North Cumbria University Hospitals NHS Trust

NHS Cumbria

# North Cumbria - Challenges and Solutions

**Report to Cumbria County Council Health & Wellbeing Scrutiny Panel 12.12.11**

## Introduction

1. The local NHS wants safe, high-quality care for everyone in north Cumbria.

2. Over the last three years there has been seen a steady improvement in the range and quality of community health services to improve health services as a whole and prevent inappropriate and unnecessary admission into acute hospitals.

3. Alongside a continued expansion in the range and quality of community health services available in north Cumbria, the NHS also needs strong hospitals in Whitehaven and Carlisle.

4. An enormous amount of things work well in our hospitals: there have been no cases of MRSA for more than 18 months; waiting times remain low and new investment has gone into Cumbria's first gold-standard Heart Centre which opened this month in Carlisle.

5. The overwhelming majority of patients are receiving a consistently high standard of care at hospitals in north Cumbria and there are things which, as a health system, the local NHS can continue to improve.

## Background

6. In 2007/08, NHS Cumbria and North Cumbria University Hospitals Trust consulted on a strategy (Closer to Home) to expand community health services, safeguard threatened community hospitals and create smaller acute hospitals in Carlisle and Whitehaven.

7. The consultation received more than 1,000 individual responses and its outcome was reviewed by the Cumbria health overview and scrutiny committee and NHS Gateway.

8. The strategy envisaged a shift in the centre of gravity from the acute hospitals into new and existing community services – this included the transfer of some of the skills and knowledge previously locked into hospital services. It also envisaged changes and developments in clinical practice (both in the community and in hospitals) to bring it in line with best contemporary clinical practice across the country.

9. The local NHS undertook to develop alternative services and clinical pathways (reflecting best practice) which would contribute to a reduction in the use of acute hospitals. Funding would be available to sustain the new patterns of community oriented services by releasing resources from secondary care and reinvesting in the community.

10. The strategy focused on reshaping key elements of the health system and in doing so, integrating services around the needs of patients from a primary care perspective. This involved:

- Empowering people with long-term conditions by providing training and education to enable them to take control of their own conditions in the context of their own lives.
- Integrating primary and community health teams at a local level and re-shaping them to provide proactive, focused interventions.
- Integrating community and hospital care by:
    - Developing the county's community hospitals into high quality, productive facilities with the capacity to provide step-up and step down-care as a core part of a wider local community health system
    - Ensuring a proactive transfer of patients from acute to community hospitals
    - Developing Primary Care Assessment Services (PCAS) as part of the management of the interface between hospital skills and services and community alternatives
    - Developing integrated emergency floors (redesigned A&E departments) which incorporate primary care and secondary care.

11. NHS Cumbria provided leadership alongside North Cumbria University Hospitals NHS Trust in the health community and the accompanying detailed case for change was based on clinical and financial modelling of the strategy. This provided NHS Northwest with sufficient confidence that there was an opportunity to resolve the historic problems in the county, agreeing to provide funding to address the historic debt.

12. The agenda since 2007/08 has been to drive forward the delivery of this approach in a changing context and environment. There has been substantial progress. Key indicators of success include:

- A long-term reduction in non-elective admissions to secondary care and between 2008/09 and 2010/11 with one in ten fewer patients having to go into hospital in an emergency.

- Community hospitals have seen a reduction in patients' average length of stay with a shift from 21.4 days in 2008/09 to 17.5 in 2010/11. At the same time, occupancy of community hospitals has increased from 75.4 per cent to 86.7 per cent, making them more efficient and clinically robust.

- Integrated health and social care teams have been formed which are now available in every Cumbrian locality to provide rapid support to patients at-risk of having to go into hospital.

- Making it easier for patients to choose hospitals in Carlisle and Whitehaven for planned procedures is a key component of the strategy and work is taking place between primary and secondary care clinicians to achieve this. The recent opening of Carlisle's new Heart Centre will result in 700 fewer patients each year having to have to travel outside Cumbria for their care.

13. At the same time there have been substantial challenges. The North Cumbria University Hospital Trusts downsizing plans were envisaged as interlocking with the wider approach of providing more care in different settings.

14. At the outset, significant emphasis was placed on a managed approach across the health system, with hospitals in Carlisle and Whitehaven being part of the process and working in a collaborative way.

15. As a result of the difficulties the hospitals' Trust has faced in right-sizing in line with the agreed strategy and in delivering on its own internal cost improvement programme, it has become dependent on additional external resources from other parts of the Cumbria NHS system and NHS Northwest.

16. Latterly, the financial challenges faced by the hospitals Trust and the challenge of gaining Foundation Trust status has led to it moving into an acquisition process.

17. The Closer to Home strategy also has sought to create a public health focused primary care led NHS in Cumbria important groundwork has been laid, including the successful implementation of diabetes prevention and management programmes which are now available to patients in Cumbria.

**The first challenge – right care in the right place at the right time.**

18. The shift away from an historical reliance on hospital-centred health care is now the direction which the whole of the NHS is being asked to move towards.

19. From a Cumbria perspective, greater support for people to remain at home and independent for as long as possible is also the strategic direction set by Cumbria County Council which is currently holding its own public consultation on proposals to downsize its residential care home estate.

20. For the NHS in north Cumbria, cooperative working between family and hospital doctors will be the key to meeting a series of interconnected challenges which require the implementation of service changes, previously consulted upon, and new ways of working.

21. Too many patients, for example, still travel outside the county for hospital services that could be provided in north Cumbria. As well as being inconvenient for patients, this also results in NHS funds leaving the county.

22. Three years ago, around £14m (fourteen million pounds) of hospital funding was being lost through patients choosing to travel outside the county for care each year. The latest estimate now stands at approximately £24m (twenty four million pounds) with around 60 patients each day leaving the county for treatment that is available in Cumbria. Plans are being developed to repatriate this care back into Cumbria starting with those services hospitals in Carlisle and Whitehaven already provide and then moving on to thinking about how further changes to hospital services will prevent other patients having to travel as far for their care.

**The solution**

23. Hospital and connected NHS services need to be organised around patients.

24. Reorganising the way hospital theatres are used will help free-up more appointments and enable more patients to be treated locally. Greater access to primary and community health services will free-up hospitals to improve their capacity for planned hospital procedures.

25. Hospital A&E departments need to be designed to work differently with a greater mix of doctors and skills so patients no longer have to put up with some of the frustrations they have today – with different appointments in different places, with different people, all to discuss the same thing.

26. Hospital doctors and GPs in Carlisle and Whitehaven have been working on plans consulted upon in 2008 to combine senior hospital specialists, GPs, nurses and other staff on redesigned A&E departments which will be up and running in the early part of next year. This system is known as an emergency floor.

27. This is better for patients in an emergency who will see the best doctor for their needs and for the one-in-four of patients who visit hospital A&E departments who could be better helped by a different NHS service.

28. In addition to changes to existing services, new investment in services such as Carlisle's Heart Centre will result in 700 fewer patients each having to have to travel outside Cumbria for their care.

**The second challenge - Quality**

29. Quality of care at North Cumbria University Hospitals Trust has improved in a number of key areas. Hospital infection rates in Carlisle and Whitehaven have fallen dramatically in the last three years and are now amongst the lowest in the country.

30. The hospital Trust is also one of the best performing in the North West for ambulance turnaround times – the West Cumberland is third in the North West out of 33 hospitals and the Cumberland Infirmary is fifth in the region. The Trust is also consistently performing above national targets for the length of time patients are required to wait in A&E departments.

31. In January 2011 the Trust Board approved specific terms of reference to undertake a review of clinical governance. This review looked at a range of core clinical governance functions and made a number of recommendations for improvement which the Trust Board fully endorsed in July 2011.

32. The Trust is working hard to implement these recommendations in order to make further improvements to the Trust's systems and processes for clinical governance, which is fundamental to the continuous improvement of the quality and safety of care given to patients. The Trust has invested in key roles, following the review of governance, to ensure key areas have dedicated expertise and leadership, for example medical governance in preparation for the introduction of medical revalidation, which is also central to raising standards of governance across the NHS.

33. The Trust has in place specific reporting direct from the clinical divisions on the Trust's core pillars of governance. The Governance and Quality Committee reviews and scrutinises the divisional reports each quarter.

34. The Trust Board reviews on a monthly basis a range of quality indicators which are summarised below:

- Infection rates
- Referral to treatment
- Mixed sex accommodation
- A&E specific quality indicators
- Cancer treatment
- Venous Thromboembolism
- Length of stay
- Cancelled operations
- Mortality
- Sickness absence rates
- Training and appraisal rates
- Slips, trips and falls

- Pressure sores
- Never events
- Complaints
- Serious untoward incidents
- Negligence claims and litigation

35. The Trust Board also receive a specific report on compliance with the Care Quality Commission Regulations and Outcomes. This report draws together key information on the following sources:

- Outputs from the Quality Risk Profile (issued each quarter)
- The status of Provider Compliance Assessments
- What is happening in practice regarding assurances that our policies and procedures are working.

36. North Cumbria University Hospitals Trust has a robust system in place for staff to report any concerns they may have over the safety of their patients. The Trust previously used a paper-based system for reporting of any incidents, which was not reliable or effective. A new online reporting system, which is used in the majority of NHS Trusts, was introduced across the Trust to improve risk management reporting. The Trust continues to make further improvements to the system, including the feedback to staff on incidents.

37. The Medical Director, Director of Nursing, Director of Governance, Heads of Nursing and Governance Team meet weekly to discuss incidents, including those which require escalation and patient complaints. This meeting ensures that there is monitoring and escalation in place for all incidents across the organisation on a weekly basis.

38. The Trust always encourages staff to report any untoward incident or near-miss involving patients so that these can be investigated as soon as possible and any lessons learnt quickly so that changes can be made.

39. The Trust is also implementing ward-level nursing indicators which is similar to a 'Ward MOT'. These indicators look at a sample of patients against the nursing standards which are most important patients, including hygiene and cleanliness, management of pain, nutrition, communication and privacy and dignity. The results from the nursing indicators will form part of the monthly Board performance report in February 2012 to allow greater clarity on the nursing standards of care across the Trust.

40. The quality of care given to patients remains the Trust's number one priority and it has made significant improvements to some of the basic fundamentals of governance during the last 12-18 months, which will continue to be driven forward across the organisation.

41. The drive to ensure that the people of Cumbria can access consistently high standard local services is at the heart of collaborative approaches across the health economy and a constant challenge for all involved. This creates a challenging agenda for clinical staff in primary and secondary care.

42. In October 2010, a report by the National Clinical Advisory Team (NCAT) highlighted separate working arrangements between North Cumbria's two main hospitals which, if not addressed, would be an impediment to the changes to hospital services consulted upon in 2007/08.

43. In May 2011, a second NCAT report established that 'substantial progress' had been made in this area since the previous October.

44. Joint working across hospitals in Carlisle and Whitehaven remains a critical component to the delivery of quality healthcare.

**The solution**

45. The 2010/11 Dr Foster Guide supports the case that the NHS nationally can achieve both better outcomes and better value for money and gives practical examples of where that has been achieved.

46. Dr Foster's analysis clearly reinforces the need for changes in the way some services in the UK are designed to ensure the highest standards of quality and safety including moving towards centres of excellence for high risk procedures and the use of hospital networks.

47. Areas highlighted in this year's Dr Foster Hospital Guide include:

- *Delivering safe care 24/7 does not require more resources. Local A&E departments need to identify the services they can provide safely and link with others to provide the services they can't. Examples of best practice, from London to Northumbria, demonstrate what is possible.*

- *London has now achieved the lowest mortality rate following a stroke in England by cutting the number of A&E departments treating stroke from 31 to eight, but making sure those eight provide the highest standards of care. The rest of the country should follow suit.*

- *Better care saves money. Hospitals that implement best practice in helping patients recover quickly from surgery achieve better outcomes for less money.*

48. A collaborative Systems Board is now being put in place which takes its membership primary, community and acute hospital health services. This is the first multi-organisational body to cover the whole county.

49. Its purpose is to transcend organisational boundaries to achieve clinical service change. Each organisation is represented by chief executives, senior medical staff and other key personnel.

50. It is 'task and project' driven and aims to achieve full delivery of much of the system change required by the public consultation of 2007/08, including the establishment of redesigned A&E departments.

51. It is expected that the System Board will become the focal point for the delivery of strategic change – reflecting the imperative of having a co-ordinated and integrated approach across the different health (and social care) sectors.

52. During the last 12 months the Trust has been working to develop cost reduction and improvement plans to ensure that we continue to reduce waste and improve the overall efficiency of the organisation in order to achieve financial turnaround.

53. As part of the turnaround process the Trust is reviewing a number of pay and non pay areas. The Trust pay bill is approximately £137m, therefore ensuring the Trust has the correct workforce, in terms of skill-mix, numbers and grade, to deliver high quality services is a key part of the turnaround process.

54. All proposals for contributing to financial turnaround are signed off by clinical staff and include a patient safety and quality checklist, for example:

- Does the scheme provide care in line with current guidelines where these exist?
- Does the scheme preserve the privacy and dignity of patients? (same sex accommodation)
- Does the scheme provide safe numbers of nursing staff of the appropriate skill level?
- Does the scheme provide safe numbers of doctors of appropriate skill level?
- Is the provision of other therapies at a safe level? (physio, OT, etc)
- Will the scheme lead to breaches of key access targets? (4hr waits, cancer targets, etc)
- Will the scheme lead to failure to deliver safe care?
- Access to results
- Access to records
- Timeliness of communications

55. The Trust's review of nursing is being progressed in three key stages:

**Stage 1: Implementation of new senior nurse structure**

56. This option reduces layers of nurse management, maintains clinical divisional leadership and protects the matron roles to focus on raising nursing standards of care instead of operational management. The

new structure has been consulted on during November and is now being implemented during December.

57. The following objectives have been identified in relation to implementing stage 1 of the nursing review:
- Implementation of a senior nurse structure that ensures the provision of safe, quality care.
- Provides the senior nursing team with clarity over roles and accountability.
- Ensure the senior nurse structure provides value for money.

**Stage 2: Review of nurse staffing establishments**

58. From the review that has been undertaken during the last 12 months, it is evident that a more detailed review of the ward staffing establishments is required, including benchmarking against other organisations / best practice. The key rationale for this is to ensure that the correct skill mix and nursing leadership is in place to meet the needs of patients.

59. The Trust has carried out a detailed review of the ward sister positions; however it is important that these posts are reviewed in the context of the overall nursing structure for the individual ward areas.

60. This stage of the review will commence in January 2011 with a specific consultation paper on the proposed changes to the role of the ward sister and nurse staffing establishments produced. This paper will describe the proposed nurse staffing levels along with the bed base and acuity of patient case mix.

**Stage 3: Review of Nurse Specialist Roles**

61. It is recognised nationally that the need for dedicated nurse specialist/practitioner roles will increase. Therefore it has been agreed that the third key area of work which will also be reviewed are the specialist nurse/nurse practitioner roles.

62. The key aims will be to understand the level of specialist nurse roles across the Trust and the input they have into the respective specialties/directorates.

63. The timescale for this commencing stage three will be January 2011. This stage of the review will also receive external nurse input to ensure the Trust can compare the specialist nurse positions with other organisations and best practice.

**The NHS funding challenge**

64. All hospitals in England are paid under a national tariff based on the number and complexity of patients they see. Every time a patient goes to hospital, local NHS commissioners receive a bill which is paid. The system is called Payment by Results (PbR).

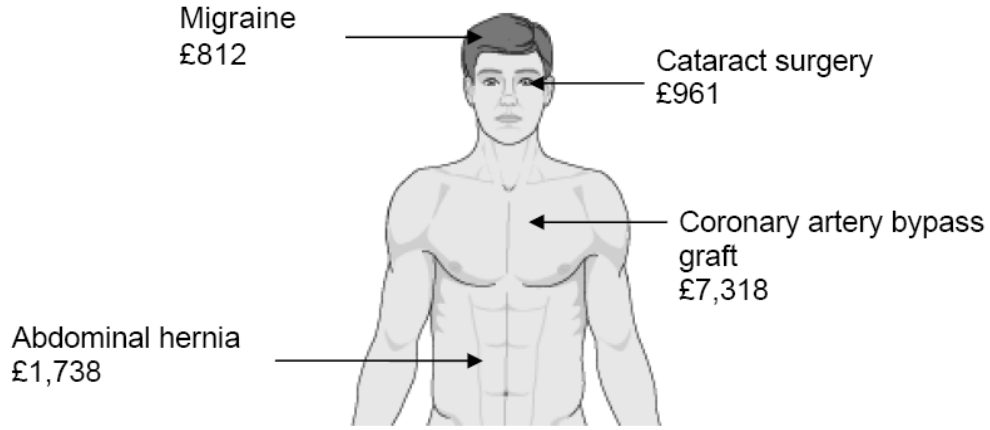
65. The PbR system was introduced in 2002 to, 'reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions.'

66. Before PbR, commissioners tended to have block contracts with hospitals where the amount of money received by the hospital was fixed irrespective of the number of patients treated.

67. The funding system is similar to the one introduced for schools in the 1990's which saw a move away from block-funding to one more closely linked to the number of pupils in each school.

68. Under PbR, NHS commissioners pay hospitals a national tariff (price) for each patient seen or treated. The price, which is set by the Department of Health each year, varies according to the complexity of the treatment or condition, as illustrated in Figure 1.

Figure 1: National tariffs for different treatments and conditions




69. The price received by a hospital is multiplied by a nationally determined market forces factor (MFF) unique to each organisation to reflect the fact that it is more expensive to provide services in some parts of the country than in others.

70. The total amount of NHS funding for Cumbria this year is around £860m. This is broken down into funding for primary care services, acute hospital care services and remainder spent on medicines, free nursing care for the elderly and other services which patients need highlighted in Figure 2 (below).

71. A contract for hospital services in north Cumbria was agreed for this year which again sees hospitals in Carlisle and Whitehaven receiving the largest share of hospital funding in Cumbria.

**Share of NHS spending in Cumbria – 2011/12**

| Area of Health Spend (recurring) | £ million |
|---|---|
| **Primary Care Total Spend** | **200** |
| *Major areas of spend* | |
| Prescribing & Pharmacy | 104 |
| GP Services | 74 |
| Dental services | 18 |
| **NHS Hospital Total Spend** | **563** |
| *Major Providers* | |
| NCUHT | 165 |
| UHMBFT | 116 |
| CPFT Community Services | 92 |
| CPFT Mental health Services | 64 |
| Specialist Services (brain injury, renal, specialist cancer etc) | 42 |
| NW Ambulance | 24 |
| Other providers out-of-county (patient choice, specialist mental health etc) | 60 |
| **Other Significant Areas of Spend** | **73** |
| NHS Funded Nursing Care & Complex Care Packages | 44 |
| Other care (inc out of hours GP services and learning disabilities) | 29 |

72. The split in funding provided to Cumbria's two main hospital Trusts under the PbR system mirrors the populations in each area and the greater density of community hospital facilities in north Cumbria.

| Hospital Trust | Spend (%) | Population served (%) |
|---|---|---|
| NCUHT | 59 per cent | 61 per cent |
| UHMBFT | 41 per cent | 39 per cent |

73. The NHS Operating Framework is published annually and sets out the national requirements which each NHS organisation needs to meet as part of a National Health Service.

74. The Operating Framework for 2012/13 stipulates that, *'The PbR guidance and accompanying Code of Conduct will describe one system and one set of rules for England that are mandatory. Where commissioners and providers find the rules prevent them doing the best for patients, then local variation is permitted. However, variations which in effect enable the continuation of poor-quality, inefficient models of care or restrict patient choice are not valid.'*

75. Systemic and long-term variation from the nationally mandated NHS funding formula is not accounted for in the annual funding settlements provided to Cumbria to pay for health services.

76. Due to wider changes in the way health is provided in Cumbria – everything from reduced length of stay due to medical advances in areas such as cataract and joint replacement surgery, to developments that are seeing more people treated in their local community or at home, rather than in hospital – the amount paid to North Cumbria University Hospitals Trust from the county's allocated NHS pot will gradually reduce as a share of health spending in Cumbria.

77. The long-term trend of hospital admissions over the period of the Closer to Home strategy has seen Cumbria buck a regional and national trend of rapidly rising activity. Over the period of the strategy, one in ten fewer people have needed to go into hospital in an emergency

78. Under the PbR system, a more pronounced reduction in north Cumbrian hospital admissions would have resulted in less income for hospitals in Carlisle and Whitehaven

79. This financial year (2011/12) the contract for hospital services in Carlisle and Whitehaven is £165 million. To help the Trust manage its changes, it is also receiving extra funding support from the regional Strategic Health Authority (SHA).

**The solution**

80. Every part of the NHS is being asked to look hard at what it does to make sure it frees up as much investment as possible to recycle back into front-line patient care.

81. This is very important, particularly in Cumbria where the ageing population means, in future years, we will see a big rise in the number of people with long-term conditions that need to be supported in the community, such as diabetes and dementia.

82. Over the next two decades, the number of people in Cumbria with diabetes is expected to rise by almost 50 per cent to 40,000 (forty thousand). Over the same time period, around 10,000 (ten thousand) people in the county will be living with some form of dementia.

83. To help meet this growing demand for more community-based health care in the years to come, the NHS nationally has been asked to find £20billion in efficiency savings over the next three years.

84. To meet this challenge, every NHS Trust in England is required to reduce its spending by 4 per cent annually.

85. The hospitals Trust has reported that this year will be the first time in recent years that it will have delivered significant cost efficiencies in line with the rest of the NHS.

86. Like every NHS organisation in the country, North Cumbria University Hospitals NHS Trust is looking carefully at what it does. A lot of the proposed changes it is examining are around making the hospital system work better by using operating theatres more efficiently so they are not closed for large parts of the day, reducing management costs and being able to flex beds up and down depending on patient need.

87. This is a clinically-led process that will not impact on safety of care. Advances in medicine mean the NHS has to work differently. Several years ago, for example, a cataract operation would require a two-day stay in hospital. These procedures are now carried out as day-cases due to advances.

88. Hip-operations which previously required a two-week stay in hospital are now completed within 24 hours in some areas. Being efficient is not about making cuts – but rather increasing productivity; doing things in a better, more productive and efficient way.

89. Changes to the existing PbR system announced for next year will increasingly focus on outcomes (how well a patient has been treated) and integration with other parts of the health service (redesigned A&E departments being one example).

90. The move to incentivise the different parts of the NHS in England to work in a more integrated way will also enable the benefits of clinically better and more efficient working to be shared - allowing investment in more areas which make patients' experience better.

91. The new emphasis on outcomes will also drive improvements which will benefit patients. Research has shown that the difference between good care and excellent care in the NHS is 30 per cent in terms of the cost to the health service through avoidable admissions and readmissions to hospital.

92. North Cumbria University Hospitals NHS Trust is one of six Trusts identified as potentially requiring support with their Private Finance Initiative (PFI) payments. Annual unitary payments for the Cumberland Infirmary PFI scheme total £18.6million

93. The hospital has also been required to appoint some temporary medical staff to maintain levels of service, these temporary staff cost more than permanent staff and whilst costs have risen over the last few years these have remained constant through 2010/11 and 2011/12. However, the Trust has recently been successful in recruiting to key consultation positions including four cardiologists, a colorectal surgeon and a consultant obstetrician.

94. Longer-term, the hospitals trust is engaged in an acquisition process which is designed to help deliver a more stable financial footing for hospital services in Carlisle and Whitehaven.

**Conclusion**

95. The challenges and solutions outlined in this paper reflect the work going on within the local NHS to deliver improvements in a period of change.

96. Critical to the future success of the NHS in north Cumbria will be a fundamental change to the way in which people currently work. At the heart of this will be strong clinical leadership. It will require clinical leaders to identify and tackle the behaviours and cultures that can stand in the way of innovation.

97. Previous management arrangements have sometimes impeded change. The creation of a doctor-led Systems Board is one catalyst to unite clinicians from every part of the health service around moving change forward.

98. The voice of the patient will need to increasingly be brought to the fore in assisting doctors to take bold, long-term measures that secure sustainable change.

99. In 2011/12, patient experience will increasingly be used by the NHS in Cumbria to help shape improvements to care, reward organisations that adopt best practice and new ideas, and ask those organisations that do not respond to patients to explain why.

100. The overview and scrutiny committee has an important future role to play in taking this agenda forward (together with the new health and Wellbeing Board), holding NHS organisations to account and working in lock-step with clinicians to help deliver sustainable improvements for patients.