



## North Yorkshire and York clinical services review

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The next phase of the North Yorkshire  
and York independent review

## **North Yorkshire and York health community**

22 January 2013

Report outlining the process for developing high level strategic direction to support the North Yorkshire and York health community to achieve financial balance by 2016/ 17. The report contains the high level emerging strategic themes and recommendations for the next steps.

## 1 Introduction

- 1.1. North Yorkshire and York (NYY) health economy has, for the past six years, not been able to maintain financial balance without either support from the Strategic Health Authority or by overspending its budget.
- 1.2. The UK's economic position and specifically the new commissioning arrangements mean that this support will no longer be available from April 2013. NYY also faces burgeoning health demands from its ageing and articulate population. The lack of ongoing financial support coupled with the forecast increased demand meant that the current pattern of healthcare provision across NYY needed to be urgently examined.
- 1.3. In August 2011, an independent review of North Yorkshire and York, chaired by Professor Hugo Mascie-Taylor<sup>1</sup> was published. This made several recommendations regarding the shifting of care to community settings and the reduction of 200 or more inpatient beds as well as the introduction of strategic planning for integration between the different elements of the care sector.
- 1.4. In July 2012, the NYY health community (NHS North Yorkshire and York, the five North Yorkshire CCGs, Harrogate and District NHS Foundation Trust, York Teaching Hospital NHS Foundation Trust, Airedale NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust, Yorkshire Ambulance Service NHS Trust) tendered for support to take the 2011 North Yorkshire Review, to the next level of analysis. Specifically this next stage of the review sought to understand NYY's forecast financial position by 2016/17, the size of the potential deficit based on the current pattern of provision and the increased demand as well as to identify new models of care that could potentially meet these significant challenges.
- 1.5. The NYY health community worked together from September to December 2012 to examine the current pattern and cost of services and to identify opportunities to restructure services across the system to maintain or ideally improve the service offering, but at lower overall cost to the system. KPMG have been supporting the health community in this work.
- 1.6. This report is a summary of the work to date. It must be recognised from the outset, however, that this report is still very much a staging point which sets out the agreements and vision for services in the future as envisaged in January 2013, recognising the constantly and rapidly changing environment

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<sup>1</sup> Independent Review of Health Services in North Yorkshire and York; Report of the Independent Commission, 2 August 2011



- 1.7 The outputs from this stage of the review are being taken forward by the system as a whole but the driver in the future will not be the PCT (which will not exist from April 2013) but primarily will be the constituent CCGs. The way in which this is envisaged is set out later in this report.

## **2 National Context – case for change**

- 2.1 The NHS is undergoing unprecedented levels of change informed by the following:

- System reform (Health and Social Care Act 2012)
- Economic decline (£15-20bn Quality, Innovation, Productivity and Prevention challenge across the NHS in England)
- Acute Trusts face a current net tariff deflation of 1.5% as the 4% efficiency targets are embedded into the provider contracts off-setting modest inflation assumptions
- This level of efficiency is predicted to continue in the medium term with Monitor predicting efficiency requirements for 2013 to 2016/17 of 4.2% - 5% (base case) or 5%-5.5% (downside case) to ensure that Trusts maintain their Financial Risk Ratings
- The King's Fund has predicted that the NHS saving target could rise to £50bn by 2019/20 because of the UK economic outlook
- The second Francis report, which is scheduled for publication in early 2013, is widely predicted to lead to a sea-change in service provision with further focus on quality and safety which may have additional cost and system implications for the NHS

- 2.2 The Autumn Statement on the 5 December 2012 announced:

- Pay freeze lifted with 1% pay rise for the public sector and abandonment of the proposed introduction of regional pay
- Health budget to receive "relative protection" from government spending cuts to 2015/16
- Next generation of Private Finance Initiative (PFI) deals will exclude soft facilities such as cleaning and catering
- The Office for Budget Responsibility (OBR) has revised the Gross Domestic Product (GDP) deflator for 2013-14 to 2016-17 downwards since the 2012 budget from 2.5% to 2%. The GDP deflator is the measure of inflation used to uprate the NHS budget. This could affect the potential deficit range for North Yorkshire (outlined in point 2.3 below)
- The need for a sustainable funding solution for social care was not addressed and a further reduction in local government spending of £445m in 2014/15 could put further pressure on social care and therefore into the health and social care economy overall.



- 2.3 There are also national guidelines which have recently been published to which all health economies are responding. Examples of these include the national guidelines for Stroke (revised September 2012)<sup>2</sup> and the proposals from the Royal College of Obstetricians and Gynaecologists Expert Advisory Group. Their report on High Quality Women's Healthcare (June 2011)<sup>3</sup> focuses on a network and life course approach to maternity services and promotion of births outside the hospital setting and if accepted may impact on the way services are delivered across the localities.
- 2.4 The NHS Commissioning Board published 'Everyone Counts' in December 2012 which highlighted the key objectives for the NHS over the next 12 months. The main areas offered locally to CCGs as priorities and solutions to be addressed as part of commissioning discussions include:
- NHS services available 7 days a week
  - More transparency, more choice
  - Listening to patients and increasing participation
  - Better data – informed commissioning, better outcomes
  - Higher standards, safer care
  - Prevent people dying prematurely
  - Enhancing quality of life for patients with LTC
  - Recovery from episodes of ill health
  - Positive experience of care
  - Safe environment and protect from avoidable harm

These objectives and priorities are very much tied in with a set of key strategic enablers which have been devised to progress the outcomes of this Review (See section 4 for further details).

- 2.5 There are several national workforce drivers that will also affect the way services are delivered in NYY such as the Shape of the Medical Workforce (February 2012)<sup>4</sup> and the Seven Day Consultant Present Care (December 2012)<sup>5</sup> which will impact across all aspects of health and social care and are likely to have significant organisational and resource implications.

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<sup>2</sup> National Clinical Guideline for Stroke, 4<sup>th</sup> Edition; 2012

<sup>3</sup> High Quality Women's Healthcare; Royal College of Obstetricians and Gynaecologists, June 2011

<sup>4</sup> Shape of the Medical Workforce – starting the debate on the future consultant workforce – a discussion document for Leaders; Centre for Workforce Intelligence, February 2012

<sup>5</sup> Seven Day Consultant Present Care; Academy of Medical Royal Colleges; December 2012



- 2.6 Current national negotiations on the GP contract will also have implications for the potential models of care as primary care is seen as a key enabler to the delivery of a significant amount of the reduction in demand for hospitals and shift in care away from secondary care that is necessary.

### **3 Local context - case for change**

- 3.1 As outlined above, the NHS is facing an unprecedented level of change and NYY, like other health economies, needs to proactively respond to this change to ensure that they can provide a long term clinically sustainable and financially viable health and social care system for their local population. As well as the financial implications, there have been several national drivers for change such as the first Francis report<sup>6</sup> on Mid-Staffordshire which highlighted the need for a significant improvement in quality and safety in the NHS. The second Francis report is due to be published in January 2013 and it is anticipated that the outcome of this report will have far reaching implications for the future delivery of services within the NHS.
- 3.2 NHS North Yorkshire and York (NHS NYY) has had a structural deficit for the past six years and despite additional efforts by the commissioners to rectify this, they have been unable to return to financial balance without support. In 2011/12 this amounted to approximately £15m<sup>7</sup>.
- 3.3 The aim of the Commissioners is to return to financial balance in 2014 which will require paying off the remaining underlying deficit. Under the allocation formula used to allocate monies to PCTs, there was an acknowledgement that NHS NYY received approximately £17m less than the allocation should provide for their local population demographics as this is phased in over time. With the change to the new system in 2013, allocations are being made to CCGs for most secondary care services and to the National Commissioning Board for primary care and specialised services. Allocations have been made for 13/14 without reference to any target formula but by a straight uplift on the historical allocations. As this is nationally determined, it is recognised that it is outside the control of the health economy and therefore beyond the scope of this review. However the resources are allocated, the CCGs have a statutory duty to live within their allotted sums.
- 3.4 Based on the current funding and allocation assumptions, KPMG worked with the Directors of Finance across the health economy to overlay demographic predictions of demand and activity assumptions. It is predicted that by 2016/17, the health economy may be facing a potential overall deficit in the range of £93m to £156m. These figures do not include the current structural deficit figure so if this is not paid off by 2014, then the total figure could be significantly higher.

<sup>6</sup> Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009, Volume I, The Mid Staffordshire NHS Foundation Trust Inquiry Chaired by Robert Francis QC, 24 February 2010

<sup>7</sup> NHS North Yorkshire and York Finance Department



- 3.5 During the course of this work, the resource allocations and NHS Operating Framework have been published for 2013/14 (Everyone Counts: Planning for Patients 2013/14). Since the CCGs and Foundation Trusts are currently assessing the implications of this framework and are preparing their plans for 2013/14, it has not been possible to factor in any assessment of the impact of this in this report. The report is therefore based on the situation and information available just prior to Everyone Counts.
- 3.6 At the time of this review, Hambleton, Richmondshire and Whitby CCG, in partnership with South Tees Hospitals NHS Foundation Trust were leading a consultation on the proposed clinical reconfiguration of maternity and paediatric services on the grounds of clinical safety and viability.
- 3.7 Under the Transforming Community Services agenda (TCS), in April 2011, each of the acute trusts were awarded the community services provision at different levels including the community hospital provision in their locality. As part of this process, Harrogate and District NHS Foundation Trust (FT) became the main provider for a number of regional services including the Out of Hours GP provision (excluding Scarborough). This should allow the development of seamless “end to end” patient pathways
- 3.8 It is clear that the local health system across North Yorkshire needs to respond to the national challenges facing the NHS, as well as the local challenges. Hence this work was commissioned as the next phase in designing the detail (following the recommendations set out in Professor Hugo Mascie-Taylor’s independent review) for the clinical strategy for reconfiguring the provision of healthcare across the region to ensure a viable future. The CCGs (Vale of York CCG, Hambleton, Richmondshire and Whitby CCG, Scarborough and Ryedale CCG, Harrogate and Rural District CCG, Airedale, Wharfedale and Craven CCG) have been at the forefront of leading this phase of work, along with the Chief Executives of the acute trusts (Harrogate and District NHS FT, York Teaching Hospital NHS FT, South Tees Hospitals NHS FT, Airedale NHS Foundation Trust), Yorkshire Ambulance Service NHS Trust, and NHS North Yorkshire and York. The Governing Bodies of the five CCGs and the four acute trusts are committed to working together to address the financial and service demand challenges faced by the health economy.

#### **4 High level strategy and road map**

- 4.1 To inform development of the high level strategy, a series of clinical workshops were held with clinicians from across the localities. Feedback from this was subsequently discussed at a wider stakeholder event, where key emerging strategic were identified to be taken forward. The approach and process followed as part of this review is set out in detail in Appendix 2 to this report.



4.2 The stakeholder event also agreed a list of enablers which all organisations thought to be important and which need to be taken forward as part of the next phase of work. It should be noted that these enablers are critical to the successful delivery of the strategy. If these enablers are not capable of being delivered, then this could put at risk implementation of one or more of the strategic themes set out below. These enablers are as follows:

- Seven day working across all health and social care sectors. It is recognised that it might be a challenge in some areas, such as primary care, where there is a national contract.
- Increased use of assistive technology and, where appropriate, shared care records.
- Strategic collaborative commissioning across the NYY footprint for areas such as frail elderly, to have a single approach (eg Comprehensive Geriatric Assessment to support community teams).
- New medical and nursing workforce models, including new specialist roles working across acute and community, Enhanced Care Practitioner, and create roles such as Home Care Workers to care for ventilated and stoma care patients.
- Local tariffs (eg year of life tariff for certain specialties /conditions).
- Enhanced capacity and capability in primary care.
- Opportunity to manage urgent care. The Directory of Services within the new urgent care 111 number (from March 2013) provides an opportunity to manage urgent care needs closer to home and reduce the need for a hospital attendance.
- Development of mental health urgent care liaison model (RAID) in both acute A&E and community hospitals to support the early discharge of patients with dementia and other mental health diagnosis (as part of the urgent care strategy and to reduce length of stay).

4.3 The work to date has led to the development of a high level clinical strategy and emerging strategic themes under a range of clinical areas. These are summarised in the chart at Appendix 1 and are as follows:

**a) Primary care**

- Primary care has a significant enabling role in the delivery and implementation of new models of care. North Yorkshire needs to ensure it maximises value for money by preventing patients from being admitted to hospital and facilitating earlier discharge
- Primary care transformation needs to focus on keeping people in their own homes – key enablers to support this such as assistive technology and near patient testing need to be defined
- Explore models to maximise impact primary care can have in rural areas
- Undertake risk stratification & establish Multi-Disciplinary Teams (MDTs) to more effectively manage long term conditions





- Review out of hours provision and move to 7 day working
- Establish virtual clinics and use telemedicine to seek specialist opinion to reduce outpatient referrals
- Develop an End of Life Care strategy

**b) Community care**

- Reassess entire community services provision in conjunction with CCG and local acute trust to properly define service needs locally and improve efficient use
- Move appropriate acute services into the community such as specialist care supporting long term conditions and frail elderly services
- Develop integrated health and social care community teams
- Adopt a model with primary care and the acute sector to support patients through the system to enable appropriate discharge
- Focus on dementia care in line with the national strategy

**c) Frail elderly**

- Develop an overarching clinical strategy for the care of the frail elderly
- Link with the urgent community, social and primary care plans
- Develop support for nursing and residential homes and link to telemedicine

**d) Social care**

- Integrated health and social care supporting across the system to keep people well and out of hospital and to support patients through the system to enable appropriate discharge once in hospital.

**e) Planned Care**

- Manage demand through use of clinical thresholds, shared decision making and patient decision aids
- Review further opportunities to collaborate across the acute trusts to develop joint clinical networks and alliances, or where feasible create centres of excellence
- Use enhanced recovery to reduce elective length of stay
- Use assistive technology to support more community based follow up care



**f) Maternity and Paediatrics**

- Consultant led maternity services are to be sited on at least the three sites of Harrogate, York and Scarborough. Provision at Northallerton is still to be determined
- Review the provision of Midwifery Led Birthing Units
- Assess whether community infrastructure is appropriate to reduce ante-natal admissions
- Review the provision of paediatric inpatients in line with maternity services
- Integrated strategy for paediatrics across acute and primary care to reduce inpatient admissions

**g) Urgent care**

- In line with national and college guidance and existing clinical networks, review the provision of urgent care across NYY including the number of Minor Injuries Units and the effectiveness of out of hours primary care provision
- Review the provision of emergency surgery and define the optimum model for quality and productivity in line with national guidance
- Review the role of the ambulance trust in supporting the optimum models for urgent care. Review opportunities arising from '111'
- Examine the potential for A&E departments to implement an integrated model of care, for example a GP practice at the front door of A&E to reduce attendances
- Examine new workforce models such as the clinician in the ambulance control room and use of Emergency Care Practitioners
- Develop stroke services in line with national guidance considering role of local clinical networks
- Consider the impact of any changes above on the trauma network

**h) Mental health**

- Mental health to support on a system wide perspective particularly in integrated community teams and the urgent care review
- Review patients who at present are placed out of North Yorkshire with a view to providing their care closer to home



- 4.4 Key to supporting this work is the role of mental health and social care services. Collaboration with mental health services is important to support a reduction in length of stay and A&E admissions through the development of models such as Rapid Assessment Interface and Discharge (RAID) in A&E and on the wards. This model of care has a strong evidence base for the reduction in length of stay and improvement in patient experience<sup>8,9</sup>. This area will be picked up in the urgent care clinical work-stream.
- 4.5 Social care have an integral role in the development of integrated community teams and services that work as part of an end to end pathway to prevent elderly patients and people with long term conditions from being admitted to hospital and for supporting early discharge if they are admitted. The relevant clinical work-streams will work with social care colleagues to ensure they are included where relevant in the detailed plans.
- 4.6 Included in this work is also the review of the role of the community hospitals and the role they play in preventing admissions or facilitating earlier discharge. The plans will ensure that they include the community hospitals role in relevant pathway redesigns to ensure that they are used most effectively and most likely for patients requiring either step up/ step down care or rehabilitation.
- 4.7 The role of nursing and residential homes will also be examined as part of this strategy, including the development of an end of life strategy that aims to keep people in their own home (including where this is a nursing or residential home) if this is their wish. This includes support to the care homes from primary and community care to reduce admissions and building on the evidence from the Airedale Collaborative Community Team of the reduction in A&E admissions through the use of telemedicine in care homes.

## **5 Next steps**

- 5.1 The next stage of the work is for each of the NYY CCGs to consider the outputs from this review and map them against their existing strategic plans. Much of what is contained in this review here already exists within the local CCG plans but new themes identified need to be considered within the local context of the individual CCG and if appropriate added to the locality plans.
- 5.2 The urgency of delivery of new schemes must be judged alongside existing priority areas, to produce an overarching plan including key collaboration partners, timescales, milestones and outcomes.
- 5.3 The new combined CCG plans will describe the overarching strategic direction of North Yorkshire articulating clearly the diversity of locality, geography and clinical alliances that exist across the county.

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<sup>8</sup> Birmingham and Solihull presentation by Professor George Tadros (RAID Lead Clinician, Birmingham [http://www.dementiauk.org/assets/files/what\\_we\\_do/networks/liaison/RAID\\_Faculty\\_of\\_Old\\_Age\\_Psychiatry\\_17.3.111.pdf](http://www.dementiauk.org/assets/files/what_we_do/networks/liaison/RAID_Faculty_of_Old_Age_Psychiatry_17.3.111.pdf) as accessed on 6 December 2012

<sup>9</sup> Economic evaluation of a liaison psychiatry service; Michael Parsonage and Matt Fossey, Centre for Mental Health



- 5.4 County wide co-operation will exist on projects which span more than a single CCG: this will be particularly important on issues which affect or include strategic partners such as North Yorkshire County Council, Yorkshire Ambulance Service NHS Trust and local mental health Foundation Trusts.
- 5.5 Local and county wide plans will need to determine if the strategic themes and detailed pieces of work require any investment or pump priming.
- 5.6 An important aspect of the future work programme will concern closer collaboration between York and Harrogate NHS Foundation Trusts. York and Harrogate NHS Foundation Trusts already have well established Clinical Alliances in place across a number of clinical specialities. This has enabled local expertise to be maintained in North Yorkshire and a full range of services to be provided between the two providers with commissioner support for service models developed. In order to take this work forward, both organisations are committed to continuing to use this approach to deliver service change. This will enable further opportunities to maximise efficiencies and deliver changes in the way services are delivered to the population of North Yorkshire. Over the next 6 months a detailed work programme will be agreed and work streams identified to take forward key actions.
- 5.7 This programme will be regularly monitored through the Clinical Alliance Board which has Chief Executive, Executive Director and Clinical Director representation across both provider organisations and which will also in the future liaise with local CCGs. In addition, both Provider Trusts will continue to work in partnership with commissioners on whole system activities, for example the future role of the community hospitals, use of telemedicine and patient decision aids. Existing Provider discussions with neighbouring Commissioners and Providers in Leeds and Hull will also inform the work agenda.
- 5.8 The initiatives described in this review work will help address the forecast deficit and will help restore financial balance to the community. The schemes will deliver financial savings to commissioners and will deliver financial efficiencies for service providers. This is entirely consistent with the national efficiency requirements currently faced by the NHS.
- 5.9 As highlighted in the context to this report, there are a range of issues which are very current and which need to be fully assessed and worked through as part of the next stage of this work. The most significant ones are as follows:
- The latest financial allocations to CCGs for 2013/14.
  - The impact of the planning assumptions and framework in 'Everyone Counts'.
  - The impact of the second Francis report due imminently – this in particular may set out recommendations for quality which may have profound implications on the way services can be reconfigured for the future. It may also have significant resource implications.
  - The financial position and residual issues inherited by the CCGs from the PCT on 1 April 2013.



- The agreement of activity levels between commissioners and providers over the medium term to enable providers to plan for and ensure long term capacity.

5.10 While the vision and proposals in this report have the support of all the relevant participating NHS organisations, all of whom are committed to taking forward the relevant schemes for their locality, there is a considerable degree of interdependency. Hence the ability of FTs to remodel services, for example, depends in part on the ability of GPs and the CCGs to remodel primary and community services to manage patient demand more effectively. Similarly the ability of CCGs to invest further in community services which need to form a major plank of the strategy, depends on the ability to release costs from the acute hospitals through having a lower bed base.

## **6 Programme governance structure**

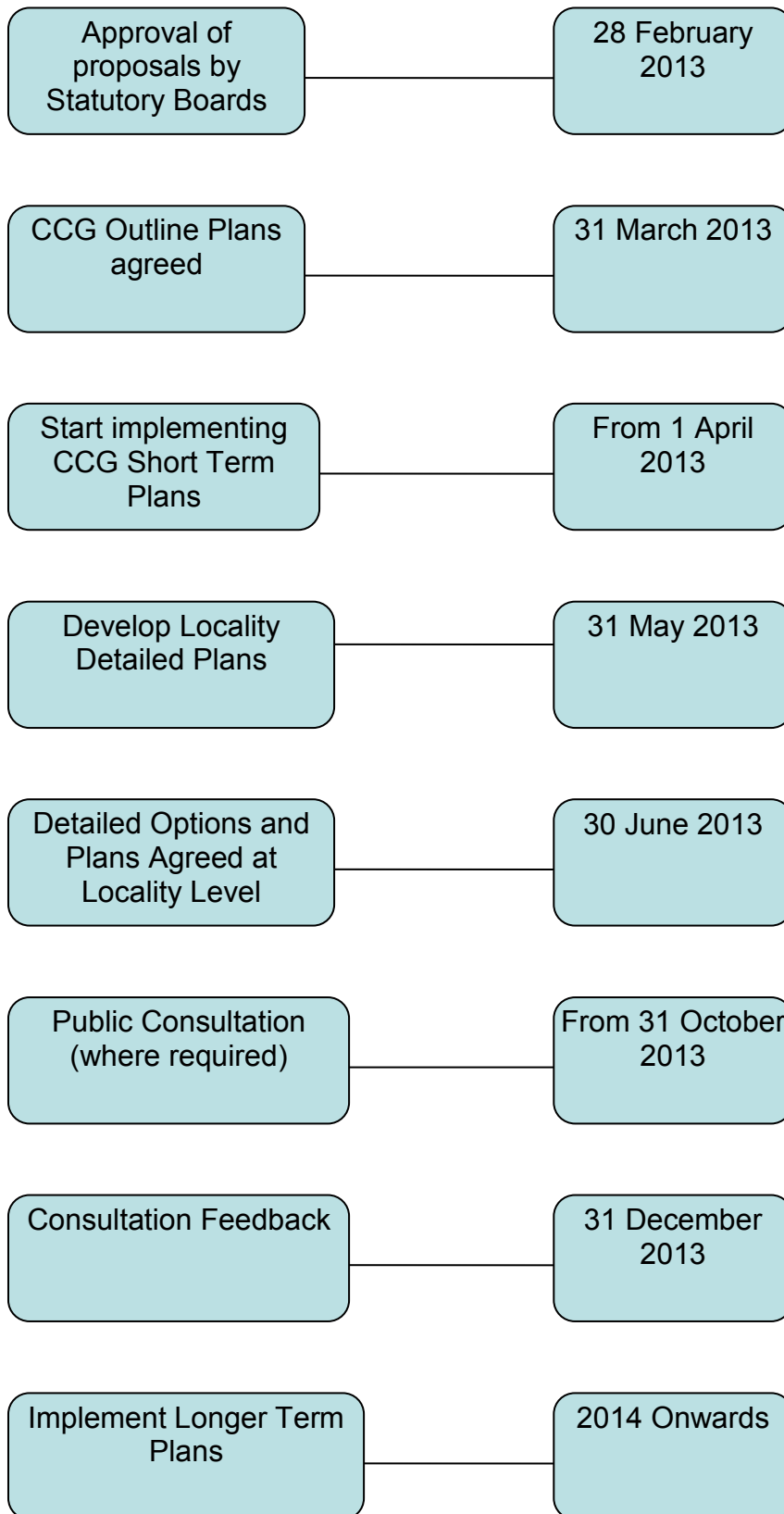
- 6.1 A robust governance structure is required to ensure pace and delivery of this work. This will be led by the Chief Executives forum that commissioned and approved this report.
- 6.2 The operational delivery of the majority of the work will be at local CCG level. Therefore the governance structures need to reflect this and enable autonomy whilst ensuring oversight of the programme.
- 6.3 Each CCG will establish a Local Delivery Board to include local providers of health and social care and other stakeholders to oversee and drive forward the delivery of the plans.
- 6.4 An overarching NYY wide group with membership from all commissioning and provider organisations of health and social care will be established.
- 6.5 The Chief Executives Forum will be responsible for providing oversight and support as well as focus and ensuring progress. There may be additional groups providing support and capacity on finance and communications/engagement at both a county-wide and local level.
- 6.6 Some work may involve several CCGs and providers. It is suggested that a series of smaller task-focused multiagency delivery groups will be established where appropriate and will include membership from the commissioners and providers involved in the specific initiative. These groups will report jointly to the local Delivery Boards of the localities involved. Alternatively, the existing York/Scarborough and York/Harrogate Clinical Alliance Boards will be used, with senior management and clinical involvement from CCGs to drive the work.
- 6.7 The local office of the NHS Commissioning Board, the North Yorkshire and the Humber Area Team, will have two key roles. They are a major health commissioner in North Yorkshire for primary care and specialist services and will be included in delivery of the primary care elements of the review. They are also responsible for ensuring that local CCG plans are coherent and will sign off CCG operational plans. They also provide an assurance role in holding CCGs to account for the delivery of their plans.



## **7 Proposed timescales**

- 7.1 At this stage it is not possible to finalise a detailed timetable or confirm a critical path for all the actions that will be needed to ensure that this strategy is taken forward with the overall objective of getting the system into financial balance by 2014.
- 7.2 Where there is a possibility of a major service change, formal consultation will of course need to take place. Ideally consultation would need to take place later in 2013 if change is to be implemented during 2014. There are a series of milestones that need to be reached between January and November 2013 in order for the delivery of the service reconfigurations to be successful and the clinical and financial benefits to be realised within these timescales.
- 7.3 The first step is of course to get the agreement formally of all the Boards to the way forward set out in this paper. The PCT Board on 22 January is on the critical path. The second target date is to ensure that any public consultations that may need to be undertaken can take place in the autumn (possibly October to December 2013). There is a significant amount of analysis and development of clinical models to be undertaken during the next six month window if this is to be achieved.
- 7.4 The dates outlined in the critical path below are the indicative milestone completion dates for the next phases of work assuming this overall timeline is to be achieved.

**Proposed Timescales**





## 8 Conclusion

The work undertaken over the past few months, supported by KPMG, has set out a broad strategy across a wide range of areas. However, more detailed work is required over the next few weeks to turn these proposals into specific plans for change with timescales and costings. Some proposals may require formal public consultation before final plans can be firmed up. Others may be a continuation of existing plans which can be taken forward immediately as part of the operational plans of CCGs in the forthcoming financial year. All this work will now need to be taken forward by the new NHS structures post March 2013.

### Primary Care Trust:

Chris Long, Chief Executive, NHS North Yorkshire and York

### CCGs:

Amanda Bloor, Accountable Officer, Harrogate and Rural District CCG

Simon Cox, Accountable Officer, Scarborough and Ryedale CCG

Dr Mark Hayes, Clinical Chief Officer, Vale of York CCG

Dr Vicky Pleydell, Clinical Chief Officer, Hambleton, Richmondshire and Whitby CCG

Dr Philip Pue, Chief Clinical Officer, Airedale, Wharfedale and Craven CCG

### Foundation Trusts:

Patrick Crowley, Chief Executive, York Teaching Hospital NHS Foundation Trust

Bridget Fletcher, Chief Executive, Airedale NHS Foundation Trust

Professor Tricia Hart, Chief Executive, South Tees Hospitals NHS Foundation Trust

Richard Ord, Chief Executive, Harrogate and District NHS Foundation Trust

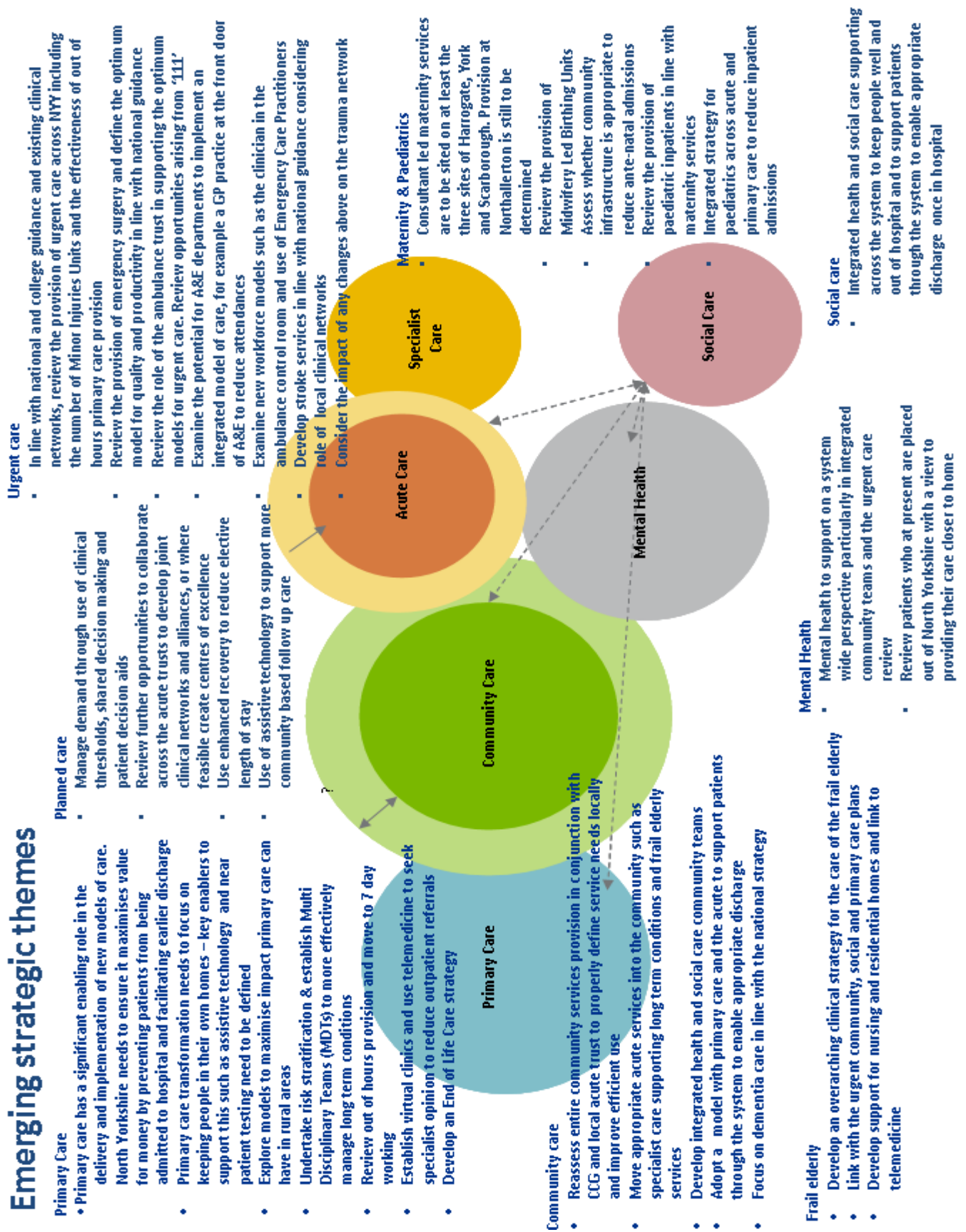
### Ambulance Trust:

David Whiting, Chief Executive, Yorkshire Ambulance Service NHS Trust



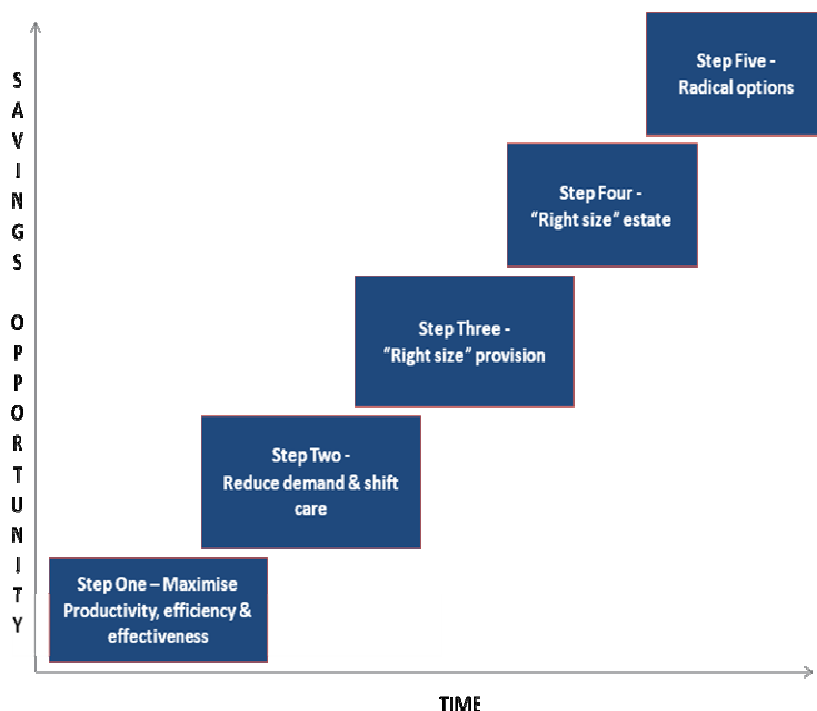


## APPENDIX 1 – Emerging Strategic Themes



## **APPENDIX 2 - Summary of approach**

1. The approach was facilitated by KPMG, who were commissioned by the health community to work in collaboration with them to support the understanding of the current pattern of service provision and the future financial impact of this by 2016/17. KPMG facilitated the clinicians and managers to develop a series of potential high level options that could maintain or improve the quality of services within the level of resources available.
  2. For this process to be successful, the approach was both “bottom up” – working with the clinicians in the locality clinical working groups – and “top down” – with a panel of experts facilitated by KPMG to provide examples from elsewhere to bring further challenge to the system leaders. This approach ensured that the views across the healthcare system have been captured and enabled over 150 clinicians and managers across all sectors with the opportunity to contribute.
3. Stepped Approach
- 3.1 A five stage or ‘staircase’ of stages provided the framework for potential options to be considered. The five steps are shown in the diagram below and then each of them is explained subsequently in more detail below:





### **3.2 *Maximise productivity, efficiency and effectiveness***

The first step examined the size of the opportunity if the providers move to the top 25% performing providers in the country (upper quartile) and/or the top 10% performing providers (upper decile) across a range of productivity and efficiency indicators. This also examines the potential size of the opportunity generated through centralising and/or outsourcing back office and/or clinical support services and maintaining a better grip on outgoings such as rent. It also examines the economies of scale generated through joint commissioning with the local authority.

### **3.3 *Reduce demand and shift care***

Step two considered and quantified the opportunities to shift care to a lower level of acuity (i.e. shift care out of acute hospital setting into community or primary care). This step examined the different options to reduce elective demand and also move more care into primary and/ or community care utilising enablers such as assisted technology where appropriate.

### **3.4 *“Right size” provision***

The third step then considered how care can be reconfigured across acute sites and across community hospital sites to “right size” hospital care. In NYY, as in many other health economies, there are elements of duplication and fragmentation across the provision of acute services. In line with national best practise guidance there is emerging evidence<sup>9 10</sup> that greater volumes of activity result in better quality and safety outcomes. This step considered these opportunities. In addition to quality improvements, economies of scale can also be achieved through the centralisation of services. This step examined opportunities in maternity, urgent care, stroke, community services and planned care across a range of specialities.

### **3.5 *“Right size” estate***

On the back of steps one, two and three, step four then considered where there were opportunities to reconfigure or rationalise the estate across NYY. The estate requirements are driven by the clinical strategy and service provision model and once services are centralised or demand reduced, then the estate requirements change in line with the new requirements. This step also examined the community hospital infrastructure and the role of the community hospitals within a pathway of care.

### **3.6 *Radical options***

This final step is a catch all and considered any further more radical options that could be undertaken such as a radical reduction in the acute bed base based on techniques such as telemedicine and also “bed-less” hospital



models such as in Washington USA or the Abingdon model in Oxford<sup>10</sup>, and the Germantown Maryland stand-alone Emergency Room (which saw 22,000 patients with no inpatient beds the year it opened in August 2006 with 95% of all patients being seen, treated and discharged).<sup>11</sup> Also, where the clinical working groups generated really radical options such as build a new hospital, these were also included under this step.

#### 4. **Process**

- 4.1 A number of workshops were held with a wide range of stakeholders, to shape the high level strategy and emerging strategic themes. For instance, to ensure strong frontline clinical input, a number of clinical working groups were run in each of the CCG locality areas. These generated options which broadly fell into the categories for steps 1 -3 in the majority of cases.
- 4.2 To generate more radical thinking, the KPMG Expert Panel (Professor Nigel Edwards, Professor Marc Berg, Professor Hilary Thomas and Andrew Hine from KPMG) held a challenge session with the system leadership to increase the thinking around more radical options.
- 4.3 The outcome of all the engagement activity was the generation of the clinical services strategy and the emerging themes to take forward. A number of enablers to ensure delivery of the work were also identified, as outlined below:
  - Seven day working across all health and social care sectors. It is recognised that it might be a challenge in some areas, such as primary care, where there is a national contract.
  - Increased use of assistive technology and where appropriate, shared care records.
  - Strategic collaborative commissioning across the NYY footprint for areas such as frail elderly, to have a single approach (eg Comprehensive Geriatric Assessment to support community teams).
  - New medical and nursing workforce models, including new specialist roles working across acute and community, Enhanced Care Practitioner, and create roles such as Home Care Workers to care for ventilated and stoma care patients
  - Local tariffs (eg year of life tariff for certain specialties /conditions)
  - Enhanced capacity and capability in primary care
  - The Directory of Services within the new urgent care 111 number (from March 2013) which provides an opportunity to manage urgent care needs closer to home and reduce the need for a hospital attendance.
  - Development of mental health urgent care liaison model (RAID) in both acute A&E and community hospitals to support the early discharge of patients with dementia and other mental health diagnosis (as part of the urgent care strategy and to reduce length of stay).

<sup>10</sup> Professor Nigel Edwards Expert Panel presentation 25 October 2012

<sup>11</sup> Report on the operations, utilization and financing of freestanding medical facilities; Maryland Healthcare Commission, 18 February 2010