System redesign needs strong leaders and a ‘patient is paramount’ ethos

Andrew Sansom | 09 Feb 2017

The UK’s future healthcare system and infrastructure must be built around the patient if the transformation of the health economy is to be sustainably realised, but strong leadership and effective partnership are also crucial ingredients.

This was one of the key conclusions to emerge from a SALUS Foresight round-table event involving some of the UK’s leading healthcare property and design professionals, held on 24 January in London at the Royal College of Physicians (RCP).

Produced in collaboration with AECOM and chaired by the company’s global head of healthcare John Hicks, the round table, ‘Transforming UK healthcare: Visioning the future of healthcare infrastructure’, featured a mix of architects, health estates and planning professionals, an academic and an economist. Their objective: to identify ways to deliver infrastructure transformation to drive value and support system and service redesign, while acknowledging the familiar constraints imposed by financial and human resource, technology, demographics, lifestyle and consumer demand.

Focus on flexibility

Unsurprisingly, given the demographic shifts now taking shape and never-ending changes in technology, flexibility was highlighted as a vital element in transforming the health system. But, according to Duane Passman, director of 3Ts at Brighton & Sussex University Hospitals NHS Trust, this has to be seen not only in the context of “greater flexibility in the assets we deploy” but also in relation to funding, capital and revenue.

He described NHS capital and public funding as imbued with its own inflexibilities relating to process, but added that some of the alternative models, such as PFI and LIFT (Local Improvement Finance Trust), are equally inflexible in being able to back out of the very long-term contracts associated with them. While lamenting what he called the “bewildering array of approval bodies, regulators and others who hold providers to account”, he called for a re-engineering of the system as a whole so that both public-sector capital and alternative funding methods could be accessed in a much more “predictable, slick, flexible and proportionate way”.

There was some hope that the UK’s new planning framework of sustainability and transformation plans (STPs) – where the NHS and local councils have come together in 44 areas in England to develop proposals and make improvements to health and care using a place-based approach – might provide the chance to create greater flexibility, but concerns, too, that the intensifying pressures facing the health system might see this opportunity lost.

Jim Chapman, visiting professor at the Manchester School of Architecture, was quick to latch on to the importance of both leadership and collaborative partnership in this area.

“You need a strong leader who knows where they’re going and communicates well with the people who are going to use the facility,” he explained. “That’s very important – the value of the estate. What we’ve got to do is put the STPs together with the district and neighbourhood plans [the mechanism by which communities are given direct power to develop a shared vision for their neighbourhood and shape the development of their local area], so you put the buildings in the right place for the people.”

Highlighting the hurdles in the continuum of care and the need to engender greater flexibility and connection between the health and social care sectors, Passman wondered if the STP system offered an opportunity to use resources in specific STP areas in a more sophisticated fashion – and, importantly, at scale.

Chris Shaw (left), Richard Darch (centre) and Jim Chapman (right) tackle the key issues

“We need to get much cuter and, sadly, our political masters need to get their heads around how that works instead of offering buckets of funding, where everyone desperately runs around trying to get something out of the same bit. We might look at how we can create a slightly larger bucket and do something at scale in an integrated and flexible way.”

Chris Shaw, chair of Architects for Health and senior director at Medical Architecture, argued that the current business case and process are hampered by inertia that “points us the wrong way and backwards to existing hospitals and clinics, and existing locations. They all have totemic value and are much loved, but they diminish the productivity of the whole system and reduce the quality of the spirits of those who work in those settings.”

Considering what should replace this increasingly obsolete infrastructure, Shaw remarked: “I think the new estate needs to be agile, it needs to have lean provision, and it needs to be able to cater for *that* and *that* and *that*.

"The idea of a much more generic public estate, the terms of quality of space and shared space, these apply universally,” he contended. “You can’t build a proton-beam therapy unit generically; it’s

Tricia Down

highly specific, but for 80% of what we do, it can be much more generic."

Sustainability, technology and unintended consequences

Issues around sustainability and technology are also crucial to the flexibility of health infrastructure. Tricia Down, head of health and capital planning, and PFI project director for Southmead Hospital, North Bristol NHS Trust, explained that the trust's redevelopment has resulted in very energy-efficient buildings operating well below the targets it had set. However, having doubled the amount of space and invested in a lot of new, automated technology, some unintended consequences are now coming to bear.

"In the case of our pathology building, we've a significant amount of automation that we didn't have previously, and that is increasing the amount of energy the building takes," she explained.

"Sustainability needs to be built in as a completely integrated solution when you're developing your building but there also needs to be an opportunity to add other features that weren't available at the time."

Danny Gibson, technical director at MJ Medical, said the type of issue to which Down refers and, more generally, an obsession with capital costs over whole-life costs, should be addressed.

He commented: "It's interesting when you talk about medical technology and ask what's best breed, what's going to be sustainable, what's best practice, what's best for the patient; we're not thinking about those things at all. It doesn't feature in BREEAM at all and it's not part of the assessment.

We spend a fortune on thinking about buildings from day one and we need to think about using our buildings for a long life and loose fit; it's the duffel-coat approach, which gives us a lot more flexibility to use more spaces in different

ways."

Leaving the queue and thinking like a business

Health economist Richard Darch, chief executive officer and founder of Archus, suggested that the current business-case model was not just beset by inertia but was also stuck in a traditional public-sector mentality. He argued that there is a risk of being burdened by seeing capital as "something you get given, an allocation, something you're in a queue for".

Danny Gibson

The primary care infrastructure, he suggested, should be well designed but can be simple in form and paid for by having commercial space (as well as residential space) in and around and above that. This, he explained, represents a move away from the old 'queuing approach' to taking advantage of the intrinsic value of the health estate to use it more effectively.

"How do we identify what we need in terms of debt and how do we service that debt?" he asked. "We can only do that in one of three ways: we either increase our income, which is very limited; we reduce our costs; or we do a mixture of the two. That's how every other business operates."

Thinking like a business is a mantra supported by Alistair Gourlay, director of asset management at Guy's and St Thomas' NHS Foundation Trust. Non-clinical healthcare services are provided for the trust through its in-house provider Essentia. According to Gourlay, the model is almost the reverse of PFI, with Essentia looking at how income can be obtained through private-sector occupants on the estate and exploited to meet the trust's capital requirements.

Another aspect to this is, as Gourlay puts it, re-establishing the art of developing people. The Essentia Academy places a focus on developing managers through training courses and helping them develop career skills. In this way, explains Gourlay, the trust develops its own people to deliver the efficiencies required, with these efficiencies then used to generate the capital.

While a more commercially savvy approach has its merits, it's essential, too, that the patient sits at the heart of the model.

He elaborated: "When we were first doing this, I was really worried about how patients would feel about using a public-sector building with private-sector occupancy. But, as soon as the patients realised that having private-

Alistair Gourlay (left) and Duane Passman

sector occupants meant we had an effective NHS, they were completely on board, and that drove a funding model that proved to be very successful.

“The patient voice is really, really important. Focusing on doing the right thing for the patient – that’s something we believe in strongly.”

Taking this argument further, Darch stressed that it’s not just about the commercial opportunities, but social and care occupants might also be brought together on a more joined-up, unified estate.

“How many years have we been talking about step-down?” he asked. “How many analyses have we done? All the evidence internationally says that patients moving into that environment have a better outcome than in an acute environment. Why hasn’t it happened?”

Down responded to Darch’s remarks by explaining that an acute trust may not want to take responsibility for something it believes is the duty of social care.

She said: “We’re probably spending more money because we’ve got more patients in hospital who didn’t used to be there, but it’s social care that should provide a step-down. In the end, the whole system pays more for that, but it’s about individual responsibility and not being prepared to acknowledge ‘we’re just going to have to pay to sort it out’.”

Partnerships, building trust and acting braver

This sense of ‘passing the buck’ also relates to one of Down’s key messages: the need for partnership and collaboration.

She described a current atmosphere of intransigence, whereby trusts are reluctant to really tackle the question of how their estate might be best utilised (and, perhaps, sold) for fear they might need it further down the line. As a way forward, she stressed that conversations needed to be had with people, so that better decisions about estate utilisation could be reached.

“We need to be getting into partnerships with experts who can really help us deliver our property,” she explained. “What can we bring into the organisation that would help? If we had a hotel, for example, with a private partner helping us deliver carer accommodation, or a nursery – that kind for thing. Key worker housing – those are the things we need to get into. How can we diversify the use of our estate so that we bring funding in that can help support us with some of the development?”

Bringing the discussion back around to the STPs and patient care, Down added: “What we’ve done, historically, is design systems around the type of clinical service, and what we need moving forward – and we need to be supported by the STPs – is to centre the whole thing around the patient.

“I feel the STP discussions are starting to encourage more partnership thinking with our colleagues in primary care and clinical commissioning groups, and with councils. It’s the development of better relationships that would help build trust, and enable us to be a bit braver about some of the things we’re going to do in the future.”

AECOM's John Hicks (right) chairing the event, alongside SALUS founder Marc Sansom

Chapman added that the NHS also needed to use the vast amount of data, which it is currently “sitting on”, to not only help trusts design better hospitals but to take a more holistic approach to designing the whole estate and masterplanning.

“Some of the data needs to be updated and refreshed,” he explained. “But it needs refreshing by the users and designers, not the accountants and lawyers. It’s an amazing source of valuable information.”

A tale of two architectures

Shaw took the discussion on data further by describing it as “a matter of economic survival” post-Brexit to build a health system that “not only provides all of the patient experience but also capitalises on that dataset and supports the biotechnology industries that go with that, links to the universities, and maintains the pharmaceutical industry”.

He called for a three-tier approach to finance decisions around health, from top-level, population planning around urban infrastructure, through to what specific health facilities are needed, and, finally, recognising that technology changes on, roughly, seven-year cycles.

At the same time, Gourlay stressed that physical and IT architecture could no longer be considered separately. “The whole healthcare planning model needs to embrace technology and use it properly,” he said.

Passman added that how the two architectures are joined up and how the relative risks are managed need to be thought through rigorously before the private sector is approached for finance.

Leadership from within

With regard to risk, Darch also underlined that the NHS should rely on, and rebuild where necessary, its in-house expertise and leadership in delivering the transformation of the estate. He argued that planning and development, and management of construction, are the riskiest parts of a project, but that expertise can be found within the health system and should not be outsourced.

The health system, he concluded, needs to recognise, just like any other industry, the importance

of “continually investing in its capital stock in order to remain competitive – competitive in the sense that it is seen as providing a high-quality environment to deliver effective patient care”.

‘Transforming UK healthcare: Visioning the future of healthcare infrastructure’, a SALUS Foresight event was kindly sponsored by V. Guldmann A/S.