

NORTH YORKSHIRE COUNTY COUNCIL

SCRUTINY OF HEALTH COMMITTEE

23 September 2011

Independent Review of Health Services in North Yorkshire and York

Purpose of Report

1. The purpose of this report is to provide an opportunity for Members to reflect on the meeting with Professor Hugo Mascie-Taylor (Prof. HM-T) held on Friday, 9 September 2011 and the Committee's involvement in the implementation phase of the Independent Review.

Introduction

2. Members will recall that NHS Yorkshire and the Humber invited Prof. HM-T to chair an Independent Commission to review health services in North Yorkshire and York.
3. At the fact finding stage of the review Members from the Scrutiny of Health Committee met with Prof. HM-T on 9 May 2011 to discuss the challenges facing the health economy of North Yorkshire. At that initial briefing Prof. HM-T undertook to meet again with Members once his report had been published.
4. Following publication of the Commission's report on 2 August 2011, a second briefing took place with Prof. HM-T on Friday, 9 September 2011 when he summarised the biggest challenges facing future healthcare provision in North Yorkshire as:
 - Supporting people to receive care in their own homes,
 - Making sure the NHS operates within budget,
 - The forecast increase in demand brought about by an aging population,
 - Rurality, including ensuring services are sustainable in the long term but which are also accessible.
5. The Commission's report calls for a radical solution and a shift in how healthcare is provided to be achieved through:
 - Redesign the model of care so that patients are treated according to their level of need.
 - Reduce hospital inpatient beds, while increasing activity.
 - Make efficiency savings and increase productivity in every sector.
 - Shift care from the hospital to the community sector, and significantly develop community services (health and social care).

- Introduce strategic planning to improve integration within primary care, and between primary care, secondary care, community services (health and social care), mental health, and public health. These services will also need to integrate with the voluntary and private sectors.
 - Create more responsive provision by encouraging innovation by new and existing providers.
6. A copy of the Executive Summary from the Commission's report is attached as Appendix 1.
 7. At the briefing on 9 September Members expressed a good deal of support for the report's findings on the main issues facing the health economy of North Yorkshire and the conclusions for a way forward. In particular Members supported the need for a greater emphasis on integrating health and social care. An enhanced role for community hospitals for diagnostic procedures and for step-up and step-down care was also supported. It was also agreed that a letter from this Committee be sent to NHS Yorkshire and the Humber in time of the meeting taking place with the Independent Commission on Monday, 26 September 2011. Time is short; consequently your Chairman is liaising with leading Members to agree a final version which will be tabled at your meeting on 23 September.

Recommendation

8. That this report be noted.

Bryon Hunter
Scrutiny Team Leader

County Hall
NORTHALLERTON

13 September 2011

Background Documents: None

Independent Review of Health Services in North Yorkshire and York
August 2011

Independent Review of Health Services in North Yorkshire and York

Report of the Independent Commission

2 August 2011

Chapter 1: Executive summary

- 1.1 The independent review of health services in NHS North Yorkshire and York – the primary care trust (PCT) for the North Yorkshire and York area – was set up to make recommendations for the future commissioning of services within a sustainable financial framework to ensure future financial balance.
- 1.2 Commissioned in January 2011 by the strategic health authority (SHA), NHS Yorkshire and the Humber, on behalf of local GPs and the wider health community, the review's purpose was to:
 - Gather and review evidence from stakeholders.
 - Develop options for the efficient use of resources.
 - Make recommendations for future commissioners.
- 1.3 The review has been led by an independent Commission of 13 members appointed by the SHA Board, and chaired by Professor Hugo Mascie-Taylor, which has considered the evidence and formulated the options and recommendations.
- 1.4 Given the review's context, the recommendations had to be commensurate with the level of the challenge.

Background and context

NHS reorganisation

- 1.5 The review has taken place at a time of uncertainty in the NHS. The final content of the Health and Social Care Bill and shape of future commissioning were to some extent unknown during the process, and details are still to emerge following the Government's announcement in June 2011. However, the overall direction of travel was clear and the Commission used this as a broad framework in which to develop its strategy for future commissioners. It took the view that its recommendations should not be dependent upon a particular organisational structure.

NHS efficiency savings

- 1.6 The high level of NHS growth is at an end, and the scale of the productivity and efficiency gains needed, to meet the rising demands on the service, are extremely challenging. The NHS has been guaranteed a budget which will increase broadly in line with inflation. However, in order to meet growing demand, largely from an increasing and increasingly ageing population, and to absorb rising costs from technological and medical advances, the NHS must identify £15-20 billion of efficiency savings over four years, and more thereafter. These are to be reinvested in the service to meet the increased demand. This challenge has been taken up by the NHS within the Quality, Improvement, Productivity and Prevention (QIPP) initiative and each PCT now has savings plans in place up to March 2015.

NHS funding formula

- 1.7 While it is explicitly not the subject of this review, one of the determinants of NHS North Yorkshire and York's financial position is the national funding formula which determines its annual budget.
- 1.8 Funding is decided by a weighted capitation formula, so that currently each PCT receives an allocation per resident from the Department of Health according to its population size adjusted for their age distribution, additional needs and unavoidable variations in the cost of providing services. Rurality is not taken into account in the funding formula.
- 1.9 Rates of funding vary enormously across England, and in 2010-11 NHS North Yorkshire and York received £1,410 per patient per year – the 13th lowest per resident allocation in the country.

Evidence

Finance

- 1.10 Despite significant, real terms financial growth over the last decade, NHS North Yorkshire and York has found it difficult to manage demand for health services and has over-spent. The overspend has largely been met by the SHA, either from its own resources, or through organising the transfer of money from other health economies in the region. Over the last two financial years, the SHA has provided a total of £30 million of non-repayable financial support and, in addition, the PCT has continued to carry an historic debt of £18 million from previous years.
- 1.11 This position is unsustainable. From April 2013, when the SHA tier is abolished, the option of SHA support will no longer be available and the PCT will need to be in financial balance to be able to hand over to commissioning groups or the NHS Commissioning Board.
- 1.12 In addition to a need to eliminate the overspend by April 2013, the North Yorkshire and York health economy must make efficiency savings of a far greater order – approximately £230 million, or 20% – which need to be delivered by March 2015. These are to be reinvested in the service to meet the increased demand. This task will be inherited by the commissioning groups or NHS Commissioning Board from April 2013.

Other evidence

- 1.13 A wide variety of evidence was gathered from many stakeholders and sources and organised into categories:
 - Benchmarked evidence
 - Evidence from the Reference Group meetings
 - Evidence from meetings with other stakeholders
 - Evidence from previous external reviews

- Other written evidence submitted to the review.
- 1.14 The benchmarked analysis was produced by the Yorkshire and Humber Public Health Observatory and NHS Yorkshire and the Humber in conjunction with NHS North Yorkshire and York in December 2010. It aimed to aid a fuller diagnosis of the ongoing financial challenges faced by the PCT by examining:
- The extent to which there is, relative to funding levels, any oversupply of healthcare in North Yorkshire and York.
 - The complexity of the commissioning challenge within the area.
 - The impact of rurality and remoteness on the ability to provide services effectively.
- 1.15 To aid analysis and decision making, the evidence was presented in nine themes (which later became eight when out-of-hours and urgent and emergency care were combined in the recommendations):
- Community hospitals
 - Community services
 - Estate
 - General practice / Primary care
 - Mental health
 - Out-of-hours
 - Planned care
 - Public health / Prevention
 - Urgent and emergency care.

The process

- 1.16 The Commission and Reference Group took part in a series of meetings during March and April 2011 to generate the evidence.
- 1.17 In addition, the Commission Chair met with stakeholders in the area. These included meetings with some MPs, local councils, overview and scrutiny committees and key NHS representatives, including the chief executives at acute foundation trusts and a mental health foundation trust. Written submissions were received from several parties.
- 1.18 In the final phase, the Commission met twice to consider the full set of evidence, debate options and agree its recommendations. The final report was submitted to the SHA Board on 5 July 2011.

Recommendations

- 1.19 The current rate of expenditure on health services is no longer an option for the North Yorkshire and York health economy. Health commissioners are spending beyond their means, and the health economy as a whole is ill-prepared to make the efficiency savings required by March 2015 in order to meet the increasing demand for services.
- 1.20 The central challenge, however, is not simply to eliminate the overspend and deliver efficiency savings; rather, it is to develop a sustainable solution to meet the future healthcare needs of the people of North Yorkshire and York within the current financial and policy context. This must be one that maintains the overall quality of services and care, whilst meeting the financial constraints.
- 1.21 The solution must be shared between local authorities and the NHS, and involve other partners. Local authorities are subject to a greater scale of efficiency savings than the NHS, and this will be an added challenge.
- 1.22 The key issue for the area is: how best to use available resources to respond to the level of demand resulting from a relatively affluent and informed population, who have high expectations of their health and healthcare. Meeting this challenge depends on the ability of commissioners to:
- Commission the best quality and fairest distribution of services across the area, according to need not demand.
 - Ensure services are used most appropriately.
 - Influence the shape of the 'marketplace' – where and how providers provide services.
 - Focus provision where it is equitable, efficient and affordable.
- 1.23 A key development will be the forecast significant increase in the older population in North Yorkshire and York. The over-65 population is expected to increase by 16% by 2013, and by approximately 40%, to 198,000, by 2020, making almost 25% of the total population. Even more significantly, by 2020 the number of people aged over 85 years is expected to increase by 60% to 30,600. This population makes significant use of health and social care services. Additionally, between 2008 and 2025, a 68% increase in dementia is forecast.
- 1.24 The Commission recognises there is a strongly held opinion that the national funding formula unfairly disadvantages North Yorkshire and York as it does not properly account for 'extreme rurality' and that, in the light of expected future increases in the older population, this needs to be challenged. The Commission accepted that this is an important question but decided it falls beyond the terms of reference for this review and that it did not have relevant evidence to make a reasoned judgement. It is a matter for the Department of Health and ultimately Parliament to decide. However, the Commission has made reference to these strong opinions in the report in the hope they will be investigated at the appropriate time.

- 1.25 To meet the financial challenge and provide health services that meet the needs of the population, protect the interests of patients and the public, and maintain the overall quality of services and care, the recommended overall strategy is to:
- Redesign the model of care so that patients are treated according to their level of need.
 - Reduce hospital inpatient beds, while increasing activity.
 - Make efficiency savings and increase productivity in every sector.
 - Shift care from the hospital to the community sector, and significantly develop community services (health and social care).
 - Introduce strategic planning to improve integration within primary care, and between primary care, secondary care, community services (health and social care), mental health, and public health. These services will also need to integrate with the voluntary and private sectors.
 - Create more responsive provision by encouraging innovation by new and existing providers.

Redesign the model of care

- 1.26 The Commission is proposing a model of care which involves fundamental gains in efficiency and productivity, a shift of resources from hospital care to community services, and the integration of community health and social care services, and wider integration where possible.
- 1.27 All too frequently, people are treated in an inappropriate place, ie at too high a level of care for their needs, with consequences for the cost and quality of care. Patients must be cared for in a community service or with support at home where this is safe and appropriate. In addition, local residents need to be encouraged to take greater responsibility for their health to ensure they lead healthier lives.
- 1.28 Rather than provision according to historic patterns, services should be better organised and more systematic to eliminate waste and duplication.
- 1.29 The model of care must be designed to meet people's needs and with the clear understanding that not every individual demand can be met. This will require a clearer focus on tackling health inequalities, through selected investment in primary care and community services (health and social care) where there are deprived populations.
- 1.30 The Commission is aware of the impact that the proposed model of care will have on those who work in the NHS and that its successful delivery depends on them achieving efficiency savings and meeting increasing demand within current resources. It is too soon to know if there will be an impact on staff numbers, but the recommendations require new, more flexible models of working which will need to be introduced across professional, organisational and geographical boundaries and this will be an added challenge to those who work in the delivery of health and social care services.

- 1.31 There is also a substantial opportunity for the use of new technology to facilitate integration and this must be immediately explored.

Table of recommendations

- 1.32 There are 44 recommendations and each has an identified lead for action:

Overall strategic recommendations: Pages 48-51	Action lead
<p>1. Develop and implement a model of care which is based on the concept of appropriate levels of care, and involves fundamental gains in efficiency and productivity, a shift of care from hospitals into community services, and the integration of community health and social care services.</p>	<p>Health commissioners (with local authority commissioners and health and social care providers)</p>
<p>2. Increase the skill mix and productivity of the health and social care workforce, and require proactive team working across professions and agencies. This will support the new model of care and the development of new, multi-skilled staff roles which are driven by the needs of the patient. This should include the development of a more generic care worker for older people, particularly those with dementia, with a focus on patients in rural areas.</p>	<p>Acute foundation trusts (with health and local authority commissioners and other health and social care providers)</p>
Community hospitals: Pages 51-53	Action lead
<p>3. Overview: Reduce total hospital inpatient beds and associated costs (a likely reduction of 200 or more beds), across district general hospitals and community hospitals, redesign community hospitals and improve and extend community services (health and social care). This will need to be kept under review by commissioners to ensure that it is delivering the required level of efficiency savings. If these are not delivered then Option B may need to be considered (See Page 52 for details of Option B).</p>	<p>Acute foundation trusts (with health commissioners)</p>
<p>4. Review and redesign community hospitals as part of a wider strategy for improved community services (health and social care) for older people and the wider population, involving community health services, social care and primary care. They should provide 'step-up' care for patients from the community and 'step-down' care for patients from acute hospital settings, so that care is matched to patient need and being provided in the right place. They could, where appropriate, become centres for simple diagnostics (blood tests, plain X-rays and ultrasound) and provide consultant outpatient clinics, and out-of-hours care as part of the urgent/emergency pathway. Admission must be on the basis of need and be equitable</p>	<p>Acute foundation trusts (with other health providers)</p>

across all general practices' patients. Commissioners should pay account to the Enhanced Community Teams model which was piloted in Malton and Whitby community hospitals.	
5. Include community hospitals in the review of the estate.	See Estate section, Page 13
Community services: Pages 53-54	Action lead
6. Overview: Develop community services (health and social care) significantly, through increased efficiency and productivity, and better organisation and integration, so that there is an extended system in place to deliver more appropriate care closer to people's homes. Seek to co-locate and coordinate health and social care services more effectively.	Acute foundation trusts (with health and local authority commissioners and other health and social care providers)
7. Using a similar model to that used in children's and young people's services, Older People's Plans should be developed immediately by the Health and Wellbeing Boards, or the structures they set up, involving the NHS, local authorities, the voluntary sector, and, where appropriate, the private sector. The plan would need to cover prevention of ill-health, delayed discharges and transfers of care, provision of alternatives to acute care, provision of re-ablement services, and effective coordination of services. It needs to take account of the fact that there may need to be different solutions in different geographical areas.	Health commissioners (with local authority commissioners, and health and social care providers)
8. Provide a mechanism to allow for and fund efficient and innovative solutions for community services (health and social care) provision proposed by qualified providers.	Health commissioners
9. Explore with local authorities the potential benefits of assistive technology – such as tele-health (See Page 54 for an explanation) – to establish its appropriate use within a managed system for provision of efficient community services (health and social care).	Acute foundation trusts (with other health and social care providers)
10. Examine continuing care costs to ensure that spend is closely aligned to need and the criteria are applied consistently.	Health commissioners
11. Include community services (health and social care) in the review of the estate.	See Estate section, Page 13
Estate: Page 55	Action lead
12. Overview: Carry out a joint review of health and local	Health

<p>authority estates to provide options for future co-location of services and premises in order to rationalise the estate, develop creative solutions and reduce the cost. Include the wider public sector and voluntary sector where possible. Maximise the benefit from the surplus estate through sale or other solution.</p>	<p>commissioners (with local authority commissioners and health and social care providers)</p>
<p>13. Take measures to improve the NHS' carbon footprint as part of the estate review.</p>	<p>Health commissioners (with health providers)</p>
<p>General practice / Primary care: Pages 55-57</p>	<p>Action lead</p>
<p>14. Overview: Maintain investment in and the quality of primary care services, and deliver improved community health services, while seeking efficiencies and increased productivity through a systematic approach, including:</p> <ul style="list-style-type: none"> - Reducing variation in referral practice, where activity against key indicators is above the PCT average level - Introducing minimum specifications of service - Better use of skill mix across primary care - Changes in established referral patterns (See Planned Care, Page 58) - Reviewing dispensing and better medicines management to reduce waste - Introducing performance management measures and reporting (e.g. a 'balanced scorecard') which provide an incentive for the shift from secondary to primary care. 	<p>Primary care providers (with health commissioners and acute foundation trusts)</p>
<p>15. Develop a formulary across primary and secondary care to further improve the cost-effectiveness of prescribing practice.</p>	<p>Health commissioners (with acute and mental health foundation trusts and primary care providers)</p>
<p>16. Ensure general practices and pharmacies work as part of integrated, co-located healthcare teams with local authority and voluntary sector staff to deliver improved community services (health and social care) and prevention using 'case management' approaches.</p>	<p>Primary care providers (with acute foundation trusts and social care providers)</p>
<p>17. Commissioners, working with the NHS Commissioning Board, should review the number and distribution of GPs across the area and ensure that patients in deprived areas have equal access and that GPs in those areas are better supported.</p>	<p>Health commissioners</p>
<p>18. PCT and GP commissioners and the Local Medical Committee should develop a Code of Practice for primary</p>	<p>Health commissioners</p>

care to ensure greater clarity and transparency about the minimum delivery expectations for primary care providers. Commissioners should aim to build on existing relationships with providers to change culture and behaviours in order to reduce variation in the quality of services provided and the use of resources within the wider system.	(with local medical committees and primary care providers)
19. Be assured that the high level of exception reporting is justified (See Page 40 for an explanation of exception reporting).	Health commissioners
20. Include primary care in the review of the estate.	See Estate section, Page 13
Mental health: Pages 57-58	Action lead
21. Overview: Reduce inpatient beds and provide a comprehensive and high quality, preventative community mental health service, focused on key priorities, and working in close partnership with community services (health and social care), education, children's services, and the employment sector.	Mental health foundation trusts (with acute foundation trusts and social care providers)
22. Ensure mental health services are integrated into the new community structures, including community hospitals, and aligned with the new Older People's Plan.	Mental health foundation trusts (with acute foundation trusts and health commissioners)
23. Strengthen liaison psychiatry to avoid inappropriate admissions to inpatient care, and provide more 'step-up' and 'step-down' services in community settings.	Mental health foundation trusts
24. Provide better services and care for the growing number of people with dementia through the more efficient use of current resources.	Health commissioners (with local authority commissioners and health and social care providers)
25. Develop a new approach to substance misuse, with a particular focus on alcohol misuse. This must take account of new solutions and partnerships and be based on the latest evidence.	Mental health foundation trusts (with acute foundation trusts and local authority commissioners)

<p>26. Commission community projects and schemes, such as those providing befriending, access to employment, social enterprise and physical exercise, where they can demonstrate social and health benefits.</p>	<p>Health commissioners (with health and social care providers)</p>
<p>27. Include mental health services in the review of the estate.</p>	<p>See Estate section, Page 13</p>
<p>Planned care: Pages 58-60</p>	<p>Action lead</p>
<p>28. Overview: Reduce total hospital inpatient beds and associated costs and increase efficiencies by treating patients in the right care setting at the right time in order to be able to develop community hospitals and community services (health and social care), through:</p> <ul style="list-style-type: none"> - Maximising the use of community hospitals (See Community Hospitals, Page 51) - Reducing lengths of stay and improving patient discharge and transfers of care - Increasing the use of day surgery - Improving consultant efficiency and matching system capacity to need - Increasing the ratio of new to follow-up cases to enable the shift to primary care - Improving pathway management, by reducing the number of visits to hospital each patient makes for diagnostics and outpatient appointments - Shifting care, such as rehabilitation, diagnostic tests and outpatient appointments, from acute to community settings - Developing clinical alliances across hospitals, which reduce duplication and increase the safety and quality of services - Introducing benchmarking to demonstrate efficiency. 	<p>Acute foundation trusts (with health commissioners and primary care providers)</p>
<p>29. Review and set clear thresholds, particularly for high value (by cost and volume) interventions, to bring activity in line with the regional average, where it is higher. Ensure all referrals are evidence- and needs-based, and there is clarity about the need to use alternatives to intervention.</p>	<p>Health commissioners (with acute foundation trusts and primary care providers)</p>
<p>30. Explore and adopt where possible shared medical decision making in relation to secondary care procedures.</p>	<p>Acute foundation trusts (with health commissioners)</p>
<p>31. Ensure that providers develop services which have been strategically planned and which will be commissioned and funded in future.</p>	<p>Health commissioners (with all health providers)</p>

32. Include district general hospitals in the review of the estate.	See Estate section, Page 13
Public health / Prevention: Pages 60-61	Action lead
33. Overview: Ensure there is evidence-based investment in efficient community services (health and social care) to promote health, improve quality of life and reduce admissions to hospital. Particular focus should be on preventing and reducing the impact of ill-health and falls in older people. There should be an additional focus on the areas of alcohol, smoking and obesity; and early intervention with families where needed.	Local authority commissioners (with health commissioners)
34. Ensure there is evidence-based public health investment in community services (health and social care) which provide early intervention to improve medium- and long-term health outcomes for parents and children.	Local authority commissioners (with health commissioners)
35. Ensure public health services are provided in an integrated way with community services (health and social care), primary care, social care and the voluntary sector.	Local authority commissioners (with health commissioners)
36. Include public health services in the review of the estate.	See Estate section, Page 13
Unplanned care: Pages 61-63	Action lead
37. Overview: Maintain investment in unplanned care services while increasing quality and efficiencies through better coordination, co-location and the better care of older people with long-term conditions or who are susceptible to falls.	Acute foundation trusts (with other health and social care providers)
38. Rapidly review the efficiency of the unplanned care pathway and the development of a new model of care, including exploring alternatives to A&E, involving acute trusts, primary care, community services (health and social care), community hospitals, the ambulance service and out-of-hours services.	Health commissioners (with acute foundation trusts, Yorkshire Ambulance Service and primary care and social care providers)
39. Ensure that, as part of the proposed Older People's Plan, there is investment in the better management in a community setting of long-term conditions and prevention of falls.	Health commissioners
40. In order to reduce admissions, provide safe, high quality alternative facilities in the community which have clear	Health commissioners

<p>routes of access and consistent availability, including:</p> <ul style="list-style-type: none"> - More responsive general practice, ensuring people needing urgent care are seen on the day - Where appropriate, extended hours in general practice (evenings and weekends). 	(with primary care providers)
41. Reduce admissions by using the latest best practice care to better signpost and triage patients as they arrive at A&E.	Acute foundation trusts
42. Ensure the new model of care would provide more coherent, consistent, high quality and accessible out-of-hours services using community health staff as well as GPs and non-medical staff.	Health commissioners (with acute foundation trusts and primary care providers)
43. Ensure clear information is provided to patients about the availability of health services in the evenings and at weekends, or about the point at which a guaranteed service is provided.	Primary care providers (with health commissioners)
44. Explore co-location of unplanned care services as part of the review of the estate.	See Estate section, Page 13

Conclusion

- 1.33 Leaders in the North Yorkshire and York health economy must focus their attention on delivering a solution that addresses the scale of the problem, is achievable within the timescale, and sets the system on a sustainable footing for the future, while maintaining the overall quality of patient care.
- 1.34 This report provides a framework and strategy and hands the challenge to the Boards of the SHA, PCT, commissioning groups and local authorities, and the Health and Wellbeing Boards, to deliver it.
- 1.35 Given the scale of the changes required, there is a need to take action immediately and the SHA Board should establish relevant structures and set the process in motion by October 2011 to realise the efficiency savings by March 2015. Further work will be needed to develop a fully costed implementation programme, but this should not stand in the way of setting priorities and making a start on delivery.
- 1.36 The Commission is confident that its recommendations provide the best way forward for the area, and that they are deliverable, especially given the low levels of deprivation and generally high quality workforce and services in North Yorkshire and York. It is difficult to know if the recommendations will meet fully the scale of the challenge and future commissioners will need to monitor and determine progress as the programme unfolds.
- 1.37 The complexities of the commissioning environment in North Yorkshire and York present a challenge, but it is no longer adequate to bemoan these, nor is it necessary to wait for the Health and Social Care Bill to be published.

Commissioners need to find a way to work with providers so that there is shared leadership, a shared vision and shared goals. Anything less will jeopardise people's future health services and these must be preserved for the benefit of whole community.