business risk.

2. UK drinks industry
In 1992 the Monopolies and Mergers Commission (MMC) examined the way the UK drinks industry was organised and decided to separate the production of beer and other beverages from pub ownership. The market at the time was highly concentrated with six national brewers owning the vast majority of pubs. Those pubs could only stock the brewer’s own products.

After several years of challenge the MMC imposed changes with some compromise. All existing brewers were required to dispose of or free up the tied tenancies of half their pubs. This resulted in some brewers, like Bass, choosing to retain their brewing and brand owning business while disposing of much of their pub estate. Others, like Whitbread, disposed of their brewing business and concentrated on pub ownership.

This rapid and large scale restructuring resulted in the virtually overnight creation of a new business model of pub retailing, quickly dominated by new entrants such as Punch Taverns, Weatherspoon and Enterprise Inns. As these new pub chains became established, they soon decided to source their products from various suppliers and to offer their consumers increased choice. This also enabled them to exert greater buying power through the ability to switch supplier.

63 Business and Enterprise Committee (2009), Pub Companies – Business and Enterprise Committee.
How did old contrast with new?
In the historic structure of the old model, the brewers owned their own distribution infrastructure and supplied pubs with the full range of products within one delivery. Because the brewery owned the pubs, and the managers had no control over the supply of product, the service ethos of the distribution infrastructure was very poor. What is more, because they controlled the distribution channel of the brewer, the workforce had for many decades applied industrial relation pressure on the brewers. So, as well as providing poor service, the distribution infrastructure was characterised by high costs, low productivity and inflexibility.\(^{64}\)

As the new business model of the pub retailers became established and sourced from multiple suppliers the retailers increasingly wanted to consolidate their distribution so that their pubs received only one delivery. The consequence of this was that the original brewers, who chose to continue as brand owners and producers, incurred higher unit costs for distribution as some retailers bought ex works. They consequently had to restructure their distribution infrastructure and downsize, improve service ethos or close down their own distribution channel.\(^{65}\)

Pubs needed to decide whether they were owned by the supply chain of a particular sort of beer or whether they were localities where consumers could choose from a variety of beer – they no longer had to be linked to one form of provider.

Important lessons for healthcare
This experience resonates with the provider/commissioner split driven by recent health policy reforms. By breaking the vertical integration of the drinks industry, consumers were offered more choice within pubs than the restricted range owned by their previous brewery owners. Alongside this, consolidation of production and retail resulted in greater levels of investment within each.

Within healthcare, the opportunity is to build greater expertise in commissioning and to do so without encumbering decisions with provider self-interest. The commissioner can make decisions to

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\(^{65}\) Office of Fair Trading (2009), *CAMRA super-complaint – OFT final decision.*
optimise the interests of patients without being compromised by the conflict of interest in protecting existing supply.

In parallel, providers that are no longer protected by controlling the channel or supply to patients are forced to innovate and invest in what those patients and their commissioner really need and want. Protectionism is ultimately damaging for those being protected because it perpetuates outdated or inefficient methods and performance which ultimately will expose the provider to extinction.

3. Retail supply chain management
During the 1990s, a UK retailer analysed their shop sales with particular attention to the level of product availability and the discounting of items in sales. They found that at any one time on the shop floor they would have available to the shopper only about 70 per cent of the colour and size options within any given range. They determined that if a shopper was unable to buy their size or preferred colour of a garment they would not return – they would shop elsewhere.

The retailer also found that they were marking down around 30 per cent of all stock for sale, eroding their direct margin by at least half. When they analysed the reasons for this, they found that it took them five seasons (i.e. one and a quarter years) to get a product through the design process to being on sale on the shop floor. They found that 80 per cent of that time was taken up with waiting for information or a decision.

By better connecting the parts of the process – the designer to the outsourced manufacturer to the distributor to the shop – they could reduce this time to one season. This would give them enhanced visibility of what the consumer wanted, they could respond much more quickly to sales and be better informed about the products and sizes that were selling fastest, so they could amend production accordingly.

The result was an improvement in shop floor option availability from 70 per cent to 90 per cent and a reduction in discounting from 30 per cent.

67 Ibid.
cent to 10 per cent – a combination that increased customer satisfaction and grew store profitability tenfold.\textsuperscript{68}

**Important lessons for healthcare**

Whilst there has been much policy talk about placing the patient at the centre of the NHS, in reality NHS healthcare has been very bad at learning from patient feedback.\textsuperscript{69} In fact, immediate patient feedback has only been gathered in the last couple of years through organisations such as Iwantgreatcare.com. Yet almost every other service recognises that speedy feedback from customers immediately improves the service. At the moment most NHS providers are guessing what patients want and trying to factor those guesses into their service over a long timeframe.

Also, excessive and unnecessary delay in patient treatment results in additional tasks or waste.\textsuperscript{70} For example, if waiting times for elective surgery are excessive, diagnostic tests must be repeated, and patients can develop other conditions or illness that result in cancellation.

As with the retailer’s analysis of elapsed time, mostly this is unnecessary and not only non-value adding but value destructive. By the application of lean methodology and rejection of traditional behaviour patterns, patients could move from diagnostic decision making to procedure within weeks – lower cost and better experience.\textsuperscript{71}

**4. Car manufacturing quality improvement**

4a: The Mini: Transforming expectations about the number of errors allowed

In the 1990s, BMW bought part of the Rover group, and one of the brands of vehicle that came with this acquisition was the Mini, just months before it was to be relaunched as the new Mini.\textsuperscript{72}

\textsuperscript{68} Ibid.
\textsuperscript{70} NHS Institute for Innovation and Improvement (2012), “Improving patient flow in the NHS. Case studies on reducing delays”.
The managers of the Mini brand went to their new bosses in Munich to sign off the launch plan but the BMW managers were horrified to see that the level of production compliance was 70 per cent. They cancelled the launch, telling the Mini team to substantially upgrade their compliance level. Although the team represented their launch plan at 75 per cent, 80 per cent and 85 per cent, the managers told them only to represent when they were at the BMW standard of 98 per cent. The result was a delay in the launch by over a year, during which time the costs of the Mini design and production had to be written off. However, when the car did launch it was to widespread acclaim, both for its design and for its quality.

Some two decades on, and the influence of German and Japanese quality standards now means that it is unusual for a car to be subject to a manufacturer’s recall for modification. Up until the 1990s, the low level of manufacturer compliance meant that car recalls were commonplace, particularly for a new model launch, with related higher accident rates and manufacturer costs.

**Important lessons for healthcare**
Within small parts of our current health and social care provision there is recognition that lean methods and technology can transform the number of errors within the supply chain. If this were made industry-wide, as it has in the car industry, this would be transformational.

**4b: Mazda: Transforming expectations about errors in the supply chain**
Mazda was a Japanese owned car manufacturer that was acquired by Ford, partly as a way of acquiring Japanese quality methodology. Shortly after acquisition the Mazda management team were called upon to explain to Ford why they employed 20 people to reconcile the purchase orders of parts suppliers with invoices. The Mazda management were embarrassed and hurriedly outlined a plan to remove this function, but Ford’s management said that they actually had a department of several hundred people carrying out the same

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73 Brady, C. and Lorenz, A. (2001), *The end of the road. BMW and Rover – a brand too far.*
task. A relieved Mazda team explained how this used to be the case for them until they had reduced this by applying various “kaizen” (Japanese for improvement) practices. They had gone back to the drawing board because they felt that this was a non-value adding function.

The new model the Mazda management team had developed recognised that the extra reconciliation task was only required because suppliers delivered quantities different to those ordered. This was the industry norm but it was fundamentally inefficient, so Mazda gave notice to all parts suppliers that they would reject all deliveries that did not conform exactly to the quantity ordered.

Although this caused some difficulties and interruptions to production for a period of time, suppliers soon accepted the new system and responded. The fact that Mazda still had 20 people in this function was because they would make the occasional exception if rejection might result in stopping the production line. However, they eliminated this exception completely within a few months.

**Important lessons for healthcare**

In each case poor quality performance or non-standard delivery became accepted as the norm – failure was tolerated and the cost of poor quality became ingrained in the system and tolerated to the extent that manufacturers tried to make something unacceptable efficient rather than fundamentally eradicating the root cause.

In healthcare we allow 18 weeks as an acceptable period of time to wait for surgery. We accept “normal” error rates for surgery and infections – how often do we say “within the normal range for surgical error”. Individual hospital or consultant mortality rates being published were resisted. NHS friends and family satisfaction levels are at similar levels to the bad old days of the British car industry. We do not always adopt a zero error outlook and build it into our methodology.

**4c: Sub-assembly and supplier parks developing a new business model by managing the supply chain**

The traditional supply chain for automotive parts was to source products from many suppliers, with a focus on selecting local
companies. This led to automotive plants carrying extensive stock, and the production line assembling each individual line item. This was costly, complex and led to multiple errors on the production line.

The first phase of industry innovation was the just in time (JIT) concept. This involved fewer suppliers being selected, but they were treated as long term partners.\(^77\) This facilitated the design of direct supply to the automotive production line, removing the need for local storage. To achieve this, the car manufacturer had to share detailed information with their suppliers – literally letting them in to their inner sanctum and no longer buying on lowest price.

**Changing ways of working**

The next stage of innovation was to organise the suppliers as sub assemblers – to combine certain component groups, for example a door with the various sub-components, or a steering wheel with integrated electronic, wiring looms etc.\(^78\) This enabled a simplification of the production line to become more of a bolting together process. This improved quality, cost and flexibility.

As a result, the plants themselves could now become multi-platform rather than single product plants. The intricacy of sub-assembly had been pushed back up the supply chain and meant that the production line bolting together concept could be applied to different models or trim levels of cars and even for different platforms entirely – cars, vans etc. The productivity of individual plants was no longer compromised by variability in demand for each model and platform: everything could be combined within one plant and assembled according to demand.

The final innovation was organising the sub-assemblers so that they were located adjacent to the final assembly plant. That way they could all share an integrated computer system, creating enviable efficiencies throughout the assembly process.\(^79\)

**Important lessons for healthcare**

Again the lessons for the new model of health and social care are obvious. None of the above works without very strong supply chain

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79 Ibid.
management. At the moment there is virtually no supply chain management in health and social care patient pathways. As a result, the old model where each supplier works to their own organisational needs and not to the needs of the patient continues.

4
Policy lessons for the NHS
The challenge of creating momentum
What is consistently seen from the development of innovations in other industries is that the new models of provision come from outside the organisations providing the old ones. Clayten Christensen in his book The Innovators Dilemma outlines the nature of that very dilemma.\(^{81}\) He notes that it is very difficult for an innovator with a new business model to get an organisation that is successful within the old business model to take on the new business model. Understandably the board of the successful organisation is unlikely to agree to radical change if they are doing well out of the old model.

So how do new innovations take hold?
Many of the examples that we have used from other industries show how the existing model was, within its own culture of performance, doing well. It took an external model to make the new happen.

The Mini team was pleased to get defects down to 70 per cent – within its own cultural experience this was considered good enough. It took BMW to insist that this had to be over 90 per cent, and to enforce that approach, before the new Mini could be launched.

The old retail stores were doing the best that they could to secure quality and price within their business model, but it took the new supermarkets to develop a new out of town model of hypermarket and then to move that model into small shops on the high street.

It is clear that providers who are external to the existing culture and business model are vitally important. As we shall see from some of the examples below, this is not to say that the NHS providers will not play a full role in the development of these new models. But change needs new input as well as the old.

If the new is going to play a big enough role in creating new models of health and social care to help save the basic principles of the NHS, then policy and structure need to find ways of allowing the new to enter the market of NHS funded services. This is not to say that all the new comes from the independent sector, but if this sector is excluded from this change, it is unlikely that the NHS will change quickly enough to develop significantly better healthcare outcomes for the

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\(^{81}\) Christensen, C. (1997), *The Innovator’s Dilemma*. 
same resource. And if the NHS cannot achieve that over the next decade it will be put in danger.

The NHS as a taxpayer-supported enterprise within a framework of public policy. That public policy framework can inhibit new models of health and social care or it can encourage them. We argue that to save the NHS for future generations the public policy framework needs to encourage new models of care.

**Competition vs integration?**

The concern across much of the NHS is that plurality of provision would result in the fragmentation of care pathways and the loss of cohesion and continuity for patients and their treatments.\(^2\)\(^2\) Whilst the implicit presumption that care pathways are currently “joined up” does not reflect common experience, nonetheless, the concern is rational.

However, this example of the automotive industry illustrates that tasks can be pushed down the supply chain with integration and without loss of control or cohesion. For example, diagnostic tests could be carried out in a one stop shop service for outpatients and other parties can be delegated to carry out pathway tasks – for example, pathology reporting, telehealth monitoring, provision of home therapies, use of advice lines for patients, integration of social care support.

The related lesson of the automotive industry is to utilise the most convenient and efficient parts of the supply chain to carry out tasks, thus freeing up more scarce resources (e.g. doctors, surgeons etc) to avoid them becoming bottlenecks in the system. So, upskill patients, relatives, care workers, support workers, nurses and others, to ensure that specialists throughout the system are productively used for their expertise rather than this being diluted across tasks that can be delegated.

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\(^2\)\(^2\) Pulse (2011), “BMA survey shows most doctors think reforms will harm the NHS”, 3 March.
How policy and framework development can hasten change

1. Outcomes-based commissioning
NHS commissioners are faced with a paradox. They are being encouraged to develop integrated care pathways and they are also being encouraged by the NHS outcomes framework to work towards patient outcomes. Both of these forms of commissioning are very different from the episodic and input based commissioning that has existed up until now.

Commissioners are being expected to develop contracts for radical new forms of provision. Yet they are also parts of local NHS health economies where some of the existing NHS providers are fragile economically and also in terms of quality. This fragility means that commissioners are very anxious about very new models of healthcare, making them resistant to new commissioning intentions.

This may mean that NHS commissioners who start to commission integrated care outcomes will be told to stop because they are destabilising the local health economy.

Alliance contracting
An alliance contract is one contract between the commissioner and an alliance of parties who will deliver the service. There is a risk share across all parties and a collective ownership of opportunities and responsibilities associated with the delivery of the project or service. Any gain or pain is linked with a good or poor performance of the alliance overall and not with the performance of individual parties. Alliance contracts create a collaborative environment without the need for merging existing and different organisations into one organisation. By having an alliance contract, all parties are working to the same outcomes and are signed up to the same success measures. It creates a strong sense of “your problem is my problem, your success is mine”.

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85 LH Alliances (2014), Lhalliances.org.uk.
Capitation Outcomes-Based Incentivised Contracts (COBICs)
The healthcare climate is challenging the traditional approach to commissioning. Static funding, growing demand and unexplained variation in clinical care between providers are calling into question the focus on process activity—number of appointments, attendances, operations procedures. Now more than any other time, commissioners need a new approach that rewards both value for money and outcomes that are important clinically and to patients—COBICs are at the vanguard of the step change in practice.

COBICs are a new form of contractual relationship that represent a radical shift from commissioning for activity to commissioning for outcomes. Each COBIC covers all care for a given group of people; for example, the frail elderly, those with mental health problems or muscular skeletal disorders. The budget is shaped around the needs of that population and financially rewards providers for achieving specified patient outcomes. In pursuit of these outcomes commissioners and providers need to work in a radically new way collaborating and problem solving to reduce efficiencies and remove barriers to high quality value for money integrated care.

2. Payment reform
If commissioners are to buy integrated care around outcomes for patients and service users, the methods of payment for organisations and individuals should provide incentives to deliver those outcomes. NHS resources are used to provide a wide variety of different forms of payment to organisations that provide care for NHS patients. Some payments are made:

- as annual block grants to providers for a wide range of different services
- as a block grant for a certain sort of service
- for individual services (Payment by Results), and
- direct to GPs

86 COBIC (2014), cobic.co.uk.
Social care resources are used to provide a variety of different forms of payment.

Whilst there are a variety of payment systems, more and more of them are paying providers for a specific activity, from a homecare visit in social care to a hip replacement in a hospital or a visit by a district nurse to treat a leg ulcer.

In most places each activity is paid for as an activity in its own right. However commissioners are increasingly in a position where they want to commission health and social care for an entire section of their population, e.g. the frail elderly. They want to do this because they recognise that in the present system they might buy, over a year, 20 different social and healthcare activities for an older patient with several long term conditions.

Each of these may be well delivered, but taken as a whole they do not add up to a coordinated experience of care. Unless the older person has the capacity to organise a complex logistical exercise, the actual experience of care is at best bewildering and at worst a self-defeating jumble.

**From paying by activity to paying by outcome**

The leadership of the NHS along with most health and social care systems in the world encourage their health systems to act in a more integrated way. But moving from a system which pays for every individual activity to one that pays for an outcome is a large organisational shift and one that is resisted by those who are successfully running the old business model.

NHS system leaders at NHS England and Monitor have a joint responsibility to set prices and the system of prices. In December 2013 Monitor started a consultation on the future of the payment system.\(^{87}\) This document recognises the need for new forms of pricing:

> “Much of the current payment system enables the NHS to deliver high quality, efficient care. However we hear more and more from NHS providers and commissioners about parts of the system that get in the way of them doing their best for patients. Everyone

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\(^{87}\) Monitor (2013), *Towards an NHS payment system that does more for patients*. 
thinks there is potential for the payment system to do a much better job…Commissioners and providers will have more freedom to arrange payments differently as long as they can demonstrate that any new arrangements will benefit patients. We’re doing this largely because we know that commissioners and providers sometimes found the old rules a barrier to designing services they believe would serve patients better.”

This signals to the NHS that new forms of outcomes-based budgeting could be developed.

Developing new prices is a priority given the context. Over the next five years they know that there will be less money per activity. During this time they will need to ensure that the old system of payments by individual activity does not collapse as providers of NHS care receive less money per episode of care. In addition, they will need to ensure that a new system of payment develops which encourages providers of health and social care to develop the new business model that provides integrated outcomes.

In 2014 there are strong pressures on system leaders in both directions. On the one hand there is a growing recognition that there needs to be a radical change in the model of health and social care being provided. On the other there is recognition that the scale of change needed will lead to a number of existing NHS provider institutions being radically changed.

**Changing payments gradually**

As a result, the move towards outcomes will have to take place with momentum and through a gradual approach. For example it would be possible that contracting towards a set of healthcare outcomes could take an increasing percentage of the contract. The first contract that moves towards outcomes could have a small part paid for on an integrated care outcome while the remainder could be paid for under the old input model. Every year the proportion based on outcomes could increase, so that, over a decade, 50 per cent would be paid on outcomes. These outcomes could be worked out initially by the commissioner with patient organisations and further developments made via a competitive dialogue with prospective providers.
The drive for the contracts is to incentivise the providers to provide better value in two sets of metrics.

1. Finance: to cover a group of patients to reduce emergency admissions and their dependency on hospital beds.

2. Patient outcomes: to reduce their dependency, the disruption to their lives caused by emergencies, and the number of days per year that patients waste in attending and spending time in hospital. This can be tracked by patient diaries and health and social care use.

3. The role of new entrants

In all of the examples showing how new business models developed in other industries there was conflict between the possibilities of the new business models and the certainties of the old. Such radical changes can leave whole sections of industries, and sometimes large chunks of a nation’s economy behind.

Rarely is there a straightforward move from the old to the new. The old defends against the new and the new needs to struggle to make its case. Often this struggle moves beyond an economic fight between firms and into the social and political arenas. The old mobilises the loyalty of its customers and will lobby government and regulators to stop the new as dangerous and unproven.

All of this is true for the conflict between new and old models of healthcare in the NHS. Large parts of the NHS (and also of private healthcare provision) depend upon a model of healthcare that is hospital based, with fragmented episodic care as its basis. The defenders of these institutions believe that they can only survive if the existing model of healthcare continues.

Of course the politics of the NHS overlays this conflict between healthcare models with very strong social and political arguments.\(^{88}\) Whilst “save our high street” has a strong social and political pull “save our local hospital” touches social and political parts that few other conflicts reach. Therefore the conflict over the entry of new models of healthcare for NHS patients is likely to be a very powerful one. In recent times when governments have tried to argue for new

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entrants and new models of healthcare to be introduced into the NHS they have often been met with a howl of protest from existing healthcare providers, as well as the trade unions representing different parts of the NHS workforce.

4. More agile providers
The organisational form that will pick up these contracts will be very different from an NHS Trust or a GP surgery. The organisations will need to be strong enough to be held to account for a large degree of risk while being agile enough to develop very different forms of service. They will need incentives to chase value in a much stronger way than existing NHS organisations.

**Promoting change at the macro level...**
The danger is that the only organisation that can enter this market when it is new will be large private sector companies used to entering new markets and with the capacity to do so. If the market stultifies around a few existing providers it would be bad for innovation. Commissioners, national and local, are going to have to work with new providers to develop a different approach to underwriting the risk. Failing to do this could lead to the new organisations becoming a very small group of providers.

**...and at the micro level**
Although there will considerable natural turnover of staff through retirement during this coming decade, the development of new business models will lead some specialist staff to exit the NHS and social care. However, the vast majority of staff who will be working with NHS patients and social care users in 2024 are working with patients now. So the main training need for 2024 will be the retraining of existing staff.

Over the next decade we need to spend much more on retraining the workforce to play their role in delivering whole patient care and to enhance patient self-management. Given the flat lining of expenditure in the NHS over this period, the only way in which this extra resource can be found is to move some of the resource currently spent on training new staff to the task of retraining existing staff.

For example, within the existing architecture in 2014 Monitor could
easily stop Foundation Trusts (FTs) from entering into this new business model by forcing them to stay within the existing one. Their current performance management system manages FTs within an existing model and adds a great deal to their worries about risk. It is in Monitor’s hands to work with FTs to ensure that they are part of a possible group of accountable lead providers.

**Creating the conditions for change**

To start and grow this process, the various centres of the new NHS need to create the structural and system conditions that allow a new model to develop. Regulators (both economic and quality related) need to regulate outcomes rather than processes – otherwise they deny the possibility of the new model by believing that the old model is the only way to deliver safe care.

Monitor and NHS England allow new forms of pricing to develop, moving away from the episodic Payment by Results, and incentivising the development of integrated pathways. As performance managers of the existing business models Monitor and the NHS Trust Development Agency could stop existing providers from becoming a part of this new market. If they continue to performance manage purely within the old system they will deny the NHS the opportunity to develop as a leader in the new model. However, if in 2014 the capacity for NHS institutions to lead new models is recognised and they allow the best NHS institutions to develop as accountable lead providers, the NHS will be allowed to be a strong part of the new model.

5. Mobilising consumers

There seems to be a near universal belief among much of the NHS leadership that patients will defend existing services and will therefore be against all changes to medical models. This belief runs very deep and stems from the experience many NHS leaders have had as a result of their mishandled attempts to bring about changes to local hospital models of care. At worst this means that NHS leaders are frightened of the public. At best it means they ignore them as a force for change.

Contrast this with consumers of most other industries. Whilst there will be different groups amongst consumers with some brand loyalty
to older ways of working, there will also be an expectation that a
group of consumers will play a role in demanding the new and better
form of service. The patient groups in England have formed
themselves into a collective organisation that is demanding much
better outcomes and much more integrated sets of pathways.\textsuperscript{89} This
organisation could play an increasingly important role in in pulling the
new model into the NHS

Later on in its development, one of the main ways that a new model
will become accepted is through the pull effect of consumer demand.
As this decade develops, patient groups will demand a model of care
that is integrated and works around the patient’s home. These patient
groups will be in conflict with other locally based patient groups
defending hospital buildings.

Macmillan Cancer Care is the major cancer charity in England.\textsuperscript{90} Its
activities range from major fund raising, providing Macmillan
nurses, advice for cancer sufferers and their families and lobbying
for major changes in policy. In 2013 it decided to work with
Staffordshire and Stoke Clinical Commissioning Groups to develop
an outcomes-based and integrated commission for end of life and
cancer services. This involves Macmillan in not only giving advice
but in funding some development work with the clinical
commissioning groups. This activity demonstrates a commitment
by a patient group to practically develop a new form of provision
on the ground for the patients that they work for.

National Rheumatoid Arthritis Society has joined with partners
including Circle, Pennine MSK and Luton and Dunstable NHS
Foundation Trust to provide a new outcomes-based integrated
care service in Bedfordshire.\textsuperscript{91} This partnership won the contract
after a competitive tender in August 2013 and demonstrates how a
patient organisation can play a role in the actual provision of
radical new services, rather than lobbying for someone else to
provide them.

\textsuperscript{89} The King’s Fund (2010), \textit{How to deliver high-quality, patient-centred, cost-effective care: Consensus solutions from the voluntary sector.}
\textsuperscript{91} Financial Times (2013), “Circle named preferred bidder to run county’s orthopaedic care”, 12 August.
6. Permissive management of performance

For these changes to grow from 2014, NHS England, as the body that commissions some care itself and performance manages the local Clinical Commissioning Groups, has to leave space for some CCGs to commission for integrated care across different populations and co-morbidities. The Secretary of State could help to create this space by giving a mandate to NHS England to do exactly that.

This extra space to commission different care will also be reduced by the traditional performance management programmes within NHS England and the other regulatory bodies whose prime activity is to work within the old system and to balance the annual books.

In early 2014 NHS England, Monitor and the NHS Trust Development Agency are both in favour and against such commissioning innovations. In policy terms it wants such new models to emerge, but in operational terms it wants the old models to work in order to balance the books in a normal way. If these organisations want to play a role in helping to create the new models of healthcare we outline above, then they need to move beyond having a policy in favour of the new, they need to ensure that their operational practice plays a strong role in supporting new models. How their staff talk to Boards is much more significant in either stopping or allowing new models of healthcare to develop than all of the policy pronouncements from their policy departments.

Conclusions

From its birth and throughout its life the NHS has been the centre of political conflict, and in that sense, the next 10 years will be little different from the last 65. We are not naïve: we do not expect that the policy measures we have outlined to encourage new business models would be simply brought in because they are good ideas. Each of them will be met with opposition from those who believe it is in their interest to restrict the NHS to its existing ways of working.

As in every other industry radical change will be met with conflict between the old and the new. We know that this conflict is going to happen and we will not be surprised by its nature or extent.

In the very early stages, from 2014, due to the monopolising power of
the old, complacency will lead people to think that the new model is unlikely to happen. However, this could provide the new model with the opportunity to start delivering services – to start proving itself by providing real integrated care.

It is certain that in the NHS, as in all other industries, the emergence of new outcomes-based integrated models of healthcare will only take place in the teeth of very sharp conflict with the old established model of care. A string of policy pronouncements in favour of new models of integrated care will not be enough. Those in favour of the new model of care will have to demonstrate on the ground how the new models are better than the old.
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