QUEEN ELIZABETH HOSPITAL KING'S LYNN CONTINGENCY PLANNING TEAM

Monitor

Final report executive summary

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McKinsey&Company

Contents

FOREWORD

In September 2014 Monitor appointed a consortium of expertise led by McKinsey & Company to form a Contingency Planning Team (CPT) to:

- Gather detailed evidence and data to describe the current picture of health and healthcare in West Norfolk
- Carry out a high level assessment of future health needs and demands and the local system's readiness to meet them.
- Design and implement a clinically led engagement programme, building on the work of the West Norfolk Alliance, to examine the clinical evidence for high quality services (as well as examples of national and international best practice) in order to describe 'what good looks like' across a number of care pathways, and to help design possible future solutions for the long-term sustainability of the Local Health Economy (LHE)
- Ensure there is a comprehensive programme of communications and engagement with staff, stakeholders, patients, carers and the public in place to support the programme, and to ensure that the patient voice and insights feed into the programme and solution development appropriately
- Develop a report to Monitor with recommendations for how long-term clinical quality and financial sustainability could be achieved for Queen Elizabeth Hospital and the broader local health economy.

This report to Monitor is the summary of the CPT findings and recommendations

EXECUTIVE SUMMARY

In line with many other areas across England, health and care services across West Norfolk have been experiencing increasing demand due to an ageing population, growing prevalence of long-term conditions and increasing availability of new services, treatments and technologies. This is projected to continue.

Current services do not best meet the health needs of an increasingly old and frail population, nor address the increasing numbers of people living with long term conditions. Further, under current models of care, in a 'flat cash' environment, there will be a "financial gap" between estimated costs and funding for local services of close to £80 million across the West Norfolk local health economy over the next five years.

The Queen Elizabeth Hospital, King's Lynn (QEH) has been in breach of Monitor's license conditions since January 2012 and was placed in 'special measures' by the Care Quality Commission in October 2013. In response to this, the trust has invested in higher staffing levels and high rates of agency/locum spend, which are partially responsible for the Trust's forecasted £14.9 million deficit in 2014/15. By 2018/19, we expect the Trust's contribution to the local health economy's overall deficit to be £39.2m.

The analysis conducted by the CPT, and tested and critiqued by clinicians and health leaders in West Norfolk, suggests that the Trust's current deficit is largely driven by operational issues which can and should be addressed. However, the scale of the future tariff deflation and cost inflation combined with clinical sustainability challenges (e.g. the need for 24x7 consultant delivered services to meet national quality standards and increasing sub-specialisation) make the projected financial situation more structural in nature. Specifically, the CPT found that a number of key services will struggle to be clinically or financially sustainable in their current form given the low volumes of activity associated with them.[1]

The CPT, working with local clinicians and managers, has identified fourteen areas where the local health economy and QEH should improve ways of working to ensure improved quality of care for the local population and improved financial

[1] We define financially sub-scale services as those where a trust does not have sufficient clinical volume to offset the fixed costs of the service under tariff, even if the trust is operationally efficient. We define clinically sub-scale services as those where the trust does not have sufficient volumes of activity to maintain and build the skill levels of its clinicians and/or maintain national minimum staffing levels and/or meet national guidelines for high quality care

performance. Together these would improve the West Norfolk position by £70 million but are unlikely to close the full financial gap of £80 million.

Further efficiency gains in all services, further reduction of duplication in services and assets across the health economy, more significant reconfiguration of services and potential organizational change could close the gap while maintaining and/or improving quality of care and should be considered by the CCG and the Trust, working collaboratively with other local providers, recognizing the particular challenges of the rural geography of King's Lynn and West Norfolk.

QEH and West Norfolk Clinical Commissioning Group (WNCCG) have already put together 2015/16 plans to address these challenges: QEH focusing on improving its operational performance and WNCCG focusing on prescribing and contractual levers, as well as on establishing a primary/community care hub in King's Lynn aimed at improving care for the frail elderly.

This report describes the scale of the challenges that will remain beyond 2015/16 and a set of actions to address those challenges. While the actions we describe are set over a 5-year time horizon, they are significant, and work will need to begin now to move forward on these.

Implementing the necessary changes will require vision and ambition. More importantly, it will require strong and collaborative leadership across WNCCG, the Trust and the broader local health economy – on a more developed scale than today.

THE LOCAL HEALTH ECONOMY

The district of King's Lynn and West Norfolk comprises approximately 170,000 people, of whom 25% are over the age of 65 (compared to 17% over 65 years for England). The population is growing at around 0.6% a year overall, with the population aged 85 and over growing by 3.4%. In contrast 15-25 year olds are declining by 1.6% per annum. The locality of Wisbech, Cambridgeshire (whose population also use QEH) comprises approximately 31,000 people of whom around 6,500 (20%) are over 65 years.

Overall mortality rates for the population of West Norfolk are in line with the England average and in some cases are better than average. However, the prevalence of various long term conditions such as asthma, chronic obstructive pulmonary disease (COPD), atrial fibrillation, coronary heart disease, hypertension, stroke, diabetes, heart failure, dementia and learning disability are higher in this area than for England overall partially explained by the older population. Prevalence rates for these conditions are expected to increase over the next 5–10 years as the population ages. Obesity in West Norfolk is 11% higher than the England average at 10.5%.

The quality of primary care across the local health economy is variable. This can result in sub-optimal care for people with long term conditions and the frail elderly and in people with relatively minor conditions attending the A&E department at QEH. Although overall A&E attendances are lower than the England average, there is variation of A&E attendances by GP practice – varying from 141 attendances per 1,000 patients (weighted for age and health status) per year to 313 per 1,000 (a variation of 122%). Non-elective ambulatory care sensitive admissions by GP practice are higher than the England average, with again high levels of variation between GP practices. Rates vary from 11 admissions per 1,000 weighted patients per year to 27 (a variation of 150%), while the England average is 18.1 per 1,000 weighted registered patients.

While the current age profile of local GPs is in line with England averages, a relatively small number of GP registrars indicates a potential for future GP shortages across King's Lynn and West Norfolk under current models of care.

The district of King's Lynn and West Norfolk ranks 300th out of 326 for population density (104 people per km^2), making it one of the most sparsely populated districts in England. Although there are local community, social and mental health providers, the closest alternative acute hospitals are over 38 miles away from King's Lynn with mostly single carriage road access.

THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN (QEH)

QEH is a small local district general hospital with an income of £165m and c.430 beds, of which c.280 are acute medical beds.

QEH has been in breach of Monitor's license conditions since January 2012 and was placed in 'special measures' by the Care Quality Commission in October 2013. Overall quality of care has improved and recent Dr Foster reports indicate QEH has a lower than expected Standardised Mortality Ratio, average lengths of stay and is in line with expected readmission rates. However, the CQC continues to identify six areas as needing improvement.

In response to this, the clinicians and management at QEH have taken considerable steps to drive improvements. The Trust has increased the presence of senior clinical staff, through recruiting more senior nurses and increasing the level of consultant-delivered care. However, due to historic recruitment difficulties some clinical posts have had to rely on expensive bank, locum and agency staff to fulfill the requirements.

Our analysis indicates that the 2014/15 financial deficit of £14.9 million at QEH is largely operational in nature. A top-down analysis comparing QEH to similar trusts (e.g. James Paget, Isle of Wight, Dartford and Gravesham) suggests the current gap can almost be closed through operational improvements:

Potential improvement action	**Potential saving**
Reducing medical pay costs	£ 1.5m (pay per doctor) and £ 7.9m (numbers of doctors[2])
Reducing average length of stay	£ 2.0m (nursing costs)
Improving procurement of drugs, consumables, services	£ 1.3m
Reducing non-clinical staff pay	£ 2.0m
Total	**£14.7m**

[2] Partially due to higher locum and agency spending levels than other trusts – agency pay costs have increased from £2m p.a. to £10m p.a. in the last year

A NUMBER OF SERVICES AT QEH ARE NOT CLINICALLY SUSTAINABLE IN THEIR CURRENT FORM

Several factors impact the future clinical sustainability of services at QEH - specifically:

- Increasing **sub-specialisation nationally and internationally**. Surgeons are now often specialised in one clinical area. For example urologists, vascular surgeons, breast surgeons, and GI surgeons now treat patients who may previously have been treated by general surgeons. This means that all of these specialties now need to be available to patients – either in a local hospital or at another hospital, provided through a networked arrangement
- Necessary **clinical scale** - specialist staff need to be seeing enough patients in their own specialist area to maintain their skills and expertise. Some specialties in QEH experience relatively low volumes of patients compared to England averages and recommended levels of activity to meet quality and safety guidelines. These specialties are most notably maternity, inpatient paediatrics, A&E, emergency surgery and more complex elective (planned) surgical procedures (e.g., procedures related to cancer).
- There is a national drive to have senior **clinicians available on a 24x7** basis to meet nationally recognised quality standards and improve patient outcomes. This typically applies to maternity care, inpatient paediatric care, critical care, A&E and emergency admissions, particularly for people admitted for emergency surgery. In smaller hospitals, such as QEH, this is hard to achieve – partly because there is not enough work to maintain the skills and expertise of the 8-10 whole time equivalent (WTE) consultants necessary to staff a 24x7 rota, which makes the jobs less attractive and results in de-skilling of the staff – and partly because the income associated with the activity is not sufficient to cover the costs of this number of senior staff.

Combined, this results in unsustainable services **if they continue to be provided in the current way**. Specifically:

- **Maternity care**: QEH is one of the smaller obstetric units in the country delivering around 2,300 births per year - an average of 6 births per day. There is 40 hours of consultant resident cover per week (around 25% of the time), meaning not all women get the same level of obstetric care during all hours of the week. The low number of births makes it difficult to staff to demand. The Deanery has announced removal of two registrar posts in 2015, thus making rotas less sustainable and more expensive to maintain. The national drive towards a consultant delivered service provides further challenge. Quality of care is not as good as it could be with a lack of a midwife led facility and a relatively high incidence of postpartum

haemorrhage and 3rd / 4th degree perineal tears. At the same time there is an increase in complex pregnancies in the West Norfolk area.

- **Paediatrics**: 61% of paediatric attendances to A&E are discharged with no follow up or follow up by a GP suggesting availability of out of hospital care needs to be improved. Current 111 and primary care staff lack specialist paediatric training. There are relatively few paediatric admissions to QEH, with 11 admissions per 1,000 children vs. an England average of 14. There are six paediatricians who support inpatient beds, a neonatal intensive care unit, a paediatric assessment unit (open 5 days a week), A&E, outpatient clinics and neonatal care; one of these paediatricians is expected to retire in summer 2015.
- **Stroke services**: QEH has around 530 stroke admissions per year while the England average for an acute hospital service is 560 and the national recommendation for minimum volumes is 600 per year. Clinical quality was assessed to be lower/worse than the England average in 4 out of 6 domains in the national Stroke Audit of 2014 but was rated more highly in the most recent national Stroke Audit, published in February 2015.[3]
- **Planned care**: QEH is a relatively small unit for cancer surgery, knee replacements, spinal surgery and interventional radiology. There are 261 knee replacements compared to an England average of 432 and 421 spinal surgeries vs. an England average of 572. The trust has had difficulties in meeting 'referral to treatment' waiting time targets.

NEITHER THE LOCAL HEALTH ECONOMY NOR QEH ARE FINANCIALLY SUSTAINABLE UNDER THE CURRENT MODELS OF CARE

The CPT estimates the financial challenge across the local health economy and QEH to be £80m by 2018/19 in a 'do-nothing' scenario, i.e. before implementation of new initiatives or cost reduction programmes across the local health economy.

This challenge is made up of £30m for WNCCG, £11m for Wisbech Local Commissioning Group (LCG) and £39m for QEH. It does not include forecasted deficits for Norfolk Community Health and Care NHS Trust, Norfolk and Suffolk NHS Foundation Trust, primary care providers and the NHS England Local Area Team – all of which face financial challenges as well. We estimate the combined

[3] QEH performing below national average in SSNAP 2014 on: scan within 1 hour, formal swallow assessment within 72 hours, joint health and social care plan on discharge, discharge with stroke specialist early support discharge team

impact of these is to increase the forecast financial challenge of the local health economy to c.£90-100m for 2018/19.

For QEH, the projected 2018/19 deficit before any commissioner initiatives are implemented – e.g. the 'do nothing' position, is a £39.2m deficit. Compared to the 2013/14 final deficit of £13m[4] the projected position arises from:

- Non recurrent pressures and full year effects of CIP under-delivery at £5.3m
- Price changes of £10.7m (i.e. tariff deflator)
- Cost inflation (pay and non-pay) of £15.5m
- Additional local cost pressures of £4.8m
- Increase in activity (demographic and non-demographic growth) for an additional income of £10.1m

The forecast deficit largely sits with emergency services where activity is relatively low in volume but where there are relatively high fixed and semi-fixed costs to maintain staffing levels on a 24x7 basis. Forecast service deficits are shown below:

QEH service	Forecast 2018/19 deficit in a 'do nothing' position, £m
Obstetrics	4.2
A&E	6.4
Acute medicine	6.6
Acute surgery	3.6
Critical care	4.5
Paediatrics	2.9
Other	11.0
Total	39.2

[4] The 2014/15 end year position is a £14.9m deficit

THE CPT, WORKING WITH LOCAL CLINICIANS AND MANAGERS, HAS IDENTIFIED 14 AREAS WHERE THE LOCAL HEALTH ECONOMY AND QEH SHOULD IMPROVE QUALITY OF CARE AND FINANCIAL PERFORMANCE

Commissioners should:

1. Increase preventative measures to improve the health of the local population
2. Decommission procedures of limited clinical effectiveness
3. Commission services from highest value/lowest cost providers
4. Improve the model of care for people with long term conditions
5. Improve the model of care for the frail elderly population
6. Reduce spend on prescribing
7. Reduce spend at QEH through contractual/transactional levers
8. Reduce the unit cost of community care through contractual levers and supporting changes to the model of care

NHS England should

9. Reduce the unit cost of primary care through contractual levers and supporting changes to the model of care.

QEH, with support from commissioners, should:

10. Reduce the unit cost of hospital care through operational improvement
11. Reduce the unit cost of hospital care through transformation of services

QEH and commissioners jointly should:

12. Reconfigure services to put in place alternative 'ceilings of care'[5]
13. Reduce fixed costs across the whole health economy
14. Reduce unit costs through organisational changes

[5] The level of care available locally to treat patients of differing levels of clinical acuity

Commissioning plans (1-8 on the list above) cumulatively result in over £41 million commissioner led savings. However, these also reduce income for QEH by an estimated £20.5m. The Trust could reduce costs associated with this activity by £15.2m[6] leaving an additional cost pressure on the Trust of around £5.3m – giving a revised financial challenge for QEH, post commissioner intentions, of around £44.5m by 2018/19.

QEH should implement a **cost improvement programme** (to deliver £27m per annum), more **transformative changes** (£4-5m) and **reconfiguration** of services (current proposals are estimated to deliver around £1m in savings).

This would result in a residual deficit of £12m.

Although the full potential of reconfiguring services (or introducing alternative 'ceilings of care') is up to £13 million, the commissioners do not believe it is achievable nor desirable given the remoteness of the area. Moreover, the clinical working groups have emphasised the importance of providing a full range of acute services locally as they are delivered today.

Organisational changes (e.g. through merger synergies) can release a further £2 million. Optimisation of estates across the local health economy could deliver an additional £1-2 million of cost savings.

Both QEH and the local commissioners have already begun working on the 2015-16 plans and some of them are well under way, e.g. prescribing plans by WNCCG and operational improvement plans for QEH. However, longer-term changes will require significant further work and commitment from the whole local health economy to close the predicted future financial gap while ensuring clinical sustainability.

[6] Based on assessment of where costs can be taken out as a result of specific detailed commissioning intentions, and based on an assumption of the Trust being able to take out 60% of costs associated with activity (as agreed with QEH)

THE CCG SHOULD IMPROVE THE HEALTH STATUS OF THE POPULATION AND ENABLE FINANCIAL SUSTAINABILITY THROUGH IMPLEMENTING EIGHT ACTIONS

WNCCG needs to reduce spend by £30m by 2018/19 in order to remain financially sustainable, and Wisbech LCG needs to reduce spend by £11m.

WNCCG should:

- Ensure sufficient focus on **prevention** – in particular continuing to support the local population to reduce smoking rates and tackle obesity. The CPT recognises the importance of this area but does not believe it will deliver financial benefits in the next five years.
- **Reduce spend on procedures of limited clinical effectiveness by up to £2.5m**. The CCG currently spends £7.2m - 60% more than other CCGs in England (on a weighted per capita basis) – on procedures identified to be of limited/questionable clinical effectiveness – largely minor dermatology procedures and hip replacements. Initial benchmarking suggest a potential opportunity to reduce this activity to the level of other England CCGs which will reduce activity at QEH by approximately 4,000 procedures per year[7] which equates to around 5 less theatre sessions per day [6] (depending on the mix of procedures), or 2 theatres out of the current 11 theatres operating at QEH (there are currently 7 main theatres and 4 day case theatres). The CCG would need to do further more detailed work to establish the precise local opportunity, and is committed to doing so. If the opportunity is less than the £2.5m quantified here, additional commissioning savings will need to be added to further savings as outlined below.
- **Reduce spend on acute medical admissions by up to £3.4m** - equivalent to 4,750 fewer admissions, which, combined with reduced length of stay, results in a need for 119 fewer inpatient beds out of the current medical bed base of 280 (total bed base of c. 450). Gross savings for WNCCG would be £9.5m - we have deducted from this the impact of the marginal rate tariff of £2.3m and £3.8m for investments in new services to facilitate this initiative. These figures were discussed with the operating and finance working group but could be changed through ongoing discussions across the LHE. Any changes would need to be reviewed with the Trust and the impact adjusted.
- **Reduce prescribing spend and address contractual arrangements to contribute £5-6m in 2015/16**, and more in the future.

[7] Based on average number of 3 day cases per day-case list at QEH in 2013/14 (using QEH actual theatre performance data for 2014/15)

- **Develop detailed plans and financial assessment for additional initiatives**, such as commissioning activity from other more cost effective providers, in order **to contribute up to £18m of financial savings by 2018/19** in order for the CCG to be financially sustainable. The CCG also has a number of other commissioning initiatives in place. Any changes to these would need to be included in any future analysis and assessed for impact on the Trust.

Combined, we estimate the impact of commissioner plans on QEH by 2018/19 to be £20.5m less clinical income (£7.2m from changes to the model of care for frail elderly and people with long term conditions[8], £2.5m from reduction in elective procedures of limited clinical effectiveness and £10.8m from other initiatives which are, as yet, undefined). This consists of:

- 4,000 less elective procedures, which equate to up to two theatres of the current eleven theatres at QEH
- 4,750 less non-elective admissions, which each have an average length of stay of 7.7 days and hence equate to 119 acute medical beds (i.e. 3-4 medical wards at QEH)

Note, this analysis will need to change if the CCG commissioning intentions are changed.

Other initiatives by commissioners may also have impact on activity at QEH, but as these are not yet detailed we cannot estimate the precise impact on activity at this stage.

QEH can and should respond to these changes and ameliorate the negative financial impact. We believe **QEH can take out £15.2m of costs associated with the £20.5m of lost income**:

- Changes to the model of care for frail elderly people and people with long term conditions will reduce income at QEH by £7.2m and reduce the bed base by up to 119 medical beds. A bottom up analysis indicates QEH will be able to take out up to £7.2m of costs
  - Staff associated with this activity - 12 consultant WTE, 13 junior doctor WTE and 111 nurse WTE (mix of registered and non-registered nurses). The impact of this on sustainability of medical rotas will need to be evaluated carefully
  - Non-pay costs associated with this activity, namely drugs and supplies.

[8] Total clinical income at QEH associated with the population targeted by this initiative is £9.5m. However, £2.3m are transferred from QEH to WNCCG as penalties for non-elective activity above the cap and hence net impact on QEH is only £7.2m

- Reduction in number of elective procedures of limited clinical effectiveness will reduce the need for two theatres out of the eleven theatres at QEH today and £2.5m of clinical income. QEH believes it can take out up to £1.5m of costs associated with this activity, through a combination of reduction in theatre staffing, medical capacity and non-pay costs.
- As other initiatives by WNCCG for a total of £10.8m more loss of income are not detailed yet, we assume QEH can take out 60% of associated costs, or £6.5m[9]. As these initiatives are developed, the exact impact on activity and staffing at QEH will need to be evaluated.

This then leaves stranded costs of £5.3m. This will move QEH from a 'do-nothing' forecast deficit of £39.2m for 2018/19 to a forecast deficit of £44.5m post commissioner intentions.

Note: more details of the operational plans required to implement these changes have been provided to the Trust.

[9] Based on the share of spend with QEH relative to total WNCCG spend. We assume QEH will have 40% stranded costs as a result, i.e. £4.3m

OPERATIONAL IMPROVEMENTS AT QEH

Our work to date on operational improvements indicates an opportunity to reduce costs by up to £7.1m by 2015/16, which will bring QEH to between the median and the top quartile of all providers within its peer group.

QEH believes there is an opportunity to reduce costs by £15m between 2016/17 and 2018/19, which will then keep QEH in line with the peer group.

Combined with £4.8m of savings already made in 2014/15, this will bring the total operational improvement opportunity for QEH for 2014/15-2018/19 to £26.9m

Specifically, in 2015/16 QEH should:

a) Reduce medical spend (focused on agency and locum) **by £3.0m per annum by:**

- Reducing Waiting List Initiative (WLI) payments by £1.2m through improved efficiency in outpatients, theatres and day surgery
- Reducing pay spend in A&E by £1.2m through changes to the workforce model. This will be achieved by the hiring of substantive consultants into ED to replace agency doctors, enabling a reduction in consultant and nursing agency spend and substantive spend on associate specialists – 1 WTE has already been hired, with plans for 3 more WTEs by March 2016
- Saving £0.6m net on medical agency spend by implementation of CMRS medical bank (Central Medical Resourcing Service)

Capturing opportunities in medical productivity will have to be underpinned by annualisation of job plans, networking with other providers to reduce the financial burden of unrequired capacity and robust performance management. QEH already has shared posts with other providers (Norfolk and Norwich University Hospital, Cambridge University Hospital and Papworth) where 20 consultants are employed for around 100 clinical Programmed Activities (PAs) per week (and 16 PAs of travel time). QEH will need to examine these working arrangements to ensure other providers also pay their fair share of sPA, training and vacation days, and that QEH is fairly reimbursed for the marginal contribution of that activity where appropriate

b) Reduce spend on agency nursing to delivery £0.8m net savings per annum by:

- Increasing the enrolment of registered nurses in the nurse bank from 67% (545 of 817 registered nurse WTEs) to 90% (excludes occupational health and other non-comparable nurses), and increasing the average shifts covered

per month per registered bank nurse from 1.1 shifts to 1.3 shifts. This would provide enough cover to entirely meet the current agency demand of 456 shifts per month, for a net saving of £0.8m (assumes an average agency rate of £40 per hour and bank rate of £20 per hour)

- Establishing a new central nurse bank

c) Reduce sickness and absence rates across all staff groups from 4.9% to 3% (40% reduction), in line with National Institute of Health guidance to deliver savings or £0.6-1.1m

d) Reduce divisional spend by £1.2m, increasing to £2m per annum

e) Reduce drug spend by £1m per annum by

- Reviewing spend on high cost drugs e.g. Lucentis and insulin analogues [Note: We recognise that costs of specialist drugs may be managed on a pass through basis, therefore some of the savings may accrue to the broader system rather than to the QEH per se]
- Putting in place improved medicine management
- Implementing a formulary, e-prescribing and networking with neighbouring providers to share best practices.

From 2016/17-2018/19, QEH will need to reduce costs by a further £15m per annum. To date, savings of £2.6m have been identified for realisation in 2016/17. Specifically, QEH should

a) Reduce medical costs by a further £1.7m through a combination of:

- Reducing spend on sPAs by £1m, through a reduction of variation in sPA allocation and aligning sPA allocation to 1.5 per consultant in line with emerging national guidance. The Trust should seek to expedite the consultation process and complete this by July 2015
- Reducing allocation on clinical excellence awards (CEAs) by £0.3m from the current 54% of the consultant body to the recommended 35%. This cannot occur in 2015/16 as CEAs cannot be withdrawn, however, a reduction in spend of £0.3m may be achievable as long-established recipients begin to retire or leave the Trust. The Trust should seek to tighten the criteria to receive new CEAs and limit further expenditure
- Further reducing pay spend in A&E by £0.4m through continued rollout of changes to the workforce model

b) Reduce spend by a further £0.9m net on nursing bank spend through increased recruitment

In addition**,** £4.4m of NHS activity now being commissioned by WNCCG from private providers could potentially be repatriated if QEH improves productivity in theatres and outpatients and reduces waiting times. Initial discussions between QEH and WNCCG indicate QEH will need to improve levels of service and waiting times to make this a tangible opportunity and the impact of patient choice would also need to be taken into account.

The CPT prioritised several areas of opportunity, namely medical productivity and non-pay, as these were highlighted through the top down diagnostic effort. There are other areas where the CPT did not look in detail, such as corporate, procurement of general supplies and clinical supplies beyond drugs, capital optimisation, ST&T workforce, non-ward based nursing workforce – all of which should be the focus of further efforts to reduce costs.

ON TOP OF "TRADITIONAL" OPERATIONAL IMPROVEMENTS, QEH SHOULD MORE RADICALLY TRANSFORM SERVICES TO ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY

Given the small volumes of activity at QEH, services will need to be delivered in fundamentally different ways to ensure clinical and financial sustainability into the future.

In **urgent care**, the trust (with local health economy support) can improve financial performance **by £1.4m** through:

- Aligning staffing levels to those in similar sized A&E departments in other parts of the country (£0.8m on top of cost improvement initiatives accounted for in the previous section of this report on operational improvement)
- Combining the GP out of hours service with the A&E to increase scale (£0.6m of additional income with no additional cost)
- Developing a new "front door" of the hospital to bring together major A&E care with the medical assessment unit, surgical assessment unit, paediatric assessment unit and frail elderly assessment unit to enable combined staffing and more efficient working (though please note the impact is not included here to avoid double counting with QEH cost reduction following the impact of changes to the model of care for the frail elderly)

These changes will leave the service (A&E and acute medicine) with an **£8.5m deficit** by 2018/19.

In **elective care**, the trust could reduce costs by up to **£1.7m p.a.** by

- Delivering outpatient consultations more efficiently by deploying technology (e.g. Skype) and moving to new ways of working such as group appointments for those patients with long term conditions (for example those with asthma or diabetes) or routine follow ups. There is evidence of these innovations working well elsewhere and delivering significant efficiencies. Note, this analysis assumes the benefit of moving to these new ways of working would fall with the Trust. Should the CCG decide to commission these services under a different/reduced tariff, then the benefit to the Trust would be reduced.
- Moving to new models of employment with consultants e.g. contracting with consultants for services required rather than a full time employment model. This would likely be required should the CCG seek to de-commission some outpatient specialities.

In **maternity care**, the trust can improve financial performance by **£1.3m** through:

- Improving midwife productivity through improved ways of working (reducing administrative burden and travel times, using IT, moving towards group consultations, supporting women to play a greater role in their care) would result into savings of **£800-900k** per annum. While capturing the savings will require QEH to move from the current 29 births per midwife per year to 35, we believe this can be achieved while also increasing patient facing time. This will require endorsement from NHS England and may have implications for CNST premiums. Our opinion is that evidence elsewhere internationally shows this increase in births per midwife does not compromise safety standards as professional skill and midwife capacity is redeployed through the freeing up of midwife time from administrative tasks, unproductive time and travel.
- Moving towards an "on call" model of midwifery rather than the current "rostered service" – this would enable a home birth service to be provided without additional investment and would also enable further efficiency gains.
- Improving consultant productivity by introducing a more flexible rota (e.g. ability to flex into the delivery suite from SPA and outpatient activities, running pre/post natal clinics 6-7 days per week). This would result in savings of **£200-400k per annum** but would require QEH to successfully re-negotiate medical (consultant and junior medical staff) rotas to accommodate greater flexibility.

These changes will leave the service with a **£3m** deficit by 2018/19.

In **paediatric care**, two potential alternative models of care have been considered:

- Model one: developing out of hospital care so that more children can be cared for outside of hospital – for example through community based hubs which bring together primary care services, community care services, community and acute paediatricians, social care and mental health services – with easier access through longer opening hours. One of these hubs could be located on the QEH site and incorporated into the QEH 'front door' - there is an interdependency with transformation in urgent care. This will reduce A&E attendances and inpatient admissions, but will have a **negative financial impact on QEH of £0.9m** due to stranded costs, as QEH will still need to staff consultants to maintain a level two neonatal intensive care unit (NICU) service.
- Model two: the same as above, but with a nurse led Level One NICU locally, which will require QEH to work in a networked arrangement with neighbouring providers. This will have a **positive financial impact of £1.1m** on QEH. Currently, the clinical working groups, have advised that a Level

Two NICU is required locally due to interdependencies with maternity services. However, in the last Strategic Oversight Group meeting this alternative model was proposed.

Assuming the local health economy chooses to stay with the current model of care, it will leave the service with a **£2.9m deficit** by 2018/19. Moving to model two as described above could improve the financial position to a forecast **£1.8m deficit**.

THE LOCAL HEALTH ECONOMY AND QEH SHOULD SEEK TO PROVIDE SOME SERVICES IN COMBINATION WITH OTHER PROVIDERS TO REDUCE SPEND BY £1.0-13.2M PER ANNUM

A range of scenarios for the future clinical service configuration at QEH has been explored ranging from QEH focusing on urgent care, care of the frail elderly, midwife led births and outpatient/diagnostic services with more acute care provided by other hospitals, through to the hospital continuing to provide the current range of services. These scenarios have been discussed at the clinical working groups and the recommendation of these groups, and the Chair of the clinical working groups specifically, is that the full range of acute services as they are today is required locally.

We have evaluated the impact of these on finances at QEH and other providers and on patients' access to care. All models assume outpatient and diagnostic services remain locally delivered as they are today to maintain maximum access to care for patients locally. They also take into account changes to the Market Forces Factor (MFF) which the CCG would need to incur, but do not take into account additional costs for patient transport.

- **Reducing out of hours surgery** can improve the financial deficit by £0.2m; 250 acute surgical cases operated on out of hours today will need to travel to other providers (assuming they all need to be operated on out of hours)
- Having **no acute surgery on site** (only stabilise and transfer along with elective surgical care), while maintaining other current services will improve the financial position by **£2.4m.** Around 1% of current patient contacts at QEH will need to travel to other providers
- **No acute surgery and midwife led obstetrics** only will improve the financial position by **£4m.** Around 3% of current patient contacts at QEH will need to travel to alternative providers
- A **core model** of care with front of house urgent care/A&E, frail elderly unit and acute medicine, access to a surgical team to stabilise and transfer, Level Two high dependency unit, paediatric assessment unit and midwifery led unit – will improve the financial position by **£6.4m,** with 10% of current patient contacts at QEH needing to travel to alternative providers
- An **urgent care centre model** with an urgent care centre, co-located primary care, stabilise and transfer for inpatient care, paediatric assessment unit and a midwife led unit will improve the financial position by **£12.4m,** and 17% of patient contacts will need to travel to alternative providers.

Consideration needs to be given to the geography of West Norfolk – other acute hospitals are at least 38 miles away on largely single track roads – resulting in journey times of up to an hour for the local population.

In all these scenarios, the trust will need to provide more services in a **network with other local acute hospital trusts,** with joint consultant contracts, common protocols and joint ownership for quality and efficiency metrics. Other similar sized hospitals in the UK already work in this way and we believe this would offer advantages to the patients using QEH and the staff who work there. The financial benefit of this is estimated to be at least **£0.8m**. Such working arrangements will need to include sharing the costs of medical staffing, holidays and training, as well as possibly sharing some of the marginal contribution of activity performed by consultants at other providers.

COMBINED, THE ABOVE INITIATIVES RESULT IN AN IMPROVED FINANCIAL POSITION FOR THE LOCAL HEALTH ECONOMY OF A £12M FINANCIAL CHALLENGE (RELATIVE TO A DO NOTHING FORECAST FINANCIAL CHALLENGE OF £80M) AND £12M DEFICIT FOR QEH (RELATIVE TO DO NOTHING FORECAST DEFICIT OF £39M).

Together proposed solutions improve the local health economy financial position in 2018/19 by £68m, with a remaining £12m gap:

- **Commissioning plans** cumulatively result in over **£41 million** commissioner savings that improve the commissioners' position but create an additional £21million pressure for QEH. QEH can address part of this pressure through cost reductions (£15 million).
- QEH is developing plans to deliver a further **£27 million** in **cost improvement programmes (CIPs)**.
- A further **£4-5 million** can be delivered through more **transformative changes**
- Collaboration with neighbouring Trusts and a slight reduction in the ceiling of care locally, if pursued, can reduce costs by a further **£1m**

Overall the impact on QEH of these initiatives results in a **£12 million forecast deficit for 2018/19**.

HOWEVER, THERE ARE A NUMBER OF OTHER AREAS WHICH COULD BE CONSIDERED.

In order **to fully close the gap**, other areas could be considered – specifically:

- Consolidating services and **rationalising the estate** across the whole health economy – specifically by co-locating all services for the population of King's Lynn in the hospital and using the physical capacity vacated through improved throughput, de-commissioning of services and a move towards 7 days a week working. We estimate the impact of this to be at least **£1-2m** based on total estate costs across the local health economy of at least £15m
- Developing new services on the QEH site – specifically nursing home beds and/or residential home beds
- Further reconfiguration of services to move to a **lower ceiling of care** (the financial impact of the urgent care centre only model on QEH is **£12.4m** relative to the current model of care, and the impact on the **LHE is £10.8m** due to an increased MFF impact on WNCCG of £1.6m)
- More radical service transformation, such as eICU. This is a novel model of care for Intensive Care Units and has been practised in the United States for 10 years now with considerable success. Currently 10% of all Intensive Care beds in the US are estimated to be eICU beds, though it should be recognized the definition of intensive care beds in the US is different to that in the NHS. This model leverages telemedicine and remote care to enable intensive care to be delivered to remote units which otherwise would have been difficult to staff because of low levels of activity, attractiveness of posts or other considerations. We estimate the impact of these at **£1-1.4m** cost reduction
- Organisational changes (e.g. through merger synergies) can release a further **£2m**
- In addition, commissioners will need to decide which services are designated as "Commissioner Requested Services" and therefore need to be provided locally at an adjusted tariff.

Together those create up to **£16.7m of additional opportunities** (not accounting for local tariff modifications). However some of them, particularly lower ceilings of care, may not be acceptable to local stakeholders and will require an aligned ambition and focused local leadership to deliver.

IMPLEMENTING THESE CHANGES WILL REQUIRE ROBUST LEADERSHIP AND A CLEAR PLAN FOR 2015/16

The scale of challenge across the local health economy is significant. All available levers will need to be pulled in order to deliver improved quality care, improved health outcomes and financial and clinical sustainability. It will require purposeful leadership across both commissioners and providers to deliver the scale of change required.

WNCCG should build capacity and capabilities to further develop and quantify commissioning plans and their impact on providers. They should work to overcome resistance to change in order to deliver improvements to care and an improved financial position.

QEH leadership should work closely with clinicians across the trust, and with neighbouring providers, to make ambitious changes to working patterns a reality and avoid losing valuable staff, in turn increasing agency costs. The Trust should consider:

- Co-creating a compelling transformation story that staff can relate to which is actively communicated
- Creating a clinical engagement programme led by the Medical Director to actively identify and promote clinical leaders to drive change
- Ensuring more accurate information on operational efficiency is available to support change through a more robust service line reporting system

Both WNCCG and QEH should ensure a strong programme of engagement with their staff, stakeholders, partners in care and, of course, patients, carers and the public to help deliver changes effectively.

Moreover, both organisations should put in place a clear implementation plan and robust governance processes to track implementation, identify and mitigate risks and to keep pace on delivering their focused ambitions.