West Norfolk Clinical Commissioning Group

Addressing the challenges facing the local health and care system

‘Evidence for Change’

February 2015
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Foreword

Just over 30 years ago I started my career as a Doctor in our NHS here at King’s Lynn. Our health service has changed immensely over this time, with treatments for many conditions which lead to an early death in the past now transforming outcomes and life expectancy. The Queen Elizabeth Hospital building on the site has changed very little, but staffing and equipment are beyond recognition. We have experienced an unprecedented growth in the NHS budget during the last decade, and although growth has continued since then despite the period of austerity in public spending, it has been at a lower rate and the NHS has been addressing in various ways how to become more effective and efficient.

I know as a local GP that the experience of patients in West Norfolk has improved over the years. However we still don’t always get the right care for patients or make the best use of resources available. We must plan now for us all, as the patients of the future. The challenges we are describing in this report tell us why we need to transform NHS services locally to create high quality and financially sustainable services now and into the future. The evidence we have gathered sets out a clear case for change and how the local NHS needs to adapt and update in order to meet these new demands.

Since the CCG was formed nearly two years ago as a clinically lead organisation, we have worked hard to build and develop the relationships between clinicians in West Norfolk regardless of whatever organisations employ them and where they work. We believe this dialogue, looking at what we are currently doing, how we could do it better and what our staffing, training and development needs are for the future, makes a firm foundation for the work we now need to do. We have looked at data describing the current and projected health needs of our population; the quality and performance of services; levels of activity and demand; workforce data; and detailed financial information. In addition, to help inform our report we have been gathering patient, carer, public and staff feedback and views on the current picture of healthcare across West Norfolk.

We have used a wealth of insight and feedback gathered by the CCG and local health organisations over the last year or so, and have been working with a Patient and Public Engagement Group over the last few months to share and test our work. We would like to thank local people who attended our drop-in information events held last month. We appreciate the feedback and comments they have given us about the work presented so far.

Our next step is to continue our work with local clinicians and health and care leaders to develop options for a new pattern of healthcare delivery that could meet the challenges we have set out. We will consult formally with the public on any changes after we have further progressed our clinical work.

We continue to welcome any comments, suggestions and thoughts local people may have on healthcare services in the local area and we invite you to feedback to us through local events, our website, face to face sessions, written feedback and social media.

Dr Ian Mack
Chair, West Norfolk Clinical Commissioning Group
Executive summary

West Norfolk Clinical Commissioning Group (CCG) is a clinically led NHS organisation responsible for commissioning healthcare services for West Norfolk. Supported by partners in the West Norfolk Alliance, West Norfolk CCG previously published a Case for Change, charting the need to respond to challenges to the sustainability of healthcare services and the opportunity to ‘do differently’. The scale of the financial challenge faced by Queen Elizabeth Hospital King’s Lynn (QEHKL) subsequently led to the appointment of a ‘Contingency Planning Team’ (CPT), tasked with understanding the future challenge of delivering healthcare services in West Norfolk. Local work has provided a strong foundation for change and this document describes, with supporting evidence, why there needs to be a review of the way in which services are delivered in West Norfolk.

The National picture

Nationally there is a significant challenge now, and for future delivery of healthcare services. Demographic changes are leading to growing healthcare need as we are getting older and living longer. More of us have one or more long term chronic condition, lifestyle risk factors are growing, as are patient expectations, which means that providing healthcare is us costing more. An ageing population, with greater complexity of conditions has required thinking to develop about how we best treat patients, maintain clinical standards and deliver 24/7 care. Hospitals now need to undergo transformational change, which will affect the type and number of patients treated and how they are treated, with greater integration of health and social care services to deliver the required standards of care at an affordable cost.

There remains significant variation in the quality of care, and outcomes of this care received in England. High profile cases of failures in quality of care recently have resulted in in-depth reviews to ensure lessons are learnt and rightly rising clinical standards and patient expectations for delivery. Consequently there are requirements for optimum levels of workforce required for safe, high quality care and fulfilling staffing requirements has required many providers to invest significant sums, adding to the financial pressure. Small district general hospitals particularly feel issues relating to scale of provision and economies of scale, and ability to attract and retain a sufficient workforce, leading to proportionately greater costs than larger hospitals. At the same time, out of hospital care also requires reform as current care is often fragmented, and there is not always the right capacity and expertise to provide the right care that is needed.

A £30 billion NHS funding gap is projected in the future and all NHS providers and commissioners are making year on year efficiencies that are becoming harder to achieve without having an impact on care. The national message is absolutely clear; transformational change is required in the way that we deliver healthcare services to avoid the ‘3 gaps’ identified by Simon Stevens, NHS England Chief Executive, of ‘Health and Wellbeing’, ‘Care and Quality’ and ‘Funding and Efficiency’. Local, clinically led change is needed to put patients at the heart of healthcare, with integrated out of hospital care, combining skills, workforce and infrastructure across primary, community and hospital care that includes greater focus on preventing illness.
The West Norfolk challenge

The national picture is mirrored locally in West Norfolk, but felt more acutely for the following reasons;

- a population that is ageing quicker than nationally with higher incidence of long term conditions and lifestyle risk factors.
- challenges faced by the geography of West Norfolk with rurality, a dispersed population and distance to other major NHS centres.
- challenges faced in recruiting and retaining workforce and reliance on temporary staff.
- scale of provision of acute hospital services at QEHKL as a small district general hospital where the income received for treating smaller numbers of patients is not always sufficient to cover the costs of providing the service.
- Care Quality Commission (CQC) hospital inspection and linked requirements for additional investment to improve the quality of services delivered.

Finances at QEHKL are challenged, for 2014/15 the Trust projects a deficit of £14m, which is likely to continue in future years if significant action is not taken. In line with the national picture QEHKL, as a small rural hospital, faces significant sustainability challenges. The challenges of providing services at high quality, attracting and retaining sufficient skilled workforce, and delivering some services at sub-scale has left the Trust with a significant financial challenge in 2014/15, and in future years.

GP practices in West Norfolk perform comparatively well compared to the England average in terms of access to services, patient satisfaction and numbers of patients attending A&E departments. Further improvement may be possible in reducing variation between GP practice performance that is not due to differences in patient population, and in the number of patients admitted to hospital as an emergency for ambulatory care sensitive conditions. Whilst there are also some strengths in the current model of out of hospital care, further improvement could be made in the way that services are integrated, and in supporting individuals to manage their own care.

The opportunity to improve care for patients in West Norfolk

Locally, this problem is not just tomorrow's problem, we are facing significant financial challenge today. There is a clear 'Call to Action', of which the primary factor is currently the QEHKL financial position which has triggered the CPT process, however the challenge is health system wide in the longer term. In spite of these significant challenges both nationally and locally we believe we can respond positively. Through the West Norfolk Alliance we have been exploring areas of opportunity to deliver further efficiency, greater integration, address workforce issues and better utilise technology and estates. We now have a chance to do more, at pace, through the CPT process.

Have your say

At this time we are not in a formal public consultation on proposed changes, but this document is part of an ongoing dialogue with stakeholders and members of the public about the CPT process, future commissioning intentions and the potential range of solutions that may help address the challenges going forward. In the final section we set out the next steps for the CPT process, and look to you for your feedback.
West Norfolk Clinical Commissioning Group (CCG) was established in April 2013; a clinically led organisation made up of GPs, hospital consultant, nurse and lay representatives, responsible for planning, designing and buying health and care services for the population of West Norfolk. West Norfolk CCG commissions the majority of healthcare services for the local population, including most secondary care (or hospital) services, and services from community and mental health providers, but is not responsible for commissioning all healthcare services. Those that it does not commission include GP Practices, and specialised hospital centres providing complex care such as organ transplantation. These services are commissioned by NHS England on a regional and national basis, and public health services such as flu immunisation or health lifestyle behaviour programmes are commissioned by Public Health departments within Local Government. The CCG does, however, work very closely with these other agencies, to ensure that the totality of services provided to the local population promote the best health outcomes, both in terms of healthcare services themselves and those linked services such as social care, housing and education, which have an indirect impact on individuals’ health.

West Norfolk CCG serves a population of 165,000, with an annual commissioning budget of circa £220 million to spend on healthcare from providers. The main providers of healthcare in the local area are the local secondary care hospital provider – Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust, the local community health and care provider – Norfolk Community Health and Care NHS Trust, the local mental healthcare provider - Norfolk and Suffolk Foundation Trust, and local GP practices.

Early on our ambition as a CCG was clear; to commission high quality, value for money services for our local population using our strength of a local clinical voice to drive service improvement. There was much to build upon; innovative services delivering better care to patients and committed staff dedicated to the highest care for patients. However, it also became clear that now, and into the future there was considerable challenge for us in terms of the sustainability of healthcare services, and significant opportunity to improve the healthcare provided to our local population.

We have long believed that working closely with partner provider and commissioner organisations across health, social care, borough council and voluntary sector is imperative to deliver the best care to our population. This has been demonstrated by collaboration to improve service delivery, and develop new integrated services such as multidisciplinary teams of health and social care professionals configured around GP Practice populations to deliver care to frail and elderly patients – known as Integrated Care Organisations. Together called the ‘West Norfolk Alliance’, our aim has been to work together to organise and deliver sustainable integrated services of high quality and value which are focused around the individual, and not any one organisation. This is intended to reduce repeated assessments and put patients in control of their care, things the public has told us are important.
In Summer 2013 we, with partners from the West Norfolk Alliance, produced a ‘Case for Change’ which sets out the challenges now, and into the longer term future in delivering care that the local population needs and wants, and the opportunities to do things differently. This was presented as part of a paper to our public CCG Governing Body in September 2013. Our Case for Change mirrored many of the themes in NHS England’s national ‘Call to Action’ (NHS England, 2013), and those that will be seen both in this document, and the recently published NHS England ‘Five Year Forward View’ (NHS England, 2014). A particular aspect we highlighted in our ‘Case for Change’ requiring immediate intervention was the financial position of the Queen Elizabeth Hospital (QEHKL) which, as a small district general hospital, faced a worsening financial challenge as seen elsewhere in the country. However, this was one of a number of factors including demographic change, geography, efficiency requirements and workforce issues, which together, required change in how we deliver services across the local healthcare system. As well as ‘challenge’ we also identified opportunities to better integrate care delivery, reduce waste, tailor care to individuals and utilise technology, workforces and estates differently to provide better care.
In producing the Case for Change we were seeking to build consensus amongst the local health and care community that there was a need for change, recognising that together we could effect greater change. As a CCG we wished to work with national agencies (Monitor – provider regulator and NHS England CCG overseer) to review our local challenges, and to draw on support in terms of resource, expertise and ‘permission to do differently’ to lead a system transformation programme. We recognised that continued incremental change would not be helpful, nor would it happen quickly enough to lessen in particular the financial pressures we faced. We also sought to lead transformational change that created a visionary model of care in West Norfolk that we and our population could be proud of.

In the months following the ‘Case for Change’ publication, as a CCG (and health system), we worked hard to continue our programme of change. We reported regularly to our Governing Body on progress of work to gain support for change and improve service delivery. In April 2014 we held a public launch of the West Norfolk Alliance, attended by Alliance partners, local stakeholders and Norman Lamb MP, Minister of State for Care and Support. Our ambitious local commitment to integration was nationally recognised via our appointment as one of 15 national integrated pioneers as part of NHS England’s national collaboration for integrated care and support. We also progressed work to design future, integrated pathways for patients through clinical dialogue with over 20 clinicians across healthcare providers, led by our highly experienced Secondary Care Doctor, Professor Paul Jenkins.

The Contingency Planning Team process

As a result of regulatory intervention protocol, Monitor appointed a Contingency Planning Team (CPT) for commencement of work in September 2014. The appointment of a CPT intervention was initiated by Monitor due to the financial and sustainability challenge faced by QEHKL, however it will need to analyse and take account of the wider health system challenges, and the intentions of commissioners.

The CPT team appointed by Monitor comprises colleagues from McKinsey and PA consultancy, and independent contractors with specialist expertise in similar projects.

Learning from experience of CPT interventions elsewhere in England, Monitor intend that the focus of this CPT intervention was to be different; considering both the particular challenges facing the QEHKL, but ensuring that analysis and recommendations would also cover the wider local health economy to ensure long term sustainability for both commissioner and providers of care.

The CPT process has been designed to analyse the issues in delivering care locally, to support the production of this Evidence for Change publication, and to develop possible options for future delivery of care that draw on local clinical knowledge and best practice evidence. It will answer questions such as ‘why is there a financial sustainability problem locally?’, ‘what has caused it?’, and ‘how could things be provided in a different way in the future?’ The culmination of this work is planned for the production of a final report by the CPT team in Spring 2015. Any material changes proposed to the way in which we deliver services in the CPT’s report will be consulted on by the CCG through a formal consultation process which will be instigated separately; recommendations approved through a consultation process will be implemented thereafter.

The CPT intervention provides the potential opportunity to develop the work locally that we began as the West Norfolk Alliance 18 months ago. It also ‘fits well’ with the national call from Simon Stevens to ‘give permission’ for local systems to do innovative and different things to transform healthcare. Our hope is that the CPT programme delivers a proposed solution, or set of solutions, that has broad consensus amongst partners, and that will support high quality care in West Norfolk in the longer term.
Now in January 2015, this ‘Evidence for Change’ document will build on our previous work locally by adding further detailed analysis and exploration of solutions from the McKinsey CPT team, and through further feedback gathered from stakeholders and patients.

The aim of this document is therefore to describe, with supporting evidence, why there needs to be a review of the way in which services are delivered in West Norfolk. It is also to build a common understanding about the need to review our healthcare services, in particular to meet the challenges of the future. We believe the evidence contained in this document creates a compelling need for change, and whilst the challenges faced are considerable, that the opportunity for transformational improvement in healthcare delivery in West Norfolk is one we should grasp. We will also paint the themes emerging nationally and locally as possible answers to this challenge; which will be further explored through the work of the CPT.

At this stage in the CPT process it is important to note that this document is an indicator that there needs to be change in the healthcare system in West Norfolk; it is not a ‘pre-consultation’ business case, nor is it the start of a formal public consultation on service change. The information within this document has been developed through the first few months of preliminary analysis by the CPT team, building on the previously published CCG ‘Case for Change’, and will be further developed through the remainder of the CPT’s work.

It is imperative that this document truly describes the challenges and opportunities that we all recognise for West Norfolk. Of primary importance to us as a CCG is the value of ensuring that we commission services that reflect local need; that is why we need to hear from you. We will use your feedback to this publication, and that which we have gathered since our inception as a CCG, to inform the solutions for service delivery that will be considered. At the end of this document we describe both the next steps in the CPT process, and give you further information about how you can share your views with us.

Key Messages: Introduction

- WNCCG is a clinically led commissioning group responsible for commissioning healthcare services for West Norfolk
- The CCG has worked with partners to establish the West Norfolk Alliance, formed through shared commitment to delivering sustainable, integrated healthcare services in West Norfolk
- 18 months ago, supported by West Norfolk Alliance partners, the CCG published a Case for Change, charting the need to respond to challenges to the sustainability of healthcare services and the opportunity to ‘do differently’ and shared these challenges with the public through engagement events
- The scale of the financial challenge faced by QEHKL led to the appointment of a CPT, tasked with understanding the future challenge of delivery of healthcare services in West Norfolk
- Local work has provided a strong foundation for change
- We need your views

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The National Health Service (NHS) was established on the three founding principles; that it meets the needs of everyone, that it be free at the point of delivery and that delivery of healthcare services be based on clinical need, not an individual’s ability to pay. However, as noted by the Kings Fund:

‘The argument for a fundamental review of how care is currently provided is based on ‘our’ assessment that radical changes in service models are needed if these core strengths are to be sustained’ (Ham, 2012).

65 years from its inception, the NHS has made many improvements in how healthcare services are delivered to the population. Healthcare treatment and technologies have improved, life expectancy for treatable diseases has risen, waiting times for treatment have reduced and patient satisfaction has grown (NHS England, 2014). The public largely still receives care free at the point of use, the equity of services between different providers of healthcare in different locations has improved and the quality of care received has been greatly enhanced (NHS England, 2014).

However, there are still improvements that need to be made as highlighted in the national document ‘The NHS belongs to the people: a call to action’

- The NHS has made significant improvements in reducing premature deaths from heart and circulatory diseases but the UK is still not performing as well as other European countries for other conditions.
- The UK rates highly on patient experience compared to other countries. A 2011 Commonwealth Fund study of eleven leading health services reported that 88% of patients in the UK described the quality of care they had received in the last year as excellent or very good, ranking the UK as the best performing country. However, the data also shows that the UK has improvements to make in the coordination of care and patient-centred care.
- People from disadvantaged groups, including the frail older population, some black and minority ethnic groups, younger people and vulnerable children, generally access poorer quality services and have a poorer experience of care (some also have lower life expectancies).

Also, in many aspects the NHS system itself remains largely unchanged; separate hospital, GP practice, community and mental health providers and largely unchanged infrastructure such as buildings (NHS England, 2014):

The current delivery model in all providers (hospitals, primary care, community services social care and mental health) is based on outdated ways of working that result in poor value for money and lack of user responsiveness. The separation between General Practitioners and hospital-based specialists, and between health and social care often inhibit the provision of timely and high-quality integrated care to people who need to access a range of services relevant to their needs (Ham, 2012).

We will see that the NHS nationally must now adapt and evolve to meet the new needs of our population, the challenges of our economic environment, and the innovations in the delivery of healthcare services to our population. National leaders in the delivery of healthcare state that this evolution will require transformational change in healthcare services, and fundamental redesign of existing systems, practice and behaviours (NHS England, 2014).
The National Challenge

The diagram below summarises the key challenges that are felt in healthcare delivery in England today, and looking to the future. We will show, as these issues are explored, how the impact of each challenge is not felt in isolation, and is contributing to a sustainability challenge at a national level.

National healthcare challenges

- Projected financial challenge of over £30 billion in 5 years time
- Rising costs of delivering healthcare
- Fragments of primary and community care
- Insufficient integration and coordination of services
- Population, quality and clinical standards leading to different requirements of hospital care
- Small hospital challenge
- Ageing population
- Rising long term conditions
- Growing lifestyle risk factors
- Rising patient expectation
- Rising quality standards, linked to staffing requirements, delivery of care, culture and leadership
- Challenge in recruiting to particular staffing groups
- Changing requirement of type and skill of staffing

National demographic changes leading to growing healthcare need

The population in England is changing in a way that will impact the type and amount of healthcare that we need.

The population is getting older

Some facts...

- People living longer means that we have an increasing number of older people. People aged over 60 now make up nearly a quarter of Britain’s population. (Future Hospitals Commission, 2013).
- Longer life expectancy is largely good news but is also leading to more people with long term conditions; nearly half of the population over 60 have a chronic illness such as dementia or heart disease. (Future Hospitals Commission, 2013).
- For many older people advancing age is associated with frailty, a term that describes how frail and elderly people live with ‘limited functional reserve’, where functions such as staying upright, maintaining balance and walking are more likely to fail, resulting in falls, immobility or delirium. (Cornwell, 2012).
What does this mean for healthcare?

- Studies suggest that older patients account for the majority of health expenditure. One analysis found that health and care expenditure on people over 75 was 13-times greater than on the rest of the adult population. (NHS England, 2013).

- Nearly two thirds of patients admitted to hospital are over 65 years old, and around 25% of hospital inpatients have a diagnosis of dementia (Future Hospitals Commission, 2013).

- People over 85 spend around eight days longer in hospital than those under 65 years old – 11 days compared to three. People over 85 years old now account for 22% of all days spent in our hospitals’ beds. (Future Hospitals Commission, 2013).

- But we know that hospitals ‘can be harmful to some people’. Frail and elderly people may be made worse by hospital admission, which takes them from a familiar home environment to a confusing and noisy place where they may become confused and disorientated, more dependent on a higher level of care, and also at risk of harm from infection and falls. Very often their medical need is small and they just need a bit more care in a community setting to help them through. (Keogh, 2013).

- Care for older people in their own home, whether that be a residential home or a nursing or care home, is the most appropriate place of care in all but the most acute cases. This has meant that the workload of many community services is, in the main, on older people.

- The majority of people nursed at home and who get help with activities of daily living such as washing, dressing and eating are 75 or older. Older patients account for more than half the caseload of district nurses. (Cornwell, 2012).

- Another half a million (around 453,000) people receive home care from social services; 84 per cent of them are over 75. Around 2.5 million people over 75 also have some kind of informal care at home from close family members, neighbours and friends. A quarter of carers are themselves 65 or older (The Information Centre, 2010 cited in Cornwell, 2012).

The incidence of LTC and co-morbidities is increasing

Some facts...

- Long-term conditions (LTC) or chronic diseases cannot currently be cured, but can be controlled or managed by medication, treatment and/or lifestyle changes. Examples of long-term conditions include high blood pressure, depression, dementia and arthritis.


What does this mean for healthcare?

- People with long term conditions make up a quarter of the population yet they use a disproportionate amount of NHS resources: 50% of all GP appointments, 70% of all hospital bed days and 70% of the total health and care spend in England. People living at higher levels of deprivation are more likely to live with a debilitating condition, more likely to live with more than one condition, and for more of their lives. (NHS England, 2013).

- People with one or more long-term conditions are already the most important source of demand for NHS services: the 30% who have one or more of these conditions account for £7 out of every £10 spent on health and care in England. Those with more than one long-term condition have the greatest needs and absorb more healthcare resources; for example, patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year. These multi-morbid, high-cost patients are projected to grow from 1.9 million in 2008 to 2.9 million in 2018. (NHS England, 2013).
Lifestyle risk factors are increasing

Some facts...

- The risk of developing debilitating diseases is greatly increased by personal circumstances and unhealthy behaviours such as drinking, smoking, poor diet and lack of exercise, all of which contribute to premature mortality. If predictions are correct, and 46% of men and 40% of women are obese by 2035, the result is likely to be 550,000 additional cases of diabetes, and 400,000 additional cases of stroke and heart disease. (NHS England, 2013).

- Obesity - the Foresight Report – indicated that by 2050, 60% of adult men, 50% of adult women and about 25% of all children under 16 could be obese. Obesity increases the risk of a range of chronic diseases, particularly type 2 diabetes, stroke and coronary heart disease and also cancer and arthritis. (Foresight, 2007).

- Alcohol – in 2012 there were 6,490 alcohol-related deaths – this is a 19% increase from 2001 (5,476) (HSCIC, 2014).

- Smoking – cigarette smoking in England is responsible for nearly one in six deaths of adults aged 35 and over. Years of mild to severely debilitating ill-health, the trauma of associated medical procedures and dependence on powerful medication is the experience of many smokers. (ASH, 2008).

What does this mean for healthcare?

- The NHS costs attributable to overweight and obesity are projected to double to £10 billion per year by 2050. (Foresight Report, 2007).

- Alcohol – in 2012/13 there were an estimated 1,008,850 admissions related to alcohol consumption where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis (HSCIC, 2014).

- Smoking – smoking cost the NHS £2.7 billion in 2006/07; more than £50 million each week is spent treating diseases caused by smoking. Each week smoking accounts for an estimated £20 million expenditure on hospital admissions, £4 million on outpatients, £10 million on GP consultations, £1 million on practice nurse consultations and £17 million in prescription costs. (ASH, 2008).
Rising patient and public expectations

Some facts…

The publication ‘Transforming the delivery of health and social care’ (Ham, 2012) points to the following factors linked to rising patient and public expectations:

- Baby boomers born in 1940s reaching retirement, with greater wealth, greater pensions and future intensive users of service with growing expectation.
- Rising expectations of younger generations, which are more akin for NHS to standards service in industries such as banking and retail where there is far greater use of technology and social media to support engagement and response to customers (with which the NHS has been slow to keep up).
- Developments within the NHS which has encouraged patient choice; e.g. Choose and Book initiative choice of hospital and treatment, Choose and Book booking technology, websites such as ‘Patient Opinion’ (www.patientopinion.org.uk) and ‘iWantGreatCare’ (www.iwantgreatcare.org) providing information to support choice decision making.
- Department of Health information strategy for the NHS to support greater online access by patients to their records, promoting electronic exchange between healthcare providers.
- Most forms of healthcare within traditional working hours – not in line with when people would wish to access services – stronger drive for convenience for patients.
- Patients now expect to be offered choice and variety, and to experience services that are convenient, personalised and provided in modern buildings and healing environments.

What does this mean for healthcare?

- Patients and the public expect more from the NHS than ever before. This includes the standards of clinical care offered, the choice of where, when and how to receive treatment, the availability and accessibility of treatment, and their experience of receiving care.

Key Messages: National demographic changes leading to growing healthcare need

- We are getting older and living longer
- The number of us that has one or more long term conditions is growing
- The incidence of lifestyle risk factors is growing
- Patient expectation is growing
- All of the above means that providing healthcare is costing us more. It also means that we need to change the way in which we provide healthcare services to better meet patient needs and wants
Driving improvement in patient safety, clinical standards and quality of care within acute hospitals

Variation in quality outcomes...we can do more to improve patient outcomes

Considering performance and quality of NHS services, it is clear that there is opportunity to reduce unnecessary variation in the quality and outcomes of healthcare (Ham, 2013).

Some Additional facts...

- Variations in health outcomes between social groups persist and in some cases are widening (Marmot 2010).
- The United Kingdom has the second highest rate of mortality amenable to health care among 16 high-income nations, despite recent falls in death rates (Nolte and McKee, 2011).
- 10,000 lives would be saved each year if England achieved cancer survival rates at the level of the European best (Department of Health, 2011).
- 24,000 people with diabetes die each year from avoidable causes related to their condition, and £170 million could be saved each year through better understanding and management (National Audit Office, 2012).
- As many as 1,500 children a year might not die if the United Kingdom performed as well as Sweden in relation to illnesses that rely on first-access care, such as asthma and pneumonia (Wolfe et al, 2011).
- The average length of stay in acute care in the UK in 2010 was 7.7 days, significantly higher than in Australia (5.1), the Netherlands (5.8) and the USA (4.9) (Future Hospital Commission, 2013).

Some of the variations seen in care delivery are linked to the gaps in provision across a 24/7 period; we know that many services are not provided to the same level 7 days a week, particularly overnight and over the weekend period. We also know that the standard of care delivery across hospital settings can vary; for example care delivered at specialist centres for more complex care, where there tends to be a higher volume of care delivered by larger numbers of experts in their field can often be seen to deliver improved quality outcomes.

So there is more that the NHS could do to address these variations in care, improve health outcomes and the way in which we spend money on health services. Some of the variations can be addressed by the way in which providers of healthcare perform, considered later in this section. Some can be improved by spending money in a different way. In ‘Call to Action: Case for prevention’ NHS England states that we could do more to prevent chronic disability and its impact on people’s wellbeing, and to prevent premature deaths by focusing more on prevention of disease and promotion of wellbeing (NHS England, 2013).

Key Messages: Variations in quality outcomes

- There remains significant variation in the quality of care, and outcomes of this care received in England
- Comparing the UK with other international countries we perform poorly on several of the most important health problems
Learning from quality reviews – we can learn from in depth reviews into delivering quality care

We have seen over previous decades significant improvement in the quality of care provided, however in the past couple of years, there have been some in-depth reviews which have pointed both in some instances to significant failures in care, and to the need for further improvement in quality. Each review has, through its considerations and findings, recommended improvements and changes in the way that care is provided, and together have been consistent in their themes for change.

The Francis report considered the situation at Mid Staffordshire Hospitals Trust, where systemic failings in quality of care and patient safety were found, driven by a multitude of factors including lack of openness and transparency, failure to listen to staff, patients and public concerns and failure to ensure quality of care, was the primary focus of the organisation. The ramifications of the Francis report were seismic, and whilst centred on one organisation it was felt that these themes could pervade in many NHS Trusts. Department of Health publication ‘Patients first and foremost’ cited the report as ‘a watershed moment for the NHS and a call to action for every clinician, everyone working in health and care, and every organisation’. It was also suggested that this ‘call to action’ is arguably more significant given that the NHS has ‘become busier and the needs of patients more complex (Department of Health, 2013).

Following on from the Francis report, the Keogh review considered patient safety and quality of care at 14 failing NHS Trusts. This found both cause for concern and need for improvement, and described the following themes that needed to be addressed:

**Patient experience**
understanding how the views of patients and related patient experience data is used and acted upon (such as how effectively complaints are dealt with and the ‘visibility’ of feedback themes reviewed at board level);

**Safety**
understanding issues around the Trust’s safety record and ability to manage these (such as compliance with safety procedures or trust policies that enhance trust, training to improve safety performance, the effectiveness of reporting issues of safety compliance or use of equipment that enhances safety);

**Workforce**
understanding issues around the Trust’s workforce and its strategy to deal with issues within the workforce (for instance staffing ratios, sickness rates, use of agency staff, appraisal rates and current vacancies) as well as listening to the views of staff;

**Clinical and operational effectiveness**
understanding issues around the Trust’s clinical and operational performance (such as the management of capacity and the quality – or presence - of trust wide policies, how the Trust addresses clinical and operational performance) and in particular how Trusts use mortality data to analyse and improve quality of care;

**Governance and leadership**
understanding the Trust’s leadership and governance of quality (such as how the board is assured of the performance of the Trust to ensure that it is safe and how it uses information to drive quality improvements).
Berwick review of patient safety (National Advisory Group, 2013) led to the following recommendations:

- NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.
- All leaders concerned with healthcare should place quality of care and patient safety at the top of their priorities for investment, inquiry, improvement, reporting and support.
- Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to boards.
- All organisations should seek out patient and carer voice as an essential asset in monitoring safety and quality of care.
- Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.

The above reviews into quality of care in the NHS have had a significant impact on both providers and commissioners of healthcare. There can be seen to be consistency in the theme areas for further action, including workforce and staffing levels, leadership, culture and transparency in the way in which care is commissioned and provided.

**Key Messages: Learning from in depth quality reviews**

A number of high profile cases of failures in quality of care recently have resulted in in-depth reviews to ensure lessons are learnt. NHS providers and commissioners have been expected, and have responded, to these lessons through improvements in care delivery, quality monitoring and oversight. These necessary changes have required change to systems and processes, to the way in which care is delivered; some of which has required significant investment.

**The link between workforce and quality**

The substantial failings in quality of care, and subsequent reviews aforementioned, have highlighted the importance of the link between sufficient staffing and quality of care provided. In their report considering the provision of hospital care from small providers, Monitor highlight that additional cost pressures have been incurred by NHS Trusts due to both quality reviews such as Francis, Keogh and Berwick, to the need to ensure staffing levels allow for compliance with European employment law, and to provide sufficient staffing over a 24/7 period (Monitor, 2014). In a recent report on expenditure on staffing, Monitor have found an additional 24,000 members of staff were hired in the last year by NHS Trusts; three times the planned number which is likely to have been at least in part driven by the above factors (Monitor, 2014). Most of these staff were frontline staff involved in the delivery of clinical care; helping to ensure NHS Trusts meet minimum staffing levels to maintain quality of service.

There is growing clinical evidence to link the standards of clinical care provided with the seniority of staff providing care across a 24/7 period. The Royal College of Physicians, in their ‘Future Hospitals’ report demonstrated an increase in mortality of approximately 10% at weekends, driven by a number of factors including a clear link between senior doctor presence and clinical outcomes. (Future Hospitals Commission, 2013).
The Academy of Medical Royal Colleges summarised evidence to highlight patients have increased morbidity and mortality when there is a delay in the involvement in consultant care across a number of hospital specialties, including emergency and acute medicine and surgery, trauma, anaesthetics and obstetrics (Future Hospitals Commission, 2013). Dr Foster found a correlation between senior staff at weekends and mortality, concluding that: ‘More senior staff per bed at weekends is associated with a lower weekend emergency mortality rate (HSMR)’ and ‘More senior doctors as a percentage of all doctors are associated with a lower weekend emergency mortality rate.’ (Future Hospitals Commission, 2013).

This has led a number of the Royal Colleges for medical and surgical doctors to make recommendations for the standards of presence of consultant care across a 24/7 period. For some areas of medicine and surgery very specific standards have been recommended about the minimum number of staffing considered sufficient to safely staff rotas of care, for example in Paediatric and Maternity care. Whilst these recommendations are guidance and should be carefully considered in the configuration and staffing of services, there may be instances where, for reasoned justifications they are not always adhered to.

Key Messages: Link between workforce and quality

- National reviews have highlighted the link between workforce numbers, skill mix, level of support/CPD and quality of care provided.
- There are both national requirements, and best practice guidelines that provide indications of the minimum and optimum levels of workforce required for safe, high quality care.
- Fulfilling staffing requirements has required many providers to invest significant sums. Whilst appropriate action, this has caused considerable financial pressure.

Changing pressures on acute hospital services...we need to change the way we provide services

General challenges for hospital delivery

Hospitals as providers of care in England have been long established. Hospitals can vary significantly in size and scale; from a large teaching hospital or regional specialist centre to a small district general hospital. Hospital care covers a wide spectrum of services, from emergency cases requiring rapid medical or surgical intervention, to planned care for both routine and very complex care. Necessarily there is variation in the scope of services offered, often linked to scale. Hospitals are required to meet the needs of their local population; in more remote, rural areas this tends to be even more challenging as the availability of alternative hospitals, and therefore ability to share work and specialism is less. Hospitals also have responsibilities as other NHS Trusts to participate in training, education and research, and to work with neighbouring Trusts to ensure that health care provided to their local population is safe and sufficient, and staff are attracted to work there 24 hours a day, 7 days a week.

In some ways hospitals have undergone significant change over past years. Hospitals have made significant improvements in their efficiency. ‘Over the last 15 years patients admitted to hospital as an emergency have increased by almost 50 per cent, yet the NHS has managed to not only improve survival rates year on year, but also achieved a reduction in annual bed-days from 37 million to 32 million by almost halving the length of stay’(Keogh Urgent Care Review, 2014).
A number of hospitals have undergone rebuilding initiatives to improve space and environment. So too have there been significant improvements in clinical practice and use of technology to provide more innovative care.

However, in some ways hospitals have not changed fundamentally; care is still provided in specialties configured around disease conditions rather than recognising many patients have multiple conditions, and many hospital environments are outdated buildings constructed decades ago.

Understanding the growing challenges in healthcare hospitals now, and in the future, will need to change. In line with the reduction in bed days, the number of beds in hospitals have reduced by a third (Future Hospitals Commission, 2013) however these reduced bed numbers need to cater for the growing needs of an ageing population and rising number of emergency admissions – 37% increase in the last decade (RCPh, 2012). With this growing volume of demand we can witness increasing difficulty in hospitals being able to achieve key performance standards designed to ensure quality of care. This includes notably the standard to ensure that 95% of patients arriving at Accident and Emergency are treated within 4 hours, and that 95% of patients requiring planned surgery are treated within 18 weeks.

The demographics of hospital inpatients has changed substantially in the 65 years since the NHS was created. Nearly two-thirds of patients admitted to hospital are over 65 years old, around 25% of hospital inpatients have a diagnosis of dementia, and people over 85 years old now account for 22% of all days spent in our hospitals’ beds. (Future Hospitals Commission, 2013) With this ageing population comes greater comorbidities, and far greater complexity of illness than previously experienced in hospitals. This makes it increasingly important that patients are treated in a holistic way that takes account of all of their needs. However, many hospital structures are centred around patient pathways of care that are often focussed on managing single diseases or conditions, with little coordination across the hospital or wider health and social care system focussed on the individuals’ entire needs.

We know that a large proportion of hospital admissions are for Ambulatory Care Sensitive (ACS) conditions that are potentially avoidable. These ACS admissions make up one in every five emergency admissions (Nuffield Trust, 2013), of which three of these conditions disproportionately affect older people (urinary tract infection, pneumonia and chronic obstructive pulmonary disease (COPD). Many of these types of conditions can be appropriately treated in the community, closer to home. Indeed, safe urgent care services in many cases does not mean hospital care (NHS England, 20142). In the future, an increased focus on prevention, and high quality primary and community care should mean that fewer people will need to be admitted to hospital.
We saw earlier the link between staffing requirements and quality of care. The link was made between higher quality outcomes and earlier intervention in hospital from more senior medical staff. The link was also made between senior consultant care across a 24/7 period – recognizing that people get ill throughout the week. The practice of healthcare is also becoming more and more specialized. For example, if you have a heart attack or another heart problem, we know that you get the best results if you are cared for by a specialist heart doctor (or cardiologist). The same applies for different types of surgery – surgeons now specialise in one part of the body – urologists, vascular surgeons, breast surgeons, GI surgeons. This means that hospitals will need to consider what number and type of specialist doctors it needs to care appropriately for its local population, whether there is a sufficient number of patients locally to sustain the volumes of care needed to maintain these specialist skills, and what links or clinical networks are needed with larger, specialist centres.

There is a recognised need to improve the fragmentation of care experienced by patients in our hospitals. As highlighted earlier in quality reviews such as the Francis and Keogh reports, care centred on individual patient needs requires improvement. Over a quarter (28%) of consultant physicians rate their hospital’s ability to deliver continuity of care for patients as poor or very poor (Future Hospitals Commission, 2013). In their ‘Hospitals on the Edge’ report, the Royal College of Physicians state that there is a systematic failure to deliver coordinated, patient-centred care’ in hospitals ‘with patients forced to move between beds, teams and care settings with little communication or information sharing.’ (RCPh, 2012) ‘Continuity of care cannot be achieved without fundamental change in the way that the NHS as a whole thinks about the role and priorities of the Acute General Hospital and how it is run’ (Future Hospitals Commission, 2013).

Key Messages: Future hospitals challenge

Whilst hospital care has improved over the years since the inception of the NHS, in a number of areas this change has not kept pace with the changing requirements of the UK population, and developments in thinking about standards of care. An ageing population, with greater complexity of conditions suffered has placed greater demand on hospital services. Our thinking about how we best treat patients, maintain clinical standards and deliver care 24/7 has developed

To keep pace with these changes hospitals will need to undergo transformational change, which will affect the type and number of patients treated and how they are treated. It will also affect the type and number of staff working in those hospitals, and how they link with neighbouring NHS Trusts
Particular challenges for small district general hospitals

So, understanding some of the broader challenges facing hospital provision, we can see that for smaller hospitals there are particular issues which are felt more acutely. In their report considering the future of smaller hospitals, Monitor identified several factors which could contribute to their sustainability, some of which are set out below (Monitor, 2014).

**Economies of scale and scope**

Smaller hospitals tend to treat fewer patients. Because hospitals receive a payment for each patient seen and treatment given, this means that they receive less income than larger hospitals. To provide hospital care there are certain fixed costs that will need to be paid for irrespective of size. This means for smaller hospitals there is an inherent pressure on budgets, as larger hospitals benefit from economies of scale and greater income received. As considered earlier, for smaller hospitals there may be some specialties where lower volumes of patients mean that there is not sufficient activity to comply with recommended clinical standards, in terms of numbers of patients or interventions required to maintain clinical competencies of hospital staff. This challenge of balancing those services that can and should be delivered locally, and those that should be delivered at regional centres, needs to be driven by evidence base and local engagement (P Jenkins, 2014). Also, the number of patients seen may attract less income than the cost of ensuring there are sufficiently senior staff present on a 24/7 basis to provide care safely. This may lead to some smaller hospitals looking at providing services via clinical networks with larger specialist hospital centres.

**Ability to attract workforce**

We saw earlier that hospitals not only provide clinical services, but often also participate in education, training and research activities, with larger centres being designated as teaching hospitals. This is an important part of attracting new staff, providing the opportunity for career development. Larger centres also have the advantage of seeing a wider array of patients, and delivering more specialist care, which again is often attractive for prospective staff. For smaller hospitals treating fewer patients, who often don’t specialise in complex care, it can often be harder to attract and retain clinical staff, thus leading to increasing costs incurred through hiring of agency staff, or the negative impact of carrying unfilled staff vacancies.

Monitor also highlight that for smaller hospitals in remote and rural areas the question of access to services for the local population versus what services can be safely and effectively offered is even more pertinent. Commissioners in these areas will need to consider what services should be offered at these smaller hospitals, and how this is balanced with patient preference and ability to travel further afield to larger, specialist centres which may be able to provide more specialist, and in some instances, higher quality care. For those smaller hospitals that are a significant distance from alternative hospital providers, a wider range of services may need to be offered (Monitor, 2014).

**Key Messages: Small district general hospital challenge**

- Particular issues faced by small district general hospitals include those relating to scale of provision and economies of scale, and ability to attract and retain a sufficient workforce. Both of these issues can mean that smaller hospitals incur greater costs than larger hospitals.
- In rural and remote hospitals the balance between access to services, travel to alternative providers and quality of care will need to be considered when agreeing the nature and location of care provided to the local population.
Requirement for change in out of hospital and primary care provision

Traditionally out of hospital care consists of a range of different NHS providers of care, from GP practices – or Primary Care, to Community Trusts who provide community nurses and therapists, Mental Health Care providers and Ambulance Trusts. These NHS services often work closely with wider social care and community providers such as the voluntary sector, and independent contractors such as Care Homes. Because of this range of providers of care, sometimes out of hospital care can feel fragmented for patients; patients can experience care treatment given by a multitude of organisations, where sometimes care is not as integrated as we would like.

In terms of demand for out of hospital care, similar increases in demand for care have been seen out of hospital, as in hospital – predominantly driven by changes in population need through an ageing population and growing incidence of patients with multiple long term conditions, but also through advances in hospital care which mean that more patients can be treated out of hospital, or with shorter stays in hospital. The average number of consultations in general practice per patient rose from 4.1 to 5.5 per year between 1999 and 2008 indicating greater demand and complexity in primary care (Urgent Care Review Keogh, 2013). Similarly, the number of calls received by the ambulance service over the last decade has risen from 4.9 million to over 9 million (NHS England, 2014).

We have also seen, as highlighted earlier, that clinically far more care could be provided out of hospital for the benefits of patients; 40% of patients attending A&E are discharged requiring no treatment at all; similarly there were over 1 million avoidable emergency hospital admissions last year (UCR, Keogh 2013). Whilst changing population has increased demand for care, it is believed that more coordinated, proactive and preventive care for individuals earlier on in their ill health, would reduce the numbers of patients who become more acutely ill and require admission to hospital (Robertson et. al, 2014).

To facilitate a large scale shift in care from hospital, to ‘out of hospital’ or the community, there will need to be a change in the way healthcare services are commissioned and provided. To enable this it will become even more important for patients to receive timely care out of hospital; for example GP appointments, or urgent care services as an alternative to A&E attendance. The way NHS professionals work will also need to develop to ensure skills and expertise are shared between hospitals and the community.

**Key Messages: Out of hospital challenge**

- The pressure created by growing demand for services from an ageing population with rising incidence of illness has been felt in out of hospital care as ‘in hospital’

- Out of hospital care requires reform; the current model of care is often fragmented, and there is not always the right capacity and expertise to provide the right care that is needed
NHS staffing and workforce needs

The NHS is one of the largest employers in the UK, with a huge breadth of professional roles and career choices available to prospective staff. However, despite this there are a number of shortages in particular staff groups including nursing and particular fields of medicine and surgery for doctors. This means that often NHS Trusts will need to develop programmes of international recruitment for key hospital staff, and at times incur additional staffing costs to fill vacancies with temporary bank or agency staffing which costs more than employing a permanent member of staff. The Royal College of Physicians points to a ‘looming crisis’ in the medical workforce, with existing staff under greater pressure due to rising population need, coupled with difficulties recruiting to substantive, and training posts (RCPh, 2012).

Changes in population need, which will require a change in the way hospital and community care are provided will also require a change in training of staff, and in the way they practice. To support a move away from hospital based services to integrated care in the community, there will need to be a transformation in the way in which professional practice (Robertson et. al, 2014).

Key Messages: Staffing and workforce

- There are national staffing vacancies in key staffing groups; meaning vacancies, additional cost to attract agency staff or substantive staff from overseas
- Changes in population need will require change in the way staff train and practice
National financial efficiency requirements and cost pressures

The financial picture looks challenging; NHS England’s ‘Call to Action’ charts that there will be a funding gap of circa £30 billion by 2020/21, driven by both flat government funding in healthcare and projected demographic changes.

**CCG Funding**

The role of a CCG is to commission healthcare services for its local population. In order to fulfil this function, CCGs are given funding each year by NHS England, who determines nationally how much of the available money is allocated to each CCG. The CCG then decides how to use this funding across all its areas of commissioning, including acute hospital services, community services, mental health care, and GP prescribing. Some of this is paid to providers as a lump sum monthly payment (‘block’) but for most acute hospital services it is paid according to a national price or ‘tariff’ on a payment-for-procedure basis.

NHS England allocations to CCGs tend to rise each year, but not as much as the demands on local budgets as a result of things like an increasing population, new technologies, and new clinical standards. Therefore CCGs need to make efficiency savings each year, generally in the range of 2%-3% of allocation. This results in the development of local QIPP (Quality, Innovation, Productivity, Prevention) programmes, which look at making savings across the breadth of CCG commissioning activity.

**Provider Funding**

All providers of healthcare (eg acute hospitals, community and mental health trusts) receive funding for the work that they are asked to do by commissioners. This is usually specified within a contract for services that will dictate the volume of work to be done and the quality standards. The prices for contracts though are generally set nationally by Monitor, who determine each year the national tariffs that apply for all “Payment by Results” activity. This covers in-patient, out-patient and A&E work at acute hospitals and means that hospital trusts charge commissioners for the patients they have treated. In setting their national tariffs, Monitor recognises inflationary pressures on hospitals but also expects providers to deliver a level of efficiency savings, which in recent years has been 4% per year. This efficiency requirement is applied to all providers with NHS contracts for services.

Therefore both CCGs and healthcare providers need to make efficiencies each year in order to break even. This results in an increasing need for whole health systems to work together to understand how services can be redesigned, so that together we can achieve a greater level of efficiency.

Year on year, in accordance with available money for healthcare services in England, NHS organisations are required to make a minimum efficiency level. For 2015-16 NHS providers will need to make just under 4% efficiency savings, however this year on year saving is becoming harder and harder to achieve through incremental change and improvement. Traditionally these savings have been realised through reducing waste, becoming more time efficient, and spending more wisely, however there is only so much efficiency that can be released through these means within existing constraints. Providers, and whole healthcare systems are being required to become more and more innovative in considering how to increase efficiency, transforming the way in which services are delivered by drawing on national and international best practice.

In addition to the requirement for increased efficiency, the cost of providing care is becoming more expensive; further compounding the financial challenge. As the extent, and sophistication of drug treatments, diagnostic procedures and surgical interventions increases, so too generally does the cost of providing this care. The NHS can now treat conditions that previously went undiagnosed or untreated – improving the quality and length of people’s lives.
However these developments come at a cost which is not offset by the improved health that these developments have bought. This is not a bad thing, nor one that we would not want to continue, however it does come with a financial cost which needs to be met.

Key Messages: Financial efficiency requirements and cost pressures

- There will be a £30 billion funding gap in the future
- All NHS providers and commissioners of care are required to make year on year efficiencies which are becoming harder to make without having an impact on care
- The costs of providing care is growing

All of the above factors have led to a national ‘call to action’

The above national trends pose the ‘greatest challenge’ in the NHS’ history and without significant, transformational change in how services are delivered, high quality, free at the point of use NHS services will not be available to future generations (NHS England, 2013). Rising demand for healthcare services, and rightly rising expectations as to how health services should be provided, will create what has been termed the ‘3 gaps’ in healthcare delivery (NHS England, 2014):

‘Health and wellbeing gap’ – widening health inequalities, spend on avoidable illness at the expense of new treatments

‘Care and quality gap’ – patients’ changing needs will go unmet, people will be harmed who should have been cured, unacceptable variations in outcomes will persist

‘Funding and efficiency gap’ – if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments

At a national level, both in terms of political expectation, NHS England directive, the views of professional Royal Colleges and ‘think tank’ and policy advisers, there is an unequivocal expectation that material change is required in the way the NHS delivers services.

Key Messages: National ‘Call to Action’

Given the above challenges there is a national ‘Call to Action’; the consequences of taking no action will mean a significant detrimental set of events for the health and wellbeing of the population, for the quality of healthcare and financially
The Chief Executive of the NHS in England, Simon Stevens, has published an ambitious programme for future change in the NHS, called the ‘Five Year Forward View’. This document proposes a series of changes required of the NHS as commissioners of care in response to the challenges faced.

These changes require local, clinical consideration and implementation of recommendations that are fit for each local area. The themes of these proposed changes are as follows:

- Greater focus on prevention of ill-health.
- Enhanced community support and role of communities in enhancing public health.
- Supporting individuals to take control of their own health, and make their own choices about how they access healthcare and support.
- Developed models of out of hospital care – across primary, community and mental health – which may include organisational integration and shared staff working across traditional organisational boundaries.
- Services tailored to provide proactive, responsive care for an ageing population, for those with long term conditions and for those with growing lifestyle risk factors.
- Adoption of best practice innovation in how services are delivered – for example technology adoption and information sharing, how efficiency is maximised and how cost can be reduced.
- Smaller hospitals considering sharing resource with larger neighbouring hospitals, and partnering to provide care.
- Redesigned maternity provision.
- Developed urgent care to better integrate GPs, out of hours, 111 and ambulance services.
- GP practices - Primary care - as the foundation for NHS delivery.

**Key Messages: National ‘look to the future’**

- Local, clinically led change to put patients at the heart of healthcare
- Integrated, out of hospital care, combining skills, workforce and infrastructure across primary, community and hospital care
- Greater focus on prevention
Locally the NHS has made concerted, incremental short to medium term improvement in responding to the above, however to fully meet the size of the challenge set out, more fundamental long term change is required. The following section describes the challenges we face locally, mirroring the national picture but some areas are felt more acutely in West Norfolk. All of the data in the following section has been presented by the early work of the CPT team, unless otherwise cited.

The diagram below summarises the challenges faced in West Norfolk, which will be explored in more detail later.

**West Norfolk healthcare challenges**

- **Projected financial challenge** of up to £70 million in 5 years time if no action is taken
- **Consolidated out of hospital provision**, with opportunity to further improve through integration and greater access
- **Small hospital**, faces difficulty in areas of quality and performance, scale of provision and recruitment which has led to £ challenge
- **Finances**
- **Population changes**
- **Geography and scale**
- **Quality standards**
- **Staffing**
- **Challenge in recruiting to particular staffing groups, increased by geography**
- **Changing requirement of staffing**
- **Population ageing more than England average, higher incidence of long term conditions and some lifestyle risk factors than England average**
- **Challenge of location of West Norfolk and rurality**
  - Distance from nearest larger hospitals >40 miles
- **Rising quality expectations on delivery of care, in and out of hospital**
- **Challenge of changing clinical standards to support service delivery**

**Our local challenges: Healthcare needs are changing, meaning we need to review how and what services we deliver to best meet those needs**

The population of West Norfolk is changing as seen nationally, but to a greater degree.

**Ageing population more than England average**

The district of King’s Lynn and West Norfolk comprises circa 165,000 people, of whom 25% are over the age of 65 (compared to 17% over 65 years for England overall). The population is growing at around 0.6% a year overall, with the population aged 85 and over growing by 3.4% while 15-25 year olds are declining by 1.6% per annum.
The locality of Wisbech in Cambridgeshire comprises circa 31,000 people of whom circa 6,500 (20%) are over 65. The locality of South Lincolnshire has higher life expectancy and ageing population compared to the England average.

We saw earlier in the national picture that an ageing population leads to higher dependency on out of hospital and in hospital care services, and greater demand on healthcare services due to frailty and multiple conditions. The impact of projected ageing on healthcare usage in West Norfolk, and therefore cost of providing healthcare, is 1.4% growth each year, which is just under £3 million increase in cost for a budget on healthcare spending of £213 million. This cost pressure will be compounded year on year, meaning a challenge of £15 million in 5 years.

**Greater prevalence of people with long term conditions than England average**

The prevalence in West Norfolk of various long term conditions such as asthma, COPD, atrial fibrillation, coronary heart disease, hypertension, stroke, diabetes, heart failure, dementia and learning disability are higher than for the England overall, and are expected to increase over the next 5–10 years as the population ages. As a percentage of the total West Norfolk population Hypertension prevalence is 18% versus 14% prevalence for England average; Diabetes prevalence in West Norfolk is 8% versus 6% prevalence for England average and Coronary Vascular Disease prevalence is 5% versus 3% England average. We saw earlier in the national picture that the cost of caring for people with one or more long term conditions is significant; patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year. The available spend per head of population for West Norfolk is approximately £1,300 per year, covering all but primary care (such as GP) expenditure.
There is a higher percentage of people with obesity than in the rest of England – 10.5% of the West Norfolk population is obese compared to 9.4% England average. There is a higher incidence of alcohol related admissions than the rest of England. Lifestyle risk factors will be more significant in the particular pockets of deprivation in West Norfolk.

**Demographic challenges:**

- The population of West Norfolk is ageing more than the national rate
- There is a higher incidence in West Norfolk of people with long term conditions and lifestyle risk factors

**Our local challenges: Our local geography**

The figure below depicts the healthcare services provided to the West Norfolk population.

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1 BMI Hospital Sandringham, Anglia Community Eye Care (ACES), North Cambridgeshire Hospital, Thetford Community Healthy Living Centre, Norfolk Surgical and Diagnostic Centre, West Norfolk Health, Universal Pharmacy.

SOURCE: WNCCG list of key health services providers in West Norfolk and the surrounding areas
The QEHKL is the main provider of acute hospital care, providing care to the West Norfolk population, but also to particular communities of East Cambridgeshire and South Lincolnshire as shown overleaf. Bordering on 3 counties provides some challenges to the hospital as services are configured currently, as each county has services commissioned by different commissioning bodies (CCGs), and different pathways of care. As shown overleaf, a further challenge for the hospital is its proximity to neighbouring providers of care. The nearest neighbouring hospital is the Norfolk and Norwich University Hospital, some 42 miles away, followed by Addenbrooke’s 47 miles away. These two larger hospitals are specialist centres, who offer both the general range of hospital services the QEHKL does, and more complex care that the QEHKL doesn’t; such as complex surgery and medical care. This means that patients sometimes have to travel long distances to receive this more complex care.

The total West Norfolk population spend on acute care is circa £127m with the majority spent on QEHKL the primary provider, and the remainder being spent on the Norfolk and Norwich Hospital in Norwich, and Addenbrooke’s Hospital in Cambridge, plus other hospitals linked to either the need for more specialist hospital care or patient choice. QEHKL provides healthcare at the QEHKL site out the outskirts of Kings Lynn, and in outreach clinics in Fakenham, Wisbech and Littleport.

In addition to hospital care, care is provided to the local population through 23 GP practices (primary care), one provider of community healthcare, one of mental healthcare and one Ambulance Trust. Other independent providers make up the remainder of out of hospital care provision; such as Independent Care Homes, Out of Hours GP, 111 urgent care call advice and patient transport services.
The district of King’s Lynn ranks 300th out of 326 for population density (104 people per km²), making it one of the most sparsely populated districts in England. This presents some challenges about how to balance the need to offer patients care close to home, with the need to deliver services efficiently. It means that careful consideration needs to be given to where to site service delivery, and what impact this may have on patient travel times. It also increases the importance of utilising technology to support care closer to home – for example telehealth care to support remote monitoring of patients’ conditions, or to provide remote support to NHS practitioners from specialists.

With the exception of King’s Lynn, West Norfolk is a relatively sparsely populated region

Geography has an impact on local health services:

The configuration of acute hospital services available to the population of West Norfolk creates some local challenge. The QEHKL provides hospital care to a large rural population. The proximity of neighbouring, larger acute hospitals, that require more complex care means that patients sometimes have to travel further to receive care.

The dispersed nature of the West Norfolk population means that careful consideration needs to be given to how to balance delivering services closer to patients home, whilst delivering economies of scale. Considering the impact of these decisions on patient access and travel times is very important.
Our local challenges: Delivering acute hospital care to patients now, and in the future

We have seen in the above ‘national section’ that there are challenges to the way both hospital care is provided, and particularly care for smaller hospitals of which QEHKL is one in a rural and geographically remote area. We will see that there are significant concerns about the sustainability of services at QEHKL which have precipitated this review; however there is also much to be proud of; areas of high quality of care provided by QEHKL, and a highly committed and caring group of staff who provide these services.

Quality and performance

The review of services across King’s Lynn and West Norfolk follows a year of increasing concerns that the local hospital services would not be sustainable into the future in their current configuration. The ‘Contingency Planning Team’ appointed by Monitor was tasked with reviewing the long term financial and clinical sustainability of the Trust and to identify potential solutions drawing on the local health system as a whole.

The Care Quality Commission (CQC) assesses NHS Trusts for their performance against a number of quality domains of care; that services provided are safe, effective, caring, responsive and well-led. In August 2013, CQC inspected the QEHKL and in October 2013 placed the QEHKL into ‘special measures’ – a heightened stage of concern requiring closer regulatory monitoring by CQC - due to ‘particular concerns relating to low staffing, a lack of training in relation to dementia care, and insufficient systems to manage that were putting patient care at risk’ (CQC, 2013).

Following the Trust being put into special measures significant internal action and improvements were taken by QEHKL. This included considerable investment in additional nursing staffing, including internal recruitment of overseas nurses, and significant internal focus to improve standards of care, and systems and processes to keep patients safe and improve quality.

In July 2014 the Trust was re-inspected, and whilst improvements were noted the CQC recommended that the Trust remained in special measures to address a number of areas that were still requiring improvement. The QEHKL was rated as Requires Improvement overall, following CQC’s inspection which took place from 1 July to 3 July 2014.

A&E, medical care, surgery, maternity and family planning end of life care and outpatients were rated as Requires Improvement. For A&E, whilst it was noted that staffing numbers were improving, reception staff were responsive and staff put effort into treating patients with dignity and respect, it was also noted that the environment was cramped, patient flow through the department was poor and there was too much pressure on senior nurses due to a large number of recently recruited junior staff. In medical services it was noted that whilst staff were very caring and compassionate, there were too many patients who were not in the right ward for their needs, nor were staffing levels flexed to meet the needs of patients and there were too many delays in patient discharges from hospital into the community. For surgery it was noted that services delivered were safe, effective and with caring and kindness but not always tailored to the needs of patients. In Maternity and Gynaecology services all women treated at the time of the inspection reported that had received good care, however midwifery and medical staffing levels were below the Trust’s minimal staffing levels.

The Trust was rated as Good with regard to whether services were caring and effective, Requires Improvement on whether the Trust was safe and responsive and Inadequate on whether the Trust as a whole was well-led.
It should, however, be noted that in all areas staff were found by the CQC to be kind, caring and compassionate towards patients, and were proud to work at QEHKL. Furthermore, there were some particular areas of good practice noted, including the use and implementation of guideline-specific simplified care bundles through the acute medical unit (AMU) into the hospital, which have improved patient care and patient outcomes and the establishment of dementia coaches to supplement the dementia team in supporting patients and families.

Alongside the CQC review of the quality of services, other bodies have considered the quality of care provided at QEHKL. More recent reviews have found that QEHKL is delivering average or above average clinical outcomes based on data for emergency and elective care as recorded by National Outcome Framework metrics and Dr Foster. Hospital Standardised Mortality Rate (HSMR) levels are better than average, as are length of hospital stay and readmission rates.

In some areas of performance, however, there is still improvement to be made. For a number of important targets the QEHKL has been failing to meet required standards. These include ensuring that 95% of patients are treated at A&E within 4 hours, ensuring minimal levels of pressure ulcers and C Difficile infections are acquired by patients within hospital, and that patients are treated within the required times for Cancer and Diagnostic services.

### Acute hospital challenge: quality and performance

| Historic quality concerns identified by CQC…some improvement – some areas still require further work, some examples of good practice |
| Quality outcomes comparatively good, however some key areas where performance against targets requires improvement |

### Workforce and recruitment

Recruitment difficulties at QEHKL mean that it is harder to staff some clinical posts and there is a higher reliance on bank and agency staff – this is a particular problem in some specialities (e.g. maternity). In September 2014, 8% of the hospital’s medical staff were temporary. This means that additional money often needs to be spent to employ temporary workers, creating a cost pressure for the Trust.

A high proportion of recent new nursing staff at QEHKL are recruited from overseas. Many of these recruitments are part of planned recruitment programmes the QEHKL has undertaken to ensure sufficient staff; because there are insufficient applications, and local or regional interest. Our nurses from overseas are undoubtedly committed and caring individuals (as are our British trained personnel) but their induction into the NHS is complex, requiring time and resource; there are local systems and processes to learn as well as careful introduction to our language and culture.

There are a number of specialties in the QEHKL, due to the volume of demand and workload, where the number of full time consultants is one or less. Whilst there will be clinical cover provided by other doctors trained in the specialty and specialist nursing staff, a low volume of consultant cover – the most senior, experienced doctors – can mean it is difficult to maintain safe and fully sufficient services all of the time.
Recruitment difficulties means that QEHKL relies on temporary staffing which is often more expensive than employing permanent staff.

The difficulties in recruiting staff means that QEHKL have had to turn to overseas recruitment.

There are a number of specialties where the number of full time consultants is one or less.

**Scale of provision**

Some specialties in QEHKL experience relatively low volumes of patient activity compared to the England average and nationally recommended minimal levels of activity, most notably in maternity, paediatrics, A&E, emergency surgery and more complex elective surgical procedures (e.g., procedures related to cancer or vascular surgery). In maternity care, QEHKL delivers approximately 2,200 babies per year (184 per month, 6 per day), compared to the average Trust in England which delivers approximately 4,200 babies per year. For acute paediatric activity per 1000 population of 0-19 year olds is 22% lower at QEHKL than the England average. The number of elective surgical admissions at QEHKL is approximately 3,700 per year (10 per day), which is 30% lower than the average Trust in England which has 5,300 admissions per year. For non-elective surgery rates QEHKL delivers 6220 per year compared to the England average of 10727.

The above levels of activity may well be appropriate from a patient and clinical perspective for the population of West Norfolk; however, they create in themselves challenges about scale. This means that these services struggle to recruit consultants who will not gain as much experience as they need to maintain their skills and capabilities. This in turn results in high costs of locum staff as set out earlier.

Furthermore, the need to have senior staff available on a 24 x 7 basis means there need to be around 10 consultants in each of these specialties to cover services round the clock. This typically applies to maternity care, inpatient paediatric care, critical care, A&E and people admitted as an emergency especially for emergency surgery.

In smaller hospitals, such as King’s Lynn, this is hard to achieve – partly because there is not enough work to maintain the skills and expertise of 10 consultants which makes the jobs less attractive and results in de-skilling of the staff, and partly because the income received for treating the volume of patients does not cover the cost of employing the staff.

Some specialties scale is low compared to the England average. This can mean it is difficult to recruit sufficient staff to provide 24/7 care.

It also means that the income received for treating smaller numbers of patients is not always sufficient to cover the costs of providing the service.
# Finances

Financial analysis has found that the Trust projects a deficit of around £14m for 2014/15. More detailed review suggests that this is due to having a higher spend on the medical workforce than expected possibly as a result of high numbers of locums and overtime due to recruitment difficulties. High costs of non-clinical staff and supply and a higher than expected length of stay also contribute to the deficit position. If the cost structure of the hospital could match other hospitals of a similar size, then the Trust could be in financial balance for this year.

## Acute hospital challenge: finances

Finances at QEHKL are challenged. For 2014/15 the Trust projects a deficit of £14m, which is likely to continue in future years if significant action is not taken.

## Acute hospital sustainability

### Acute hospital challenge: sustainability

In line with the national picture the QEHKL as a small rural hospital faces significant sustainability challenges. The challenges of providing services at high quality, attracting and retaining sufficient skilled workforce, and delivering some services at sub-scale has left the Trust with a significant financial challenge in 2014/15, and in future years.

The purpose of the CPT intervention is to support the local health system to identify opportunities for further efficiencies to save money, and redesign services for the benefit of the local population.
Out of hospital care: Primary Care GP practice performance

Performance of GP practices in West Norfolk is generally very good, however there is variation between some GP practices in terms of their performance which needs to be considered, and may be improved.

- Patient satisfaction with West Norfolk GP services, measured as the % of patients who answered ‘Very good’ or ‘Fairly good’ was 88% for the West Norfolk locality, compared to an England average of 86%, with a 37% variation between the scores of West Norfolk GP practices from the best to worst performer.

- Patient reported satisfaction with access to primary care services is above the England average – West Norfolk GP practices scored 71% compared to the England average of 68%, though there is considerable variation seen between practices (26%) between the best and worst performing.

- A&E attendances by GP practices, measured by number of A&E attendances per 1,000 weighted population 2013/14 was for 219 for West Norfolk, compared to 324 for the England average and 286 for ONS cluster peer CCG group average – with a variation of 122% between the best and worst performing West Norfolk GP practices. Close proximity to A&E is closely linked to those practices with the higher numbers of A&E attendances.

- Non-elective ambulatory care sensitive admission performance, measured by number of non-elective ambulatory care sensitive admissions per 1,000 weighted population 2013/14, showed West Norfolk average of 21.2, with ONS cluster CCG peer at 16.7 and England average at 18.1; with a variation between the best and worst performing GP practices at 151%.

- Out of the 23 West Norfolk GP practices there are several smaller practices; 7 GP practices with 1-3 GPs.

- As per the national picture the GP workforce generally is ageing, and there are pockets of shortage of GPs that are covered by locum or agency staff.

Out of hospital care: Norfolk Community Health and Care provider performance

- Patient safety and quality at NCH&C is largely better than or equal to that at other Trusts. The average length of stay for patients at Swaffham Community Hospital was 15 days for 2013/14.

- Staffing numbers and staff costs are higher than average in some areas of the Community Trust workforce. Productivity at NCH&C is lower than the England average in some cases (qualified nurses, midwives and health visitors) and higher in others (e.g. health visitors and allied health professionals).

- In 2012/13 NCH&C delivered a surplus position of £3.1m.
GP practices in West Norfolk perform comparatively well compared to the England average in terms of access to services, patient satisfaction and numbers of patients attending A&E departments. Further improvement may be possible however in reducing the variation between GP practice performance that is not due to differences in patient population, and in the number of patients admitted to hospital as an emergency for ambulatory care sensitive conditions.

Quality of care at NCH&C is generally above average. The Trust made a financial surplus during 2013/14, however there may be further opportunity to improve efficiency in the way in which services are delivered.

Whilst there are some strengths in the current model of out of hospital care, further improvement could be made, particularly in the way in which services are integrated, and the way in which individuals are supported to manage their own care.

Patients have told us that current services are often duplicated with frequent hand-offs between organisations and a lack of support to patients to manage their own care.

Looking forward, the health and care system in King’s Lynn and West Norfolk will need to develop more robust models for care in the community which can be delivered in a more cost effective way.

Out of hospital care:
Our local challenges: We have much to be proud of, but we do not always get it right for our patients

We know that over recent years patient experience of services in West Norfolk has improved. Patient satisfaction rates for local providers of care has improved – much of this is down to the dedication of our staff providing care, and in new services commissioned to better meet patient needs. However, this doesn’t mean that we always get things right for patients.

We do much to capture how patients experience their healthcare every day; through patient surveys, patient and carer focus groups, compliments and complaints received and public events. Patients have shared their experience of care when things don’t go right, and the diagram below describes a frail and elderly patient’s experience of care that we want to learn from.

Patient experience

Joan is 75 and has a number of health problems. She lives at home with her husband, who is equally unwell. During a recent admission to hospital relating to her COPD (chronic obstructive pulmonary disease):

Joan became disorientated and was assessed and diagnosed with dementia;
Discharge from hospital was complicated by an infected leg ulcer with a need for daily dressings;
At home Joan had 9 different people visiting for health and social care;
Joan and her husband feel anxious and unsupported

The experience of patients when things don’t go well illustrates some of the challenges we have described in this document; fragmentation of care, duplication of resources, lack of proactive preventative care, tailored for the complex needs of the patient and her carer.

The West Norfolk Alliance has made some progress in addressing these problems and some of the new schemes in place include:

- the use of ‘Eclipse Live’ software technology to improve drug safety and facilitate joint care planning and data sharing across agencies;
- the use of ‘telemedicine’ triage in care homes, using technology to monitor patients’ condition where they live;
- the establishment of a ‘frailty’ unit at The QEHKL for rapid expert assessment, treatment and discharge planning for the vulnerable group of patients considered to be frail;
- the setting up of a ‘Virtual Ward’ with staff from Norfolk Community Health and Care NHS Trust and Norfolk County Council Adult Social Services working with the QEHKL to promote and support an early discharge for medically fit patients who wish to return home rather than remain in hospital. Where appropriate, this service also enables patients to be supported at home rather than being admitted to hospital;
- creation of a web-based West Norfolk recruitment portal to attract staff to King’s Lynn;
- a new online directory, Living Independently in Later Years or LILY (www.asklily.org.uk), which helps to support West Norfolk’s over 65s to stay well and live independently;
- piloting three ‘care navigators’ from the voluntary sector to help older patients access the full range of health, social and community support services available to them;
- improving the coordination of community dementia support as part of a range of measures to improve services for people living with dementia and those who care for them;

These schemes help to ensure that front-line staff have the means to deliver care in the way that patients need, not bound by requirements of organisational policies that may make it hard to respond in the best way. However, there is still much that we could improve on and we need to consider the opportunities for further development.

**Getting it right for patients:**

We know that the experience of patients in West Norfolk of the healthcare provided has improved over recent years through concerted effort of the West Norfolk Alliance of commissioners and providers of care. However we don’t always get it right for patients. The challenges we have described in this report tell us about many of the reasons why this is the case, and why we need to respond to these challenges.

**Ultimately the healthcare system is West Norfolk needs to develop and change so it is fit for the future**

Using the terms introduced by NHS England, the term ‘sustainability challenge’ reflects the Health and Wellbeing, Care and Quality and Funding and Efficiency gap we face in West Norfolk now, and in the future if we ‘do nothing’. The healthcare system faces a ‘Call to Action’; if we do nothing it will lead to:

- **‘Health and wellbeing gap’**
  Growth in life expectancy will stall, health inequalities will widen and our ability to fund new treatments will be limited given our need to fund avoidable illness

- **‘Care and quality gap’**
  Variation in performance and quality will continue to exist amongst providers of care in West Norfolk against that which we would expect, patients changing needs would not be met, people will be harmed who should have been cured and variation in outcome will exist

- **‘Funding and efficiency gap’**
  QEHKL will be in significant deficit, with potential for other providers to face similar difficulties in the longer term if no action is taken

  CCG may not, given pressures in spend across the local health system, be able to balance financially, which may mean decisions need to be made about healthcare allocation
The establishment of the West Norfolk Alliance has meant that we have been exploring opportunities to do things differently and improve care for patients in West Norfolk. We believe there are a number of areas in which we can work to make services better.

**Opportunity: We could become more efficient - individually and together**

Year on year cost improvement programme delivery – designed to release financial savings by becoming more efficient, or doing differently – traditionally has been developed and delivered on an individual provider by provider, or commissioner basis. It is becoming harder and harder to deliver savings and maintain quality of care, particularly in the face of growing pressures caused by population changes.

However, when considering national opportunity for change, there is data which suggests more can be done to innovate and improve care for the better. As part of a suite of guidance documents for commissioners to inform planning, NHS England presented a number of ‘high impact innovations’ and best practice adoptions to drive innovation. These included suggestions about improved utilisation of technology, diagnostics and clinical transformation. Some of these recommendations we are already doing in West Norfolk, however we need to explore the opportunity to do more, at scale.

We also believe that there is opportunity to drive further efficiencies across providers collectively. We can see that there is often duplication in the way services are delivered – for example in back office functions, management functions, estates and infrastructure that could benefit from consolidation and release efficiencies. Delivering these efficiencies may require change in ‘the way things are done’, or in organisational form and structure, but these should be explored.

**Opportunity: We could better utilise technology**

In a rural area such as West Norfolk the use of technology could be very valuable in supporting the delivery of care to patients locally, and to help NHS professionals share information safely and swiftly about a patient’s condition. This could help care be delivered more efficiently saving money, and allow for patients to be treated closer to home, reducing travel and inconvenience. Information and communication technologies have the potential to revolutionise patients’ and users’ experience, transforming both how and where care is delivered (Kings Fund, TD 2014). Technology can help local services to plan more effectively and will help doctors, care professionals and others to give people far better and far more tailored services. It can also enable individuals to better manage their own conditions, gaining a degree of independence thought impossible until only recently (Integrated Care and Support, 2013).
Opportunity: We could better integrate services

In ‘Integrated Care and Support: Our Shared Commitment’ the Secretary of State for Health, and Minister for Care and Support set out a vision for future integrated health and care (2013). It is envisioned that in five years integrated services will be the standard model of care in the NHS. The opportunity to improve care – moving away from unnecessary clinical repeats of assessments and treatments offered by different individuals or organisations, from lack of sharing of information and from duplication effort – and towards coordination of care, cross-organisational working and single assessment, treatment and shared care.

Improved integration will require providers to do differently. It may require us to commission services in a more holistic way, to commission services around the needs of patients, avoiding artificial organisational boundaries which may create bureaucracy, duplication and unnecessary hand offs in the patient pathway.

Opportunity: We could work together to recruit and retain high quality staff

Through the West Norfolk Alliance we are exploring with partners a number of ways we can ensure we attract, recruit and retain staff to West Norfolk. We are working to establish a West Norfolk recruitment portal; a shared website created by partners from health, social care and King’s Lynn Borough Council to attract future employees to the public sector. We are also looking at ways in which we can share staff, for example through the creation of a shared staff bank and through the development of a staff rotation programme. We are working with partners to look at the development of innovative new roles – for example in nursing in primary care, and through development programmes with partners of the West Norfolk Alliance to support integration.

Opportunity: We could better utilise estates

NHS services are delivered across a broad range of properties that are a mix of public and privately owned estate. Primary care services (GPs, pharmacies, dentists and opticians) are found in high streets, villages and even within supermarkets, with the majority housed in privately owned estate. In contrast, secondary care services (acute, community and mental health services) are largely housed in dedicated public estate, such as hospitals or clinics, owned by NHS Provider Trusts.

Across West Norfolk there are 20 GP practices operating across 31 surgeries, of which 24 are main surgeries and 7 are branch surgeries. These properties are distributed widely across the West Norfolk area, with 19 located in individual villages, one in the town of Hunstanton and the remaining clustered the major population centres; 5 in King’s Lynn, 3 in Downham Market and 3 in Swaffham.

GP properties are generally operating to capacity during normal surgery hours of around 8am to 6pm and many also provide space to other NHS services and health related voluntary sector services. The fragmented nature of this estate limits opportunities for improving utilisation through physical changes, but there is potential opportunity to utilise capacity across extended hours.

The three NHS Trusts that provide services across West Norfolk operate from a total of 16 properties; 13 are located in King’s Lynn, with one each in Downham Market (shared with a GP practice), Heacham and Swaffham. The majority of these properties are owned by the Provider Trusts, with only 3 small properties being leased, with leases that expire between May 2016 and February 2019.
By far the largest single site is the Queen Elizabeth Hospital in King’s Lynn which represents around 52,000 square metres of the total 68,000 square metres of usable space across the West Norfolk NHS provider estate. Norfolk Community Health and Care NHS Trust operates 11 properties, the largest of which are the St. James Clinic in King’s Lynn and Swaffham Community Hospital. Norfolk and Suffolk Foundation Trust has 4 properties, all in King’s Lynn, the largest being Chatterton House and the Fermoy Unit, the latter co-located with the QEHKL.

There is very little spare capacity within the NHS provider estate, with only around 1,000 square meters of spare capacity currently identified, spread across 6 properties, representing just under 1.5% of the overall provider estate. Several of the larger sites already contain 24/7 services and future opportunities to better utilise this estate are likely to require significant repurposing of property to support service reconfiguration.

Our future outcomes: a patient story revisited

We believe in the future, with better integration of services the experience of patients will be far better. Our vision for the future is for care centred around the needs of an individual, supported by one single assessment, proactive care planning, a named key worker, resources supporting patient care, improved communication and timeliness of care.

Patient experience

Joan is 75 and has a number of health problems. She lives at home with her husband, who is equally unwell. Joan is well supported in the community by her GP and community matron.

During an unavoidable admission to hospital Joan received care and support from a community key worker to arrange timely discharge from hospital, with the right support at home;

Throughout their care Joan and her husband remain involved, well supported and feel safe.

Care Planning
- Proactive care planning, with full engagement of Joan and her husband

Staff
- Named key worker responsible for coordinating care

Resources
- Remove perverse incentives, resources aligned to person’s needs

Communication
- Safe sharing of relevant information between agencies

Timeliness
- Timely care, supporting Joan to remain healthy and safe, preventing avoidable crises

Assessment
- Tell the story once, leading to a single, holistic assessment
As highlighted at the beginning of this document we are not in the process of a formal public consultation on any proposed changes; however we are keen to continue ongoing dialogue with stakeholders and members of the public about this process, and to use feedback to inform future commissioning intentions and the next work of the CPT programme.

As part of the groups of people working on the CPT programme, we have established a ‘Patient and Public Engagement Group’; a forum of local representatives identified to help us ensure we capture, represent and take into account the views of local people. The membership of this group comprises patient and public engagement leads from QEHKL, representatives from the voluntary sector such as West Norfolk VCA, West Norfolk MIND, from the local community groups such West Norfolk Patient Partnership, West Norfolk Older Person’s forum and West Norfolk Family Voice. Members of this group are playing a role to help us share the programme of the CPT, and some of the messages in this document, and we will also use these channels to gain further feedback.

We planned in, and have held, several public events prior to our proposed publication of this document to share early analysis, and capture views on the information shared. This will be the first of many opportunities over the coming to get involved in the work of the CPT programme. We have had over 100 people attend these events. To date, from these events we have received the following feedback:

The key themes from these events are described below, with verbatim comments highlighted.

**There is so much to be proud of:**

“On the whole things are good”

“Recently my husband had a stroke, the support, care and follow up has been outstanding”

However, individuals recognised the need for change, and the challenges experienced:

In response to the question:

‘Do you recognise the challenges identified in West Norfolk?’, **96%** of respondents said **Yes**

In response to the question:

‘Has the ‘Case for Change’ been made in a compelling way?’, **74%** of respondents said **Yes**
In understanding the need for change:

“I understand that the system of care has to change. Finite resources”

“Publicity must keep reminding people the current service mix is not sustainable without significant structural and financial change”

“Anyone who has accessed local NHS services and experienced the QEHKL recognises where it is lacking”

In hospital care needs to improve:

“You say that the number of people visiting the QEH for surgery is lower than the norm, yet have not appeared to explain the possible reasons. I know a lot of people who want to use the QEHKL but are told the waiting list is long”

Out of hospital care – challenges, an important part of the solution:

“Has to be more care in the community and joined up care so people communicate with each other better and explain to elderly people in particular, in a simple and understandable way”

“GP access and availability, including Mental Health provision”

“Role of the voluntary sector and wider community is key”

“Wider linkage to health of things like social care, housing planning etc.”

“Access - knowing where and how to access services locally”

We also had some very useful feedback as to how we can ensure that we continue to engage people as effectively, through minimising ‘NHS jargon’ used in communication materials, presenting information in different ways recognising individuals differ in how they interpret information, using different communication mediums (such as text, visual presentation, video or audio), and finding as many ways as we can to engage people through more events and other communication channels.

This document has served to describe the challenges faced in delivering healthcare now, and in the future nationally, and in West Norfolk. We welcome any comments, suggestions and thoughts you may have on healthcare services in your local area. We invite you to feedback to us through local stakeholder events, website, face to face sessions, written feedback and social media. In particular we would be interested in your thoughts on the following questions:

Does this Evidence for Change document reflect your perception and experiences of healthcare services in West Norfolk?

Do you think we have captured and reflected all of the challenges you perceive in the delivery of healthcare in West Norfolk? Would you have anything to add?

In our early themes for exploring opportunity to improve services in the future, which we will consider further over the coming months of the CPT, do you think we are looking at the right things?

Do you have any thoughts about where you would like to see further investment or savings through redesign of services?

Overall, what is most important to you for the future of healthcare services in West Norfolk?
The early part of the CPT process to date has been to establish the key challenges faced by the local health economy. Over the coming weeks this analysis will be built on to consider the potential range of solutions that may help address these challenges going forward. We will continue to speak to local stakeholders, clinicians, patients and the public through this process to gain local views. The final report from the CPT team, proposing one or more options for future improvement will be delivered to Monitor by the end of March 2015. WNCCG will have opportunity to review and share the contents of this report with the public subsequently, considering this alongside its commissioning intentions and 5 year financial plan. Any material changes proposed to the way in which services are delivered will be shared publicly, and subject to formal proposal and consultation if appropriate.


