Public Document Pack Shropshire Council

Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 6 August 2013
My Ref:
Your Ref:

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Thursday, 8 August 2013**
Time: **1.30 pm**
Venue: **The Wrekin Room - Business Development Centre**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Joint Health Overview and Scrutiny Committee

Gerald Dakin	Beechey
Tracey Huffer	Hulme
Simon Jones	Thorn

Your Committee Officer is:

Tel:
Email:

AGENDA

1 **Minutes of the meeting held on 27 March 2013** (Pages 1 - 12)

2 **Apologies for Absence**

3 **Declarations of Interest**

4 **Sustainable Clinical Services Strategy** (Pages 13 - 40)

NHS England will present the document 'The NHS Belongs to the People – A Call to Action' and local NHS leaders will make a presentation setting out the issues facing the health and care economy, the need for change and the process they will develop to achieve this.

5 **Update on 111 Service**

To receive a verbal update on the provision of the 111 service in Shropshire and Telford and Wrekin.

6 **Update on Stroke Services**

To receive a verbal update on the temporary transfer of hyper acute and acute stroke services.

7 **Joint HOSC Work Programme**

The Committee will consider and agree the issues they want to scrutinise during 2013/14.

Committee and Date	Item No
Joint Health Overview & Scrutiny Committee 8 August 2013 1.30 p.m.	**A** Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE TASK AND FINISH GROUP MEETING HELD ON 27 MARCH 2013

10.30 A.M. – 12.50 P.M.

Responsible Officer Fiona Howe
Email: Fiona.howe@shropshire.gov.uk Telephone: 01743 252876

Present

Shropshire Council:
Gerald Dakin (Chairman), Karen Calder, and Co-opted Members David Beechey, Ian Hulme and Mandy Thorn.

Telford and Wrekin Council:
Derek White, Veronica Fletcher, John Minor and Co-opted Members Dilys Davis and Jean Gulliver.

In Attendance

Peter Herring, Chief Executive (SaTH)
Adrian Osbourne, Communications Director (SaTH)
Kate Shaw, Programme Manager, (SaTH)
Carol McInnes, Head of Programmes & Service Redesign (Shropshire County CCG)
Dr Julie Davies, Director of Strategy & Service (Shropshire County CCG)
Tracey Jones, Lead Commissioner Service Improvement (Telford CCG)
Michelle Brotherton, General Manager, WMAS
Barry McKinnon, WM Area Manager, WMAS
Fiona Howe, Committee Officer, Shropshire Council (SC)
Fiona Bottrill, Scrutiny Officer, Telford and Wrekin Council (TW)

33. APOLOGIES FOR ABSENCE

Apologies were received from Tracey Huffer (SC) and co-opted member Richard Shaw (TW).

34. DISCLOSABLE PECUNIARY INTERESTS

None had been disclosed.

35. MINUTES

RESOLVED:
That the minutes of the meeting held on 28 November 2012 be confirmed as a correct record.

36. FUTURE CONFIGURATION OF HOSPITAL SERVICES

The Chief Executive of Shrewsbury & Telford Hospital NHS Trust addressed the meeting providing an overview of the future configuration of hospital services.

Surgery had been consolidated in July 2012 in order to improve vascular surgery and as a result the Trust had been reported as the best provider in the West Midlands Cluster. Members were advised that care audits and quality were broadly stable, but there were capacity challenges on planned care and they were having an impact on the patient experience.

Head & Neck services were now sited in a fit for purpose environment receiving positive feedback from staff, patients and visitors of the new facilities at Princess Royal Hospital. The Trust had received a score of 100% from patients in response to the net promoter question, as well as receiving positive media coverage for radio interview and newspaper features. Members were advised that the staff involved in the Head & Neck Services move had recently received the Chairman's Award for their hard work and commitment.

Development work for Women's and Children's Services was on scheduled and due to complete in the Summer of 2014. The Trust was looking at phasing in moves in the context of current demand for emergency care and detailed work plans were being developed for Women's and Children's Services and the wider Trust.

Work at the Royal Shrewsbury Hospital site was planned to commence in July 2013 to create the Children's Assessment Unit and the Children's Outpatient Department, and work was progressing at pace.

Clinical and staff engagement work was ongoing with the detailed implementation of pathways, workforce, training, equipment and offices, and weekly team meetings with an open invitation to all members of staff to attend, with specific consideration of gynaecological issues. Other methods of staff engagement included a weekly 'Gossip Group', a weekly written update in 'The Future This Week', monthly focus groups, Centre to Centre workshops, clinical working groups and specific priority Task and Finish Groups.

Patient and public engagement was continuing through patient and public focus groups where specific consideration had been given to neonatology and younger women. A range of other events were also ongoing including promotion of the Trust's work through community groups and Local Joint Committees, meet the builder events, builder's hard hat competition, a photography competition in conjunction with Shrewsbury and Telford's College of Arts and Technology. A workshop was being planned in May to consider the Rainbow Unit legacy including working with patients and children to create glass tiles.

The Travel and Transport Plan was progressing and in response to concerns raised by the Joint HOSC the Trust had been developing partnership working with both Local Authorities to provide an enhanced service provision. The organisations had agreed to jointly fund a Transport Co-ordinator post, develop new cycle routes, and discussions were ongoing over the development of a 'Collector Bus' in Telford and Shrewsbury to assist staff in getting to both sites. Staff would also be encouraged to make use of Oxon Park and Ride with the introduction of an extended bus loop. The Trust was in the process of seeking tenders for the cross-site shuttle bus, and continued to work with WMAS, WAS, and NSL over emergency travel and patient transfers, and following discussions with clinicians on pathways, protocols and procedures the new models would commence in the Spring.

The Chief Executive confirmed that staff, patient and public engagement would be ongoing throughout the reconfiguration process, and the Trust would continue to develop workforce plans and staff training, and the implementation of modified staff rotas across the Trust. It was envisaged that the Trust would launch a communications campaign towards the end of 2013 to ensure patients and the public were fully aware of the changes to services through the reconfiguration process. Work had been undertaken with Greater Manchester NHS Trust to identity appropriate models and tools as they had already completed a successful reconfiguration process. It was noted that work on the new Women's and Children's Unit at the Princess Royal Hospital site was on target for completion in Summer 2014, along with the Children's zone at the Royal Shrewsbury Hospital site. The new Women's Zone would now open later than originally planned as the refurbishment work would commence following the move of gynaecology to Princess Royal site.

Members asked a number of questions, and expressed a number of comments, including:

Could the Trust confirm what services would be sited in the Women's and Paediatric Unit at the Royal Shrewsbury Hospital site.
Response – It was the intention to develop the space into front end office capacity, and ensure that clinical services were at the heart of the hospital and that offices were situated in the outer buildings. It was noted that in the future the Rainbow Unit would be used for training staff, with a focus on children.

The joined up working between the Local Authorities and the Trust and the creation of a Transport Co-ordinator was a positive move. Could the Trust provide more detailed information on progress.
Response – The ongoing partnership work had been seen as a sensible and positive approach, and once an officer was in post it was agreed that all parties would attend to update the Joint HOSC on developments. It was expected that this would come back to the Committee within the next 12 – 18 months.

Has consideration been given to linking up with the Redwoods Centre.
Response – All organisations were involved in discussions to ensure that the best use was made of the services.

Were staff available to undertake children's surgery on none core days.

Response – A lot of work had been done around core days, dedicated lists, and head and neck services and if cases were straight forward they would be placed on the afternoon lists, and more difficult cases would be taken in the morning. The Trust was working with clinicians and booking clerks to develop the system.

RESOLVED:
That detailed consideration of the Travel and Transport Plan be brought back to a future meeting.

37. PLANS AND PRIORITIES FOR THE YEAR AHEAD

The Chief Executive of Shrewsbury & Telford Hospital NHS Trust addressed the meeting providing an overview of the Trust's plans and priorities for the future.

Francis Report
Mr Herring reported on the findings of the Francis Report in respect of culture and failings at Mid Staffordshire. The main points focused on the lack of openness, defensiveness, parochial behaviour, secrecy and poor standards were accepted. Changes in culture were needed to ensure an emphasis was put on common values and regular monitoring of standards. Strong leadership was needed in all areas, and support for those leadership roles. The Government had published its initial response to the Francis Report, which detailed actions to ensure that patients were the first and foremost consideration of the health and care system. Five themes had emerged including; preventing problems, detecting problems quickly, taking action promptly, ensuring robust accountability, and ensuring staff were trained and motivated.

It was essential that the Trust was a values driven organisation, and a caring nature was a key component. Engagement with staff was ongoing to agree a care framework of expected standards including attitude, caring and competence in technical skills. The Trust was strengthening its partnership with Staffordshire University and developing nursing education, qualifications and care. Patient experience and Involvement Panel was bringing patients and carers to the heart of the Trust's approach to patient experience, with members integrally involved with ward reviews, visits, concerns and complaints.

Members raised a number of questions, including:

It would take a strong management team to openly identify faults, but it was essential to listen to staff concerns.
Response – The Trust had a mechanism in place to gain intelligence and to list to staff and the public, and they take all concerns very seriously and respond by rectifying issues going forward.

The Board had a corporate responsibility to ensure the care framework of expected standards was being delivered across the Trust, and although they were making planned ward rounds and speaking to patients, they should also undertake unplanned visits to gain an accurate picture.

Response – Members were advised that the Board undertook planned and unplanned ward visits to take feedback from patients and staff in person. It was recognised that it was very important to implement multiple routes and methods to deal with risks and issues, and the Board needed to ensure the Trust was safe and sustainable.

Discussing a patient's experience whilst in hospital would fail to provide accurate outcomes and it was more appropriate to gain the information post discharge.
Response – Feedback on independent assessment work was ongoing with Keele University and there was a need to be aware that a patient may not be in a position to respond during care, and a national mandate was in place advising that information should be gathered post treatment.

In response to a question, it was noted that work was ongoing with Keele University to develop multidiscipline training for nursing and medical personal. It was intended to bring all training together including medical education in a holistic approach. Leadership development training was also required to ensure the Trust's standards were maintained. Mr Herring stressed that unacceptable levels of care would not be tolerated and Ward Managers would be best placed to identify failings, which is why it was seen as key that the Trust developed leadership skills for their staff.

What plans were in place for future staffing to ensure inappropriate care cultures were eradicated from the Trust. Members presented anecdotal evidence of patients receiving unsatisfactory care standards whilst as an inpatient in Ward 10 at Princess Royal Hospital.
Response – It was stressed that the Trust had a zero tolerance to unacceptable standards of care through continued monitoring, and individuals would be held to account. The Trust would continue to learn from complaints as they helped monitor issues. Mr Herring stressed that they would not be able to change care culture overnight, and that a series of mechanisms were in place to ensure the required standard of care was in place. It was noted that the process needed to move forward at pace and was the Trust's top priority.

Dr Julie Davies addressed the Committee advising that it was a priority for providers and commissioners to respond to the Francis report findings. The CCG wanted to work with patients and patient groups and look at other routes to highlight issues where patients were unwilling to complain.

Successes and Challenges in 2012/13
The Trust had received financial support for the implementation of the Full Business Case and had completed the first phase of the reconfiguration work with the move of Head and Neck, the opening of a Surgical Assessment Unit at Royal Shrewsbury Hospital, and the commencement of building work for the new Women's and Children's Unit at Princess Royal Hospital. They had seen significant improvements in VTE and in-hospital mortality rates, no reported MRSA cases in the past 12 months, had launched a Frail and Complex Service, and had seen the opening of the Lingen Davies Cancer Centre.

The greatest challenges the Trust had, and continued to encounter, was the increase in attendance. This was a country wide issue but the Trust had recorded some of the

highest figures, and capacity issues were continuing to create problems. With current figures it was estimated that there was a shortage of 70 beds, but increasing the number of acute beds was not a long term answer to the growing problem, and instead the Trust was working with partners to develop a new model of care to address the capacity issues. The cancellation of day lists had been highlighted recently which were unacceptable but unfortunately necessary to maintain safety for patients requiring emergency treatment. A major in-year improvement to address the 18 week backlog had been undertaken, but a sustained position had not been achieved and elected surgery numbers had slipped. Unacceptable level of grade 3 and 4 pressure ulcers continued to be issue, and the Trust continued to be an outlier in the number of reported Serious Incidents.

The Trust had aimed to develop a high level vision and strategy putting patients first for the year ahead by seeking feedback from patients, the public and staff, reflecting the expectations of their commissioners, benchmarking themselves against other organisations to understand what they did well and where they needed to improve, and holding workshops with their clinical centres to engage frontline staff in shaping the overall plans for the Trust. The intention was to develop an environment which was well led and motivated with key priorities to work on. There were still financial challenges for the Trust and it was stressed that any future plans must be built on firm foundations.

In response to concerns raised over grade 3 and 4 pressure ulcers Members were informed that through the Quality and Safety strategic priorities all avoidable pressure ulcers were be eradicated during 2013/14. Part of the Healthcare Standards strategic priority was to ensure that bed capacity met demand and improved timely flow of patients, but until the current issues over the capacity gap were resolved they would not be in a position to move on.

A ‘Vision for Healthcare’ strategy would be developed for acute hospital services and wider partners. This would address challenges, maintain safe staffing levels, plan for future demographic, and develop efficiencies and productivity.

In response to a question, Members were advised that A&E clinical teams were working through options and would discuss the outcomes with the CCG before going forward with engagement with the wider public and stakeholders. The process had highlighted that it was essential that each facility had good access, adjacent clinical dependencies and provide the best care for assessment.

Members were advised that the next steps in the process would be to work with key partners on the shared vision. The Trust would be learning from other national examples, but stressed that the large geographical and rural nature of Shropshire meant that it would need a unique model. Significant discussions would need to be undertaken with clinicians, including GPs, and commissioners on the process and map up engagement process to develop an integrated service strategy approach.

The Chairman invited the Trust to bring the plan back to a future meeting of the Joint Committee.

In response to a question, Mr Herring advised that the 11% increase in presentations for the acute could not be identified to any single trend or condition, but highlighted the issue that Shropshire had a growing elderly population and more people were living longer with complex treatment needs. Members raised concern over long waiting lists, cancellation of day lists, poor performance in A&E targets, and low staff morale. Members recognised that their concerns were not isolated to Shropshire and were being experienced country wide, but may have been compounded by surgical services being relocated to Royal Shrewsbury Hospital. There were also issues with ambulance turnaround times with delays taking on average 3 units out of service each day. The Francis report was also critical of scrutiny's role and stressed the importance of receiving information from the Trust directly and in a timely manner. Members advised the Trust that addressing A&E was not just for SaTH but the whole health economy and stressed the need to work in partnership to resolve the issues affecting Shropshire. The Chief Executive advised Members that they would not hide difficulties and were already working with the Community Health NHS Trust and other partners to develop a model for the whole health economy. It was noted that the Trust expected to resolve the capacity issue within the next few months.

A member of the Committee raised concern over inappropriate GP referrals when other, more appropriate pathways were available to patients. Mr Herring advised that inappropriate referrals were an issue.

In response to a question raised by a member of the Committee, the Communications Director confirmed that information contained in the tabled reports around patient observations related to ward to ward experiences and patient matrixes. The information would be considered at the Trust's Board meeting on 28 March 2013, which members of the Committee were invited to attend.

The Chairman thanked the officers for their attendance.

RESOLVED:

(a) That Joint Health Overview and Scrutiny Committee endorse and support the work of Shrewsbury and Telford Hospital NHS Trust.

(b) That consideration of the Vision for Healthcare strategy be considered at a future meeting.

38. WEST MIDLANDS AMBULANCE SERVICE

Consideration was given to a verbal update from representatives of the West Midlands Ambulance Service [WMAS].

Ms Brotherton, General Manager WMAS, and Mr McKinnon, Area Manager WMAS, were in attendance. Mr McKinnon addressed the meeting advising that in the Autumn 2011 the WMAS Executive Board set out their plan for the future for the West Midlands region, and following consultation the first phase of 'Make Ready' was implemented in April 2012 in Hereford and parts of Shropshire, with the system going live across the county in October 2012. The Trust had identified hubs based in Donnington and Shrewsbury where ambulances would be cleaned and stocked, and

there would be paramedics out in the community where demanded had been identified. Sites had been confirmed in Bridgnorth, Craven Arms, Ludlow, Market Drayton, Oswestry, Tweedale, and Whitchurch. Patients who had previously been left uncovered by the service now had the benefit of a paramedic vehicle attending and remaining in the area 24/7, with an ambulance moving the patient if required. It was noted that the Trust had created additional response posts, 3 in Telford and 3 in Shrewsbury, which were manned by rapid response staff, and ambulances were deployed across the county from the bases. It was noted that each community site was able to accommodate a crew and vehicles 24/7.

A Member requested clarification on travelling time for an ambulance once a paramedic had responded to a call. Mr McKinnon advised that ambulances were deployed across the county, and based on criteria of condition an ambulance would be sent at the same time as the community paramedic vehicle. It was noted that ambulance crews were not always sent to a call in the first instance, but may be required following a paramedic assessment. Members were advised that approximately 35 – 50% of patients don't require conveying to an acute provider. On average response times were 17 minutes for Shrewsbury and 12 minutes for Telford, but there were issues with delays in more rural areas. WMAS raised concern over a 11% increase in demand for Shropshire, with Hereford and Worcester seeing at 10% increase in demand for services.

The service had experienced delays in turnaround times at acute hospitals across the county indicating that on average they were losing 70 hours a month in handover delays, and recently had seen a spike of 130 hours in the last month. The Trust was working with SaTH and the CCG to improve the situation, but no specific trend had been identified to explain the increase in demand.

In response to a member of the Committee, Members were advised that the Trust had worked with experienced officers in Staffordshire and taken on board their advice when rolling out Make Ready across Shropshire. The Trust had seen a 3% improvement with the resources they current had, but the independent Lightfoot report indicated that Shropshire could only achieve key 'Red 8' targets of 66 – 68%, but they were achieving 72% on average. Once the Make Ready system went live across the whole of Shropshire they achieved over 75% on target.

Concern was raised by Members over the continued failure by WMAS to reach targets in the rural areas of the county. They were advised that on average they were achieving 75% on 'Red 8', but the Trust appreciated the concerns and they would look to community first responders to areas where they were not able to achieve an 8 minute response time. The Trust was working with Commissioners to improve ambulance support in response to the increases in service demand. Dr Davies addressed the meeting advising that funding had been increased by £1.15m in 2012/13, however as a rural health economy Shropshire failed to get the appropriate weighting for funding, but commissioners, local authority and WMAS were lobbying for increases in rurality funding. The CCG and WMAS met monthly to look at demand by postcode, and worked with primary care and GPs to improve patient pathways.

In response to a question, Members were advised that WMAS were not currently part of the compact, which was made up of SaTH, Community Health NHS Trust, Mental Health providers, CCG and Local Authority. It was noted that as the compact progressed more partners would be involved over time. Members stressed the importance of WMAS as a partner and Dr Davies agreed to take the request back to the CCG for further consideration.

A discussion ensued on the benefit of HALO being reintroduced in Shropshire to help improve ambulance turnaround times, and although the WMAS indicated they wanted to start discussions with the CCG over the valuable provision, there was a funding disagreement across the West Midlands in respect of HALO provision and although the CCG agreed that a safety and timely handover was essential, both the CCG and WMAS would be attending an executive meeting with SaTH to pick up the key issue.

Members were advised that Shropshire was currently working on a pilot project with GPs working within Shropdoc to assessment patients to negate the need for them to attend A&E. The outcomes from this work were encouraging as they had seen an improvement to impact across the health economy.

A member of the Committee stressed the need for the ambulance service to ensure provisions were in the right locations for demand and consider joint locations with partners such as Fire Service, Police, and Community Hospital sites. In response, it was noted that that locations had been mapped on historic demand and the Trust had worked with partners to locate community sites in shared facilities where it was appropriate, and cost effective. There was also uncertainty over services and realignment of the police service. Members were assured that the Trust was always reviewing sites and would work with partners when opportunities arose. A suggestion was made to consider working with supermarket developments in the future as they could also be identified to help with costs.

Concern was raised over the dramatic increase in service demand. In response, Dr Davies reported that Commissioners had been unable to identify a specific trend or issue which would explain the significant increase in service demand, but indicated that they would be happy to take the matter back to providers and bring back data providing a summary of reasons for admission, but they stressed that this would not provide any helpful conclusions.

In response to a question, Mr McKinnon reported that Hereford had seen a 10% increase in demand, but their modelling targets had gone from 75% to 80% since the introduction of Make Ready. Ms Brotherton reiterated that since Make Ready was implemented fully across the county an advanced paramedic had been ringfenced to an area on a 24/7 basis unlike pre Make Ready where many areas were without a rapid response facility. It was noted that with the introduction of advanced paramedics, conveying patients to hospital had dropped by 57% as they were using more appropriate pathways to treat patients.

The Chairman thanked the officers for their attendance but highlighted the concern raised by the Committee over the response times for Shropshire and indicated that they would wish to see improvements to response times in rural areas.

39. STROKE SERVICES REVIEW UPDATE

Consideration was given to a presentation of the Head of Programmes & Service Redesign, Shropshire County CCG.

Members were advised that the Strategic Health Authority announced a regional stroke review in January 2012 to develop stroke specific standards. These were divided into 7 phases across the whole patient pathway (primary prevention – end of life care). The review considered 3 specific areas including; providing rehabilitation, early supported discharge in a home environment, and Hyper Acute Stroke Unit siting. It had been identified that a minimum of 600 patient flow was required to act as a Hyper Acute Stroke Unit (HASU), which would result in a single site service for Shropshire. Each regional area was tasked with developing a model that met the standards within the specification, and a project group was convened to undertake a non-financial option appraisal of HASU/ASU options, with a preferred clinical model for a single HASU/ASU for Shropshire County being submitted in February 2013.

The results demonstrated that it was both financially and physically viable for the service to be hosted on either site and with SaTH undergoing a wider reconfiguration of services across its two sites with particular focus on the sustainability of its emergency services, the decision around a single site HASU/ASU could not be taken in isolation. It was noted that quality and equality of access was paramount to patient safety and therefore other key issues were taken into account include demand on the Royal Shrewsbury Hospital site and travel times for patients in Powys. The preferred approach would be to have a single public consultation on the wider clinical strategy including Stroke and it was anticipated that the process would commence in September 2013 which would allow for effective planning and would ensure full engagement of both Local Authorities. The timescale for implementation would not be before April 2014. It was noted that late scores needed to be incorporated but the broad agreement was for a single site unit. The CCG were waiting to receive feedback through the legacy document which would highlight the learning over the last 12 months and recommend next steps. It was confirmed that once the full appraisal summary was available the CCG would be able to share the information with the Committee.

Members stressed the importance of retaining a service in Shropshire and following a recent visit to the sites were assured that either site would be suitable for a HASU/ASU, and it was important to provide a direct access facility. Members were advised that a decision had not been made on site location, but once the legacy report with recommendations had been received they would be in a position to feed into the wider reconfiguration process, but the SHA had indicated that the decision on location would be a local commissioning decision.

Concern was raised over demand on wider services at Royal Shrewsbury Hospital taking into account the increased demand for A&E and admissions. Ms McInnes stressed that all aspects would be taken into account, but no decision on location had been taken.

The Chairman thanked the officers for their attendance.

RESOLVED:
That the Joint Health Overview and Scrutiny Committee feed into the consultation process and monitor progress.

40. CHAIRMAN'S UPDATE

The Joint Chairs reported on the recent visit to the 111 Call Centre in Dudley where many of the concerns raised by the Committee had been considered and assurances received. Following the soft launch in March 2013 the system failed to cope with capacity and as a result Shropshire was being covered by Shropdoc 'out of hours' provision which had been retained. Dr Davies confirmed that the issues affecting the service were temporary and that Shropdoc had formally been requested to continue call handing for a further 3 months, whilst the regional team fully explored the situation.

Members concluded that NHS 111 provision, as a national government concept, would be implemented in some form, but it was an important opportunity to consider a local model. In response Members were advised that the Joint Project Board would continue to look at options to maintain a good service for residents across Shropshire.

In response to a question, Dr Davies confirmed that the formal contract would be reviewed regionally and local costs would be identified.

Chairman:……………………………………..

Date:…………………………………………...

This page is intentionally left blank

Working with patients and communities in Shropshire and Telford & Wrekin to shape the future of the NHS

Shropshire Clinical Commissioning Group and Telford and Wrekin Clinical Commissioning Group will be implementing, at a local level, the NHS England call to action to encourage the public and staff to joint in a nationwide discussion about the future of the NHS.

This "call to action" will set out the facts about future demands on NHS services, how the budget is currently spent and how services are delivered.

Useful References:

- **Shropshire CCG Mandate 2013/14 – available from www.shropshireccg.nhs.uk**
- **Telford & Wrekin CCG Mandate 2013/14 – available from www.telfordccg.nhs.uk**
- **NHS England's Business Plan – "Putting Patients First" is available from www.england.nhs.uk**

The NHS needs to be able to deal with challenges ahead, such as an ageing population, a rise in the number of people with long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends threaten the long-term sustainability of the health service.

Without changes to how services are delivered, a high-quality yet free at the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.

This does not mean cutting core NHS services, or charging for them. The NHS in England is governed by the NHS Constitution, which protects the principles of a comprehensive service providing high quality healthcare, free at the point of use for everyone.

Useful References:

- **"The NHS Constitution for England" sets out rights and responsibilities for patients, staff and organisations. Find out more at www.nhs.uk/constitution**

The constitution also says that the NHS belongs to the people and so does its future. In keeping with this principle, NHS England and local Clinical Commissioning Groups will be working together with staff, patients and the public to develop a series of new local approaches for the NHS.

That is why there is a call to action now. This is your opportunity to have your say about the future of the NHS and to ensure that the ideas identified are sustainable and respect the values that underpin the NHS.

NHS England has published a national document called **"The NHS belongs to the people: a call to action"** to share information and stimulate debate about why the NHS needs to change. It is based on the principle that the more people share their views and ideas on the future of the NHS, the better the service will become. Locally CCGs will be publishing local information alongside this to encourage debate in Shropshire and Telford & Wrekin.

Useful References:

- **"The NHS belongs to the people: a call to action" is attached and also available from www.nhs.uk/calltoaction**

All feedback will help NHS England and Clinical Commissioning Groups (CCGs) to inform future commissioning decisions and medium-term strategic plans.

How will the Call to Action engage with people?

The underlying principle for both Clinical Commissioning Groups is to ensure “No decision about me without me”, supporting everyone within our communities to join the debate and help shape the future.

NHS England has identified a number of ways for everyone to engage with the development of a renewed health service, including:

- **A digital call to action** - One way you can contribute is via the **NHS Choices website at** www.nhs.uk
- **Via your local Clinical Commissioning Group -** Later this year local Clinical Commissioning Groups will be inviting their communities to actively engage in the process of improving the NHS.
- **Future of the NHS events with NHS staff, patients and the public** - Take part in one of the local engagement events led by CCGs, health and wellbeing boards, local authorities and other local partners such as charities and patient groups. These workshop-style meetings are designed to gather views from patients and carers, local partner groups and the public.
- **Town hall meetings** - There will be regional events across England, which will engage local government, regional partners, businesses and the public. These regional events will give people who have not had a chance to contribute locally the opportunity to participate in regional discussions.
- **National engagement events -** There will also be a number of national events focusing on national level partner organisations to the NHS. These will include Royal Colleges, patient groups and charities, the private sector and other stakeholders.

The initial route for feedback will be via NHS Choices.

Local CCGs will complement these plans and in the coming weeks will outline the range of opportunities available to the local communities to engage and have their say about the development of a renewed health service.

What happens next?

"A call to action" is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. NHS England has described it as the broadest, deepest and most meaningful public discussion that the service has ever undertaken". The engagement will be patient- and public-centred through local, regional and national events, as well as through online and digital resources. It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how services will improve.

The call to action aims to:

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future.
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures.
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans.
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 – 10 years.

We will be developing more details plans for the Call To Action process over the coming weeks, but we currently expect this to include:

- Summer / Autumn 2013: Develop a comprehensive programme of engagement across Shropshire and Telford & Wrekin
- Autumn / Winter 2013: Deliver a Call to Action engagement programme that provides all patients and communities with the opportunity to take part and help shape the future of their NHS
- By February 2014: Publish 3-5 year commissioning plans and a longer-term shared vision for the future of the NHS in Shropshire and Telford & Wrekin.
- By Summer 2014: Consult on our shared vision and agree a way forward to secure the best health services now and for future generations.

"The NHS is one of our most precious institutions. We need to cherish it, but we also need to transform it. Future trends threaten its sustainability, and that means taking some tough decisions now to ensure that its future is guaranteed. We believe that by working together as a nation, we have a unique opportunity to transform the NHS into a health service that is both safe and fit for the future."

Your NHS needs your help. Have your say.

Why is the Call To Action important for Shropshire and Telford & Wrekin?

The principle of the Call To Action is that our patients, communities and clinical staff should tell us why it is important. Some suggestions of the critical questions we need to ask include:

- How do we make sure that we keep our range of services in the county and reduce the risk that they will move out of the county to specialist centres elsewhere?
- How do we make sure that all patients have timely access to planned care and emergency care now and in the future?
- How do we make sure that health services and social care work together to meet the needs of the individual – ensuring integrated care pathways?
- How do we address the challenges ahead without this having an adverse impact on the most vulnerable and frail people in our communities?
- How do we provide more services closer to home, and therefore what do our hospitals look like in future – including acute hospitals and community hospitals?
- What more should we do to prevent ill health and tackle the country and the county’s biggest killers?
- How will technology and skills change over the next ten years and how will this impact on the way we provide health services?

These are just a few questions that have been raised already, but the Call To Action will provide an opportunity to debate and discuss the issues that are most important to you.

Useful Resources:

Here are some few examples of reports and other publications that set out national standards for the NHS, problems and challenges experienced by patients, and recommendations for improvement:

- Equality and Diversity Strategies for Shropshire CCG and Telford & Wrekin CCG
- “High quality care for all, now and for future generations: transforming urgent and emergency care services in England” (NHS England, 2013)
- “NHS Constitution for England” (Department of Health, 2013)
- “Putting Patients First: The NHS England business plan for 2013/14 – 2015/16” (NHS England, 2013)
- “Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report” (NHS England, 2013)
- “Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry” (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013)
- “The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015” (Department of Health, 2012)
- “Transforming Care: A national response to Winterbourne View Hospital” (Department of Health, 2012)

More information about the NHS locally and nationally is available from NHS England (www.england.nhs.uk), Shropshire Clinical Commissioning Group (www.shropshireccg.nhs.uk) and Telford & Wrekin Clinical Commissioning Group (www.telfordccg.nhs.uk).

NHS England

HOW CAN WE IMPROVE THE QUALITY OF NHS CARE?

HOW CAN WE MEET EVERYONE'S HEALTHCARE NEEDS?

HOW CAN WE MAINTAIN FINANCIAL SUSTAINABILITY?

WHAT MUST WE DO TO BUILD AN EXCELLENT NHS NOW & FOR FUTURE GENERATIONS?

The NHS belongs to the people

A CALL TO ACTION

Index

Foreword	03
The NHS belongs to the people: a call to action	05
How is the NHS currently performing?	07
What challenges will the health and care service face in the future?	11
Seizing future opportunities	17
What's next?	21
Conclusion	24

Foreword: NHS Call to Action

The NHS is 65 this year: a time to celebrate, but also to reflect. Every day the NHS helps people stay healthy, recover from illness and live independent and fulfilling lives. It is far more than just a public service; the NHS has come to embody values of fairness compassion and equality. The NHS is fortunate in having a budget that has been protected in recent times, but even protecting the budget will not address the financial challenges that lie ahead.

If the NHS is to survive another 65 years, it must change. We know there is too much unwarranted variation in the quality of care across the country. We know that at times the NHS fails to live up to the high expectations we have of it. We must urgently address these failures, raise performance across the board, and ensure we always deliver a safe, high quality, value-for-money service. We must place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing rather than treating illness. We also need to do far more to help those with mental illness.

There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS. Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health and care services.

This is not about unnecessary structural change; it is about finding ways of doing things differently: harnessing technology to fundamentally improve productivity; putting people in charge of their own health and care; integrating more heath and care services; and much more besides. It's about changing the physiology of the NHS, not its anatomy.

For these reasons, this new approach cannot be developed by any organisation standing alone and we are committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre, the Local Government Association, the NHS Commissioning Assembly, Health Education England, the Care Quality Commission (CQC) and NHS England want to work together alongside patients, the public and other stakeholders to improve standards, outcomes and value.

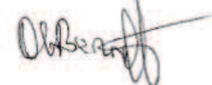
We are all committed to preserving the values that underpin the NHS and we know this new future cannot be developed from the top down. A national vision that will deliver change will be realised locally by clinical commissioning groups, Health & Wellbeing Boards and other partners working with patients and the public. That is why we are supporting a national 'Call to Action' that will engage staff, stakeholders and most importantly patients and the public in the process of designing a renewed, revitalised NHS. This is all about neighbourhoods and communities saying what they need from their NHS; it is about individuals and families saying what they want from their NHS. Above all, this is about ensuring the NHS serves current and future generations as well as it has served those in the past.

David Behan,
Chief Executive
Care Quality Commission

Alan Perkins,
Chief Executive
Health and Social Care Information Centre

Ian Cumming,
Chief Executive
Health Education England

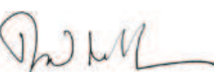
Zoe Patrick,
Chair of the LGA Community Wellbeing Board
Local Government Association



David Bennett,
Chief Executive
Monitor

Andrew Dillon,
Chief Executive
National Institute for Health and Care Excellence

Peter Melton,
Chief Clinical Officer, North East Lincolnshire CCG, Co-chair of NHS Commissioning Assembly steering group



David Nicholson,
Chief Executive
NHS England

David Flory,
Chief Executive
NHS Trust Development Authority

Duncan Selbie,
Chief Executive
Public Health England

The NHS belongs to the people: a call to action

Executive Summary

Every day the NHS saves lives and helps people stay well. It is easy to forget that only 65 years ago many people faced choosing between poverty if they fell seriously ill or forgoing care altogether. Over the decades since its inception the improvements in diagnosis and treatment that have occurred in the NHS have been nothing short of remarkable. The NHS is more than a system; it is an expression of British values of fairness, solidarity and compassion.

However, the United Kingdom still lags behind internationally in some important areas, such as cancer survival rates.[1] There is still too much unwarranted variation in care across the country, exacerbating health inequalities.[2] As the Mid-Staffordshire and Winterbourne View tragedies demonstrated, in some places the NHS is badly letting patients down and this must urgently be put right.

But improving the current system will not be enough. Future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's 65-year history.

The NHS has already implemented changes to make savings and improve productivity. The service is on track to find £20 billion of efficiency savings by 2015. But these alone are not enough to meet the challenges ahead. Without bold and transformative change to how services are delivered, a high quality yet free at

[1] Christopher Murray et al. (March 2013), "UK health performance: findings of the Global Burden of Disease Study 2010", The Lancet.

[2] For example, unwarranted variation in common procedures and in expenditure. See John Appleby et al. (2011), "Variations in health care: the good, the bad and the inexplicable", King's Fund and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".

the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.

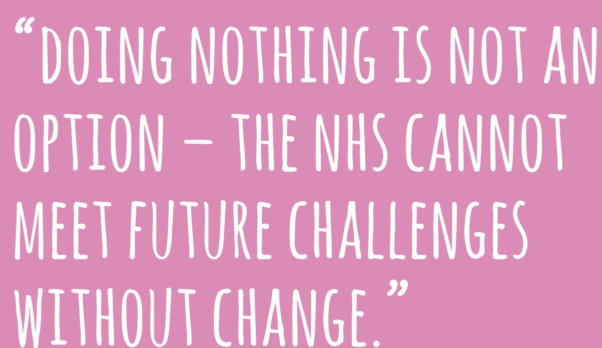
In order to preserve the values that underpin it, the NHS must change to survive. Change does not mean top-down reorganisation. It means a reshaping of services to put patients at the centre and to better meet the health needs of the future. There are opportunities to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospitals. These include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. To do so, the NHS must harness new, transformational technology and exploit the potential of transparent data as other industries have. We must be ready and able to share these data and analyses with the public and to work together with them to design and make the changes that meet their ambitions for the NHS.

So this document is a 'Call to Action' – a call to those who own the NHS, to all who use and depend on the NHS, and to all who work for and with it. Building a common understanding of the challenges ahead will be vital in order to find sustainable solutions for the future. NHS England, working with its partners, will shortly launch a sustained programme of engagement with NHS users, staff and the public to debate the big issues and give a voice to all who care about the future of our National Health Service. This programme will be the broadest, deepest and most meaningful public discussion that we have ever undertaken.

Bold ideas are needed, but there are some options we will not consider. First, doing nothing is not an option – the NHS cannot meet future challenges without change. Second, NHS funding is unlikely to increase; it would be unrealistic to expect anything more than flat funding (adjusted for inflation) in the coming years. Third, we will not contemplate cutting or charging for core NHS services – NHS England is governed by the NHS Constitution which rightly protects the principles of a comprehensive service providing high quality healthcare, free at the point of need for everyone.

The Call to Action will not stifle the work that clinical commissioning groups and their partners have already accomplished. It is intended to complement this work and lead to five-year commissioning plans owned by each CCG. The Call to Action will also shape the national vision, identifying what NHS England should do to drive service change. This programme of engagement will provide a long-term approach to achieve goals at both levels.

The NHS belongs to all of us. This Call to Action is the opportunity for everyone who uses or works in the NHS to have their say on its future.



How is the NHS currently performing?

Quality at the core

Over recent years, the quality of NHS services has improved and, as a result, so has the nation's health. However, there is still too much unwarranted variation across the country. In England the Government measures the quality of care in five areas, collected together in the NHS Outcomes Framework. Each of these areas is discussed below.

Preventing people from dying early

As a nation we are living longer than ever before. Between 1990 and 2010, life expectancy in England increased by 4.2 years.[3] 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.[4]

Preventing disease in the first place would significantly reduce premature death rates. Early diagnosis and appropriate treatment of disease can also reduce premature deaths.

Around 80% of deaths from the major diseases, such as cancer, are attributable to lifestyle risk factors such as excess alcohol, smoking, lack of physical activity and poor diet.[5]

[3] Office for National Statistics (2011) http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-227587
[4] World Health Organisation (2013) http://data.euro.who.int/hfadb/
[5] World Health Organisation (2011) "Global Status Report on Non-communicable Diseases"

Enhanced quality of life for people with long-term conditions

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.

Over 15 million people in England have an LTC. They 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.[6] 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.[7]

The NHS, working with local authorities and the new health and wellbeing boards, needs to be much better at providing a service that appropriately supports these patients' needs and helps them to manage their own conditions. Better management of their own conditions by patients themselves will mean fewer hospital visits and lower costs to the NHS overall, and more community-based care, including care delivered in people's homes

"BETTER MANAGEMENT BY PATIENTS WILL MEAN FEWER HOSPITAL VISITS & LOWER COSTS TO THE NHS OVERALL."

Helping people recover following episodes of ill health or following illness

Demand on NHS hospital resources has increased dramatically over the past 10 years: a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75.[8] A combination of factors, such as an ageing population, out-dated management of long term conditions, and poorly joined-up care between adult social care, community services and hospitals accounts for this increase in demand.

Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6% per year.[9]

New thinking about how to provide integrated services in the future is needed in order to give individuals the care and support they require in the most efficient and appropriate care settings, across health and social care, and in a safe timescale. For example, the limited availability of some hospital services at weekends has a negative impact on all five domains of the NHS Outcomes Framework: preventing people from dying prematurely; enhancing the quality of life for people with long-term conditions; helping people to recover from ill health and injury; ensuring people have a positive experience of care; and caring for people in a safe environment and protecting them from avoidable harm.

[6] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).
[7] The Marmot Review (2010), "Fair Society Healthy Lives".
[8] Royal College of Physicians (2012), "Hospitals on the edge? The time for action".
[9] Health and Social Care Information Centre http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22Hospital+Episode+Statistics%2C+Admitted+patient+care+-+England%22&area=&size=10&sort=Relevance]

This is why the first offer in *Everyone Counts: Planning for Patients*, is to support the NHS in moving towards more routine services being available seven days a week. The National Medical Director has established a forum to identify how to improve access to more comprehensive services seven days a week which will report in the autumn of 2013.

NHS England recently announced a review of urgent and emergency services in England, which will also recommend ways to meet the objective of a seven-days-a-week service. Not only will this offer improved convenience for patients, full-week services will also improve quality and safety.

Patient experience

The UK rates highly on patient experience compared to other countries. A 2011 Commonwealth Fund study[10] 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 show that the UK has improvements to make in the coordination of care and patient-centred care.

Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS. 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). This can be made worse by these groups having lower expectations of the experience of care and being less likely to seek redress. We must act to improve access and the quality of services for these less advantaged groups.

“EVERYONE WORKING IN THE NHS MUST STRIVE TO MAINTAIN AND IMPROVE ON THIS HIGH LEVEL OF PATIENT SATISFACTION AND EXTEND IT TO EVERYONE WHO USES THE NHS.”

[10] Commonwealth Fund (2011), “International Health Policy Survey”.

Patient safety

Although great improvements in patient safety have been made, the findings from the Mid-Staffordshire public inquiry set out starkly what can happen when safety is not at the heart of everything the NHS does. The NHS must work to ensure that all patients experience the safe treatment they deserve. Global healthcare expert Professor Don Berwick was recently asked by the Prime Minister to look into improving safety in the NHS and will report back with his findings later this year.

In addition to reducing harmful events, we must make it easier for staff to report incidents. In 2011, 1,325,360 patient safety incidents were reported to the National Reporting and Learning System,[12] of which 10,916 or less than 1% were serious. Despite this large number of reports we know we have not captured everything, and are working to make it easier for staff and patients to report incidents or near-misses. Learning from even largely minor incidents is important as it helps the NHS to avoid more serious incidents in the future.

Over the past 15 years, international studies have suggested that around 9 in 10 patients admitted to hospital experience safe treatment without any adverse events and our NHS is no different. But even these relatively low levels of adverse events are far too high. Of those people who do experience adverse events a third of them experienced greater disability or death.[11]

Health inequalities

Health inequalities is the term that describes the unjust differences in health, illness and life expectancy experienced by people from different groups of society. In England, as elsewhere, there is a so-called 'social gradient' in health: the more socially deprived people are, the higher their chance of premature mortality, even though this mortality is also more avoidable. People living in the poorest areas of England and Wales, will, on average, die seven years earlier than people living in the richest areas.[13] The average difference in disability-free life expectancy is even worse: fully 17 years between the richest and poorest neighbourhoods.[14] Health inequalities stem from more than differences in just income - education, geography, and gender can all play a role.

The NHS cannot address all the inequalities in health alone. Factors such as housing, income, educational attainment and access to green space are also important (the "wider social determinants of health"). In fact, it is estimated that only 15-20% of inequalities in mortality rates can be directly influenced by health interventions that prevent or reduce risk. If the NHS is to help tackle these inequalities we must work closely with Government departments, Public Health England, local authorities and other local partners to ensure the effective coordination of healthcare, social care and public health services.

[11] Charles Vincent, Graham Neale and Maria Woloshynowych (2001) "Adverse events in British hospitals: preliminary retrospective record review", British Medical Journal.

[12] National Patient Safety Agency (2012), "National Reporting and Learning System Quarterly Data Workbook" http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=135153

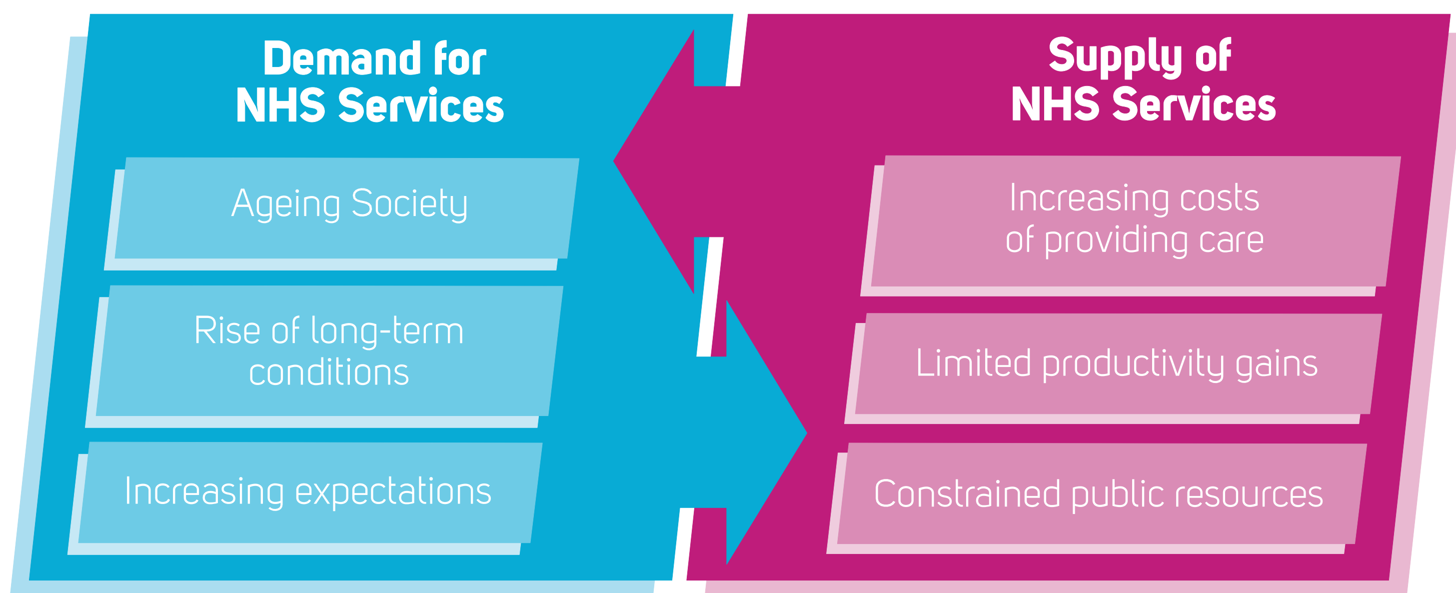
[13] The Marmot Review (2010), "Fair Society Healthy Lives"

[14] The Marmot Review (2010), "Fair Society Healthy Lives"

What challenges will the health and care service face in the future?

As the NHS strives to improve the quality and performance of current NHS services and to live up to the high expectations of patients and the public, we must anticipate the challenges of the future - trends that threaten the sustainability of a high-quality health service, free at the point of use. It is the potential impact of these trends that means that while a new approach is urgently needed, we must take a longer-term view when developing it.

Future pressures on the health service



Ageing society

People are living longer and while this is good news an ageing population also presents a number of serious challenges for the health and social care system:

- Nearly two-thirds of people admitted to hospital are over 65 years old.
- There are more than 2 million unplanned admissions per year for people over 65, accounting for nearly 70% of hospital emergency bed days.[15]
- When they are admitted to hospital, older people stay longer and are more likely to be readmitted.[16]
- Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older - the most intensive users of health and social care.[17]

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.[18]

> "STUDIES SUGGEST THAT OLDER PATIENTS ACCOUNT FOR THE MAJORITY OF HEALTH EXPENDITURE."

Extra care housing: supporting older people to stay independent

Extra care housing is sometimes referred to as very sheltered housing or housing with care. It is social or private housing that has been modified to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home.

This 'retirement village' type of housing offers an alternative to traditional nursing homes, providing a range of community and care services on site. Compared with residence in institutional settings, extra care housing is associated with better quality of life and lower levels of hospitalisation, suggesting the potential for overall cost savings.[19]

[15] Candice Imison et al. (2011), "Older people and emergency bed use: exploring variation", King's Fund.
[16] Jocelyn Cornwell et al. (2012), "Continuity of care for older hospital patients: A call for action", King's Fund.
[17] Commission on Funding of Care and Support (2011), "Fairer Care Funding: The Report of the Commission on Funding of Care and Support".
[18] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[19] A Netten et al. (2011), "Improving housing with care choices for older people: an evaluation of extra care housing", Personal Social Services Research Unit.

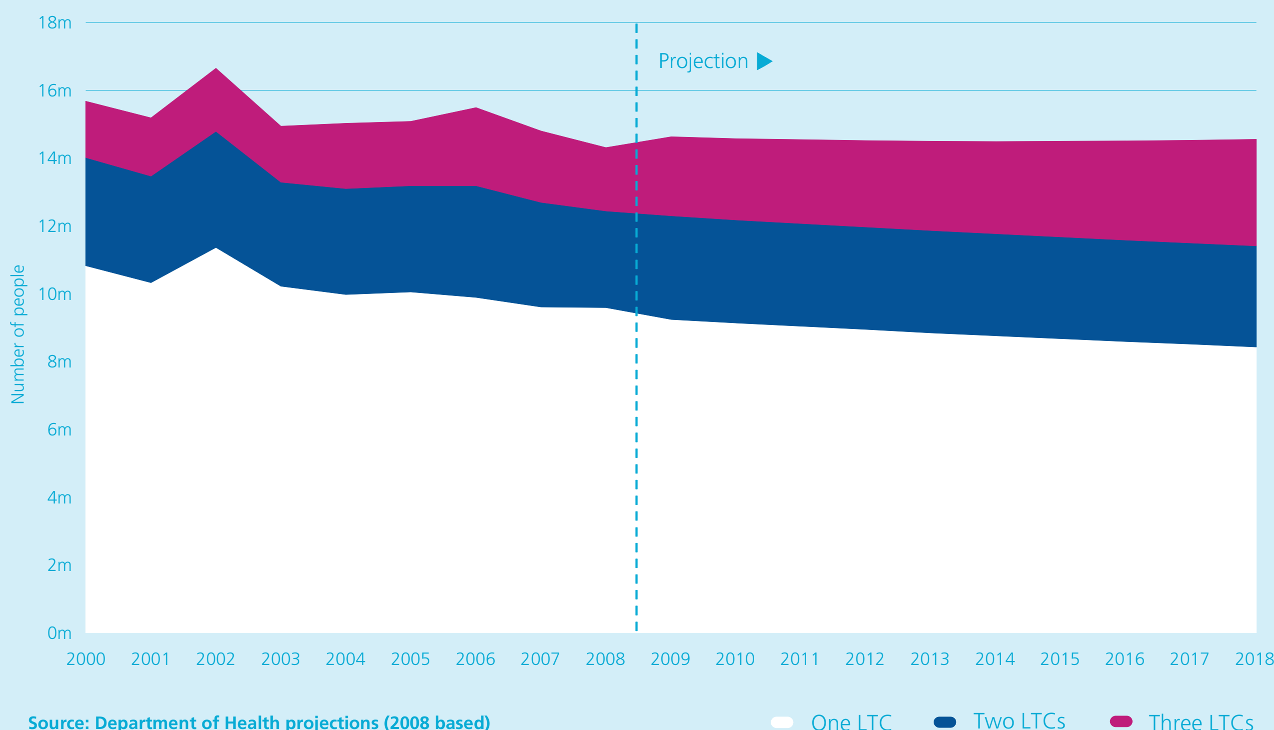
Changing burden of disease

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.[20]

Patients with multiple long-term conditions must be managed differently. A hospital-centred delivery system made sense for the diseases of the 20th century, but today patients could be providing much more of their own care, facilitated by technology, and supported by a range of professionals including clinicians, dieticians, pharmacists and lifestyle coaches. They also need close coordination amongst these different professionals.

"THE 30% WHO HAVE ONE OR MORE LONG-TERM CONDITION ACCOUNT FOR £7 OUT OF EVERY £10 SPENT ON HEALTH AND CARE IN ENGLAND"

Actual/projected numbers with one or more long-term conditions by year and number of conditions



Source: Department of Health projections (2008 based)

[20] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).

Meeting the dementia challenge: rapid diagnosis and referral

There are now 800,000 people living with dementia in the UK. By 2021, the number of sufferers is projected to exceed one million and dementia is estimated to cost the NHS, local authorities and families £23 billion a year. As the Prime Minister's 2012 Challenge on Dementia noted, diagnosis comes too late for many dementia patients and they and their families don't always get the care and support they need. This is in part because too little is known about the causes of this disease and how to prevent it, but some areas are leading the way in offering better care. In Stockport, Greater Manchester, local GPs are working with the Alzheimer's Society to increase diagnosis rates and provide post-diagnosis support. GPs have agreed a 'fast-track' referral process for suspected dementia patients that will also trigger support from Alzheimer's Society staff and volunteers. The scheme also sets out to improve the skills of clinicians to better recognise the early signs of dementia and increase early detection.[21]

Lifestyle risk factors in the young

We know that 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.[22] Although we understand the problem, we do not yet have enough evidence to be sure about what will facilitate sustainable weight loss and other associated behaviours. Working together with individuals, their families, employers and communities to develop effective approaches will be an extremely important task for the next generation NHS.

Rising expectations

Patients and the public rightly have high expectations for the standards of care they receive - increasingly demanding access to the latest therapies, more information and more involvement in decisions about their care.[23] If the convenience and quality of NHS services is compared to those in other sectors, many people will wonder why the NHS cannot offer more services online or enable patients to receive more information on their mobile telephones. Patients want seven-day access to primary care provided near their homes, places of work, or even their local shop or pharmacy. They also want co-ordinated health and social care services, tailored to their own needs. To provide this level of convenience and access, we need to rethink where and how services are provided.

[21] Alzheimer's Society (2012), "Dementia 2012".
[22] Y.C. Wang et al (August 2011), "Health and economic burden of the projected obesity trends in the USA and the UK," The Lancet.
[23] See for example Economist Intelligence Unit (2009), "Fixing Healthcare: The Professionals Perspective".

NHS England

Increasing costs

The cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures than could ever have been envisaged at its inception. New drugs, technologies and therapies have made a major contribution to curing disease and extending the length and quality of people's lives. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable. It is of course a good thing that the NHS has more therapies at its disposal and can now diagnose and treat previously neglected illnesses. However, many healthcare innovations are more expensive than the old technologies they replace - for example, the latest cancer therapies[24] - which raises affordability questions. We must ensure that we invest in the technology and drugs that demonstrate the best value and this rigour must be extended throughout the system, evaluating not just therapies and technologies, but also different models of delivering health and care services.

Limited financial resources

The NHS is facing these challenges at the same time that the UK is experiencing the most challenging economic crisis since the 1930s and adjusting to an era of much tighter public finances. The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth.

Since it began in 1948, the share of national income that the NHS receives has more than doubled, an average rise of about 4% a year in real terms. As part of its deficit reduction programme the Government has severely constrained funding growth.

In addition, recent spending settlements for local government have not kept pace with demand for social care services. Unlike healthcare funding, social care funding is not ring-fenced; councils decide how much of their budget to spend on services based on local need. As a result, financially challenged local authorities have, in some locations, reduced spend on social care to shore up their finances. Reduced social care funding can drive up demand for health services, with cost implications for the NHS.[26] We therefore need to consider how health and care spending is best allocated in the round rather than separately in order to provide integrated services.

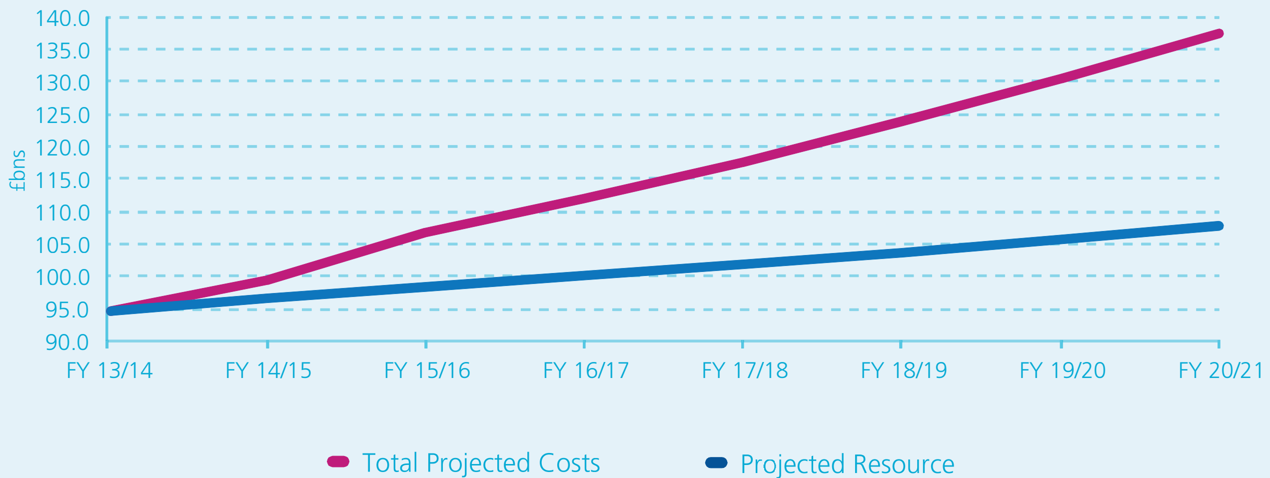
In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21). This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms.[25]

[24] Richard Sullivan et al (September 2011), "Delivering affordable cancer care in high-income countries", The Lancet Oncology.

[25] NHS England analysis.

[26] Research has found that spending on social care could generate savings in both primary and secondary healthcare and that increased social care provision is related to reductions in delayed hospital discharges and readmission rates. See Richard Humphries (2011), "Social Care Funding and the NHS: An Impending Crisis?," King's Fund and J Forder and JL Fernández (2010), "The Impact of a Tightening Fiscal Situation on Social Care for Older People", PSSRU Discussion Paper 2723, London, Kent and Manchester, Personal Social Services Research Unit.

Projected resource vs. Projected spending requirements



Source: NHS England

Limited productivity improvements

Measuring the productivity[27] of the NHS is methodologically difficult and hotly debated. The Office of National Statistics suggests that between 1995 and 2010 average productivity in the NHS grew at 0.4%, whilst in the economy as a whole it grew at a much faster rate of 2% over the same period.[28] Beneath this, NHS labour productivity levels have increased faster than equivalent rates in the wider economy by an average of 2.5% per year between 2007 and 2010.[29] This suggests that the NHS may not be using its capacity as efficiently as it could.

NHS productivity remains an unresolved debate. However, traditional productivity improvements will not be enough to plug the future funding gap. NHS England's analysis suggests that the overall efficiency challenge could be as high as 5-6% in 2015/16 compared to the current 4% required efficiency in 2013/14.[30] Improvements such as better performance management, reducing length of stay, wage freezes or better procurement practices all have a role to play in keeping health spending at affordable levels. However, these measures have been employed to deliver the so-called "Nicholson Challenge" of 4% productivity improvements each year, amounting to some £20bn in savings, and there is a limit to how much more can be achieved without damaging quality or safety. A fundamentally more productive health service is now needed, one capable of meeting modern health needs with broadly the same resources.

"THE OVERALL EFFICIENCY CHALLENGE COULD BE AS HIGH AS 5-6% IN 2015/16 COMPARED TO THE CURRENT 4% REQUIRED EFFICIENCY IN 2013/14."

[27] At its most basic productivity is the rate at which inputs (like labour, capital and supplies), are converted into outputs (like consultations or operations) and outcomes (such as good health) in order to improve quality of life.

[28] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[29] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[30] This is the challenge for the NHS after national action to constrain wages and other input costs. In recent years these have typically delivered c.1% per annum in savings which over the period modelled would equate to c.£8bn.

Seizing future opportunities

The future doesn't just pose challenges, it also presents opportunities. Technological, social and other innovations – many of which are already at work in other industries or sectors – can and should be harnessed to transform the NHS. These exciting opportunities have the potential to deliver better patient care more efficiently to achieve the transformation that is required, some of which are discussed below. These are not exhaustive and it is crucial that as a service we become better able to spot other trends and innovations with the potential to reshape health services.

A health service, not just an illness service

We must get better at preventing disease. In the future this means working increasingly closely with partners such as Public Health England, health and wellbeing boards and local authorities to identify effective ways of influencing people's behaviours and encouraging healthier lifestyles. The NHS has helped many people quit smoking (although there are still about 8m smokers in England), but has yet to develop similarly sophisticated methods for assisting people to improve their diet, take more exercise or drink less alcohol.

About 4% of the total health budget in England is spent on prevention and public health, which is above the Organisation for Economic Co-operation and Development (OECD) average,[31] but this will strike many as too little. We need to look at our health spending and how investment in prevention may be scaled up over time. It is not just about investment; partnering with Public Health England, working with health and wellbeing boards and local authorities and refocusing the NHS workforce on prevention will shape a service that is better prepared to support individuals in primary and community care settings.

[31] Department of Health (2009), "Public Health and Prevention Expenditure in England".

Giving patients greater control over their health

Developing effective preventative approaches means helping people take more control of their own health, particularly the 15 million people with long-term conditions. The evidence shows that support for self-management, personalised care planning and shared decision making are highly effective ways that the health system can give patients greater control of their health. When patients are involved in managing and deciding about their own care and treatment, they have better outcomes, are less likely to be hospitalised,[32] follow appropriate drug treatments[33] and avoid over-treatment.[34] Personalised care planning is also highly effective.[35] A major trial of Personal Health Budgets, a tool for personalised care planning, has shown improved quality of life and cost-effectiveness, particularly for higher needs patients and mental health service users.[36]

Manchester Royal Infirmary: home dialysis

Manchester Royal Infirmary has developed an innovative dialysis provision pathway, which allows patients to perform extended haemodialysis at home, rather than in hospital. This has delivered improved health and longevity, empowering patients through greater involvement, freedom and flexibility, and offers wider benefits of fewer medications and hospital visits resulting in substantial reductions in healthcare costs.[37]

Harnessing transformational technologies

The digital revolution can give patients control over their own care. Patients should have the same level of access, information and control over their healthcare matters as they do in the rest of their lives. The NHS must learn from the way online services help people to take control over other important parts of their lives, whether financial or social, such as online banking or travel services. First introduced to the UK in 1998, now more than 55% of internet users use online banking services.[38] A comparable model in health would offer online access to individual medical records, online test results and appointment booking, and email consultations with individual clinicians. Some of the best international providers already do this.[39] This approach could extend to keeping people healthy and independent through at-home monitoring, for example. These innovations would not only give patients more control, they would also make the NHS more efficient and effective in the way that it serves the public.

[32] JH Hibbard and J Green (February 2013), "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs," Health Affairs.
[33] Expert Patients Programme (2010), "Self-care reduces costs and improves health: the evidence".
[34] D Stacey et al. (May 2011), "Decision aids to help people who are facing health treatment or screening decisions", Cochrane Summaries and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".
[35] "RCGP Clinical Innovation and Research Centre (2011), "Care Planning: improving the lives of people with long term conditions".
[36] https://www.phbe.org.uk/
[37] NHS England (2013), "Catalogue of Potential Innovation".
[38] Office for National Statistics (2009), "e-society" (Social Trends 41).
[39] For example Kaiser Permanente and the Veterans Administration, both in the USA

e-Intensive Care: a second pair of eyes

Guy's and St Thomas' NHS Foundation Trust, in London, has recently deployed a new e-Intensive Care Unit (ICU) to keep a 'second pair of eyes' on critically ill patients. Used in about 300 hospitals in the US, where studies have shown the system has reduced mortality rates and hospital stays, the eICU allows critical care specialists to remotely monitor patients using high-definition cameras, two-way audio and other instruments that keep track of vital signs. Not only does the system facilitate provision of 24/7 care, it also enables the most experienced specialists to spread their skills more widely and to help more patients with the greatest need.[40]

> "THE NEW FRIENDS AND FAMILY TEST ASKS PATIENTS WHETHER THEY WOULD RECOMMEND THEIR HOSPITAL TO THEIR FRIENDS & FAMILY AND THE FIRST RESULTS WILL BE PUBLISHED ON NHS CHOICES IN JULY 2013"

Digital inclusion will have a direct impact on the health of the nation, and so innovation must be accessible to all, not just the fortunate. From April 2013, 50 existing UK online centres in local settings, such as libraries, community centres, cafes and pubs, are receiving additional funding to develop as digital health hubs where people will be able to find support to go online for the first time and use technology and information services such as NHS Choices to improve their health and wellbeing.

Exploiting the potential of transparent data

To support active patients the best quality data must be collected and made available. Dramatic improvements need to be made in the supply of timely and accurate information to citizens, clinicians and commissioners. Commissioners can use improved data to better understand how effectively money is being invested. For patients, more and better data will enable them to make informed decisions about their health and healthcare.

The new Friends and Family Test asks patients whether they would recommend their hospital wards or A&E department to their friends and family should they need similar care or treatment. Beginning in July 2013, the results will be published on the NHS Choices website. This is just one example of transparency which will for the first time allow citizens to compare NHS performance based on the opinions of the patients.

[40] Guy's and St. Thomas' NHS Foundation Trust, www.guysandstthomas.nhs.uk/news-and-events/2013-news/20130703-eICU.aspx

Moving away from a 'one-size fits all' model of care

A relatively small minority of patients accounts for a high proportion of health service utilisation and expenditure. This suggests an opportunity to manage patients, and help them manage themselves, more intelligently, based on an understanding of individual risk.

Healthcare is becoming more personal in other ways too. Recent biomedical advances suggest a revolution in medicine itself may be afoot that could enable clinicians to tailor treatment to individuals' specific characteristics. For instance, it has been proven that mutations in two genes called BRCA1 and BRCA2 significantly increase a person's risk of developing breast cancer. Individuals can now be tested for these mutations, allowing early detection and targeted use of therapeutic interventions. Similar progress is being made in understanding the biological basis of other common diseases. The health service needs to consider how to invest in this work and how it can most effectively be translated into everyday practice.

Risk-stratification in North West London

As part of the Inner North West London Integrated Care Pilot, patient information was combined across primary, secondary and social care providers to understand the impact of high-risk patients on services and expenditure. The data showed that the 20% of the population most at risk of an emergency admission to hospital accounted for 86% of hospital and 87% of social care expenditure. Yet despite this high concentration in expensive downstream services, only 36% of primary care resources were expended on these same patients.[41] This suggests that through better management of these patients in primary care many hospital admissions could be prevented and intensive social care support reduced, resulting in improved care with reduced costs.

Unlocking healthcare as a key source of future economic growth

All too often we think of health expenditure as solely a cost, but investment in individuals' wellbeing and productivity delivers vast benefits to society and the economy. Conversely, illness costs the UK economy dearly: in 2011, 131 million work days were lost due to sickness.[42] This translates into an annual economic cost estimated to be over £100bn whilst the cost to the taxpayer, including benefits, additional health costs and forgone taxes, is estimated to be over £60bn.[43]

In addition to preventing and relieving illness, the NHS has a central role in contributing to economic growth. The NHS is the largest single customer for the UK health and life sciences industries including pharmaceutical, biotechnology, medical devices and other sectors,[44] and Britain is recognised as a leader in biomedical research. We must consider how the NHS can work with industry partners to make sure that the health and life sciences continue to be a growing part of the UK economy.

[41] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[42] Office of National Statistics (2012), "Sickness absence in the labour market".
[43] Department of Health (2011), "Innovation, Health and Wealth".
[44] Department of Health (2011), "Innovation, Health and Wealth"

What's next?

This document discusses the key problems and opportunities that a renewed vision for the health service must address. In the next phase of work, we will analyse, with our key partners, the causes of these trends and challenges and share these more widely in order to begin to generate potential solutions. Some of these solutions may come from reviews that are already underway such as the Urgent and Emergency Care Review and the Berwick Review on improving safety in the NHS. Some solutions may be adapted from small-scale pilots or international models that can demonstrate success, but there is no doubt that new ideas are needed.

We cannot generate these new ideas alone. NHS England is committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, NICE, the Health and Social Care Information Centre, the Local Government Association,the steering group of the NHS Commissioning Assembly, Health Education England and the Care Quality Commission want to work in partnership with NHS England to understand the pressures that the NHS faces and to work together alongside patients, the public and other stakeholders to identify new and better ways to deliver health and care.

The NHS constitution stipulates that the NHS belongs to the people and so does its future. In keeping with this principle we will be working together with staff, patients and the public to develop new local approaches for the NHS. We need your help to ensure that the ideas identified are sustainable and respect the values that underpin the health service. To enlist your help, we are launching a nationwide campaign called *'The NHS belongs to the people: a Call to Action'*.

A call to action

A call to action is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. This programme will be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. The engagement will be patient - and public-centred through hundreds of local, regional and national events, as well as through online and digital resources. It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how services will improve.

The call to action aims to:

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future.
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures.
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans.
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 – 10 years.

What will happen with the data and views that are collected?

All data, views and information will be collected by CCGs and NHS England. This information will then be used by CCGs to develop 3-5 year commissioning plans, setting out commitments to patients about how services will be improved.

This information will also be used by NHS England to shape its direct commissioning responsibilities in primary care and specialised commissioning.

Information gathered in this way will drive real future decision making. This will be evident in the business plans submitted for both 2014/15 and 2015/16. These plans will signal service transformation intentions at both local and national level.

There is no set of predetermined solutions or options about which we are consulting. Bold, new thinking is needed and we will consider a wide range of potential options. However, there are three options that we will not be considering:

1. **Do nothing.** The evidence is clear that doing nothing is not a realistic option nor one that is consistent with our duties. We cannot meet future challenges, seize potential opportunities and keep the NHS on a sustainable path without change.

2. **Assume increased NHS funding.** In the 2010 spending review, the Government reduced spending on almost all most public services, although health spending was maintained. We do not believe it would be realistic or responsible to expect anything more than flat funding (adjusting for inflation) in the coming years.

3. **Cut or charge for fundamental services, or 'privatise' the NHS.** We firmly believe that fundamentally reducing the scope of services the NHS offers would be unconstitutional, contravene the values that underpin the NHS and - most importantly - harm the interests of patients. Similarly, we do not think more charges for users or co-payments are consistent with NHS principles.

How will the call to cction engage people?

The call to action will offer a number of ways for everyone to engage with the development of a renewed vision for the health service including:

A digital call to action

Staff, patients and the public will be able contribute via an online platform hosted by NHS Choices. This platform will enable people to submit their ideas, hold their own local conversations about the future of the NHS and search for engagement events and other interactive forums.

'Future of the NHS' surgeries with NHS staff, patients and the public

Local engagement events will be led by clinical commissioning groups, health and wellbeing boards, local authorities and other local partners such as charities and patient groups. These workshop-style meetings will be designed to gather views from patients and carers, local partner groups and the public. We will also be holding events designed to capture the views of NHS staff, for instance, through clinical senates.

Town hall meetings

Held in major cities across the NHS, these events will engage local government, regional partners, business and the public. These regional events will give people who have not contributed locally a chance to participate in regional discussions.

National engagement events

A number of national events focusing on national level partner organisations to the NHS will be held. These will include Royal Colleges, patient groups and charities, the private sector and other stakeholders.

Conclusion

The NHS is one of our most precious institutions. We need to cherish it, but we also need to transform it. Future trends threaten its sustainability, and that means taking some tough decisions now to ensure that its future is guaranteed. We believe that by working together as a nation, we have a unique opportunity to transform the NHS into a health service that is both safe and fit for the future.

The NHS needs your help. Have your say.