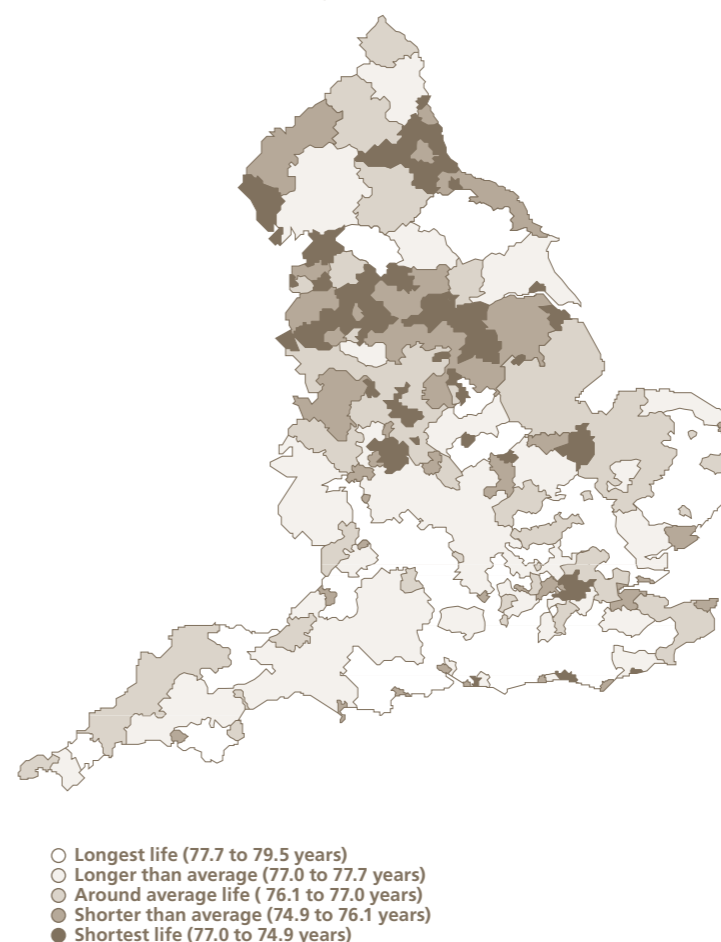


The Case for Change

Reason one
We want, and need, to improve the health of people living in Yorkshire and the Humber and to reduce inequalities.

Figure 7. Male life expectancy at birth (quintile) / Source: © Crown Copyright 2008, all rights reserved. Ordnance Survey Licence no DH10002020. Chart provided by Department of Health



1 Why does healthcare need to change? Why can't we just carry on doing what we have always done? This chapter seeks to make a compelling case for why we need to tackle some of the root causes of ill health in Y&H, and why we cannot stand still in our provision of services.

Population health and inequality

2 Some parts of Y&H have the lowest life expectancies in England, as shown in figure 7 – using male life expectancy as an example.

3 Over the previous decade, we have seen an increase in life expectancy in Y&H – by over two years for men (76.6) and one year for women (81.0). But this is still below the national average life expectancy in England of 77.3 years for men and 81.6 years for women. And it masks significant variation within Y&H. A baby boy born in Bradford is almost three times more likely to die before their first birthday than a baby born in Hambleton.

4 Public health experts tell us that we have a 'demographic time bomb' in Y&H. The biggest avoidable threats to the health of our population are the continued prevalence of smoking, abuse of alcohol and rising obesity. If current trends continue, by 2010 we are likely to have the highest number of obese or overweight girls aged 11-15 in England.





Reason two
The local NHS is not always meeting the expectations of the public.

5

At the deliberative event in September, 94% of people supported strongly or to some extent the concept of the NHS free at the point of use, available to those in need. This has been a cornerstone of the NHS for the past sixty years. To ensure that the NHS not just survives, but prospers, into the next decade, we will need to halt and reverse these trends – otherwise costs will go up exponentially.

6

Alongside this, we know that our population is ageing and that there are predicted to be over 1.5 million living with some kind of long-term condition in Y&H by the end of the next decade. These changes in the make-up of the population, and the change from acute patterns of disease to chronic ill health will place a different burden on services.

7

In addition, there is a clear link between wealth and health. The NHS, as one of the biggest employers in the region, has a key role to play in improving the health of the economy. In turn, improving the economy can have a major impact on health.

Satisfaction with services

8

The NHS in Y&H has relatively high levels of satisfaction from people who are using services. But still a substantial minority (14%, from September 2007 polling data) are not very satisfied with services.

9

Why are people not satisfied? The number one issue of concern to people in Y&H is cleanliness – see figure 8 opposite.

10

This was backed up in our January deliberative event, where 97% of the audience agreed that getting the basics right – clean facilities with competent staff – was very important; and of all the issues raised, it was the issue that most mattered to them. We have not waited for this review to start tackling this issue. For example, a major programme is underway to “deep clean” all our hospitals in Y&H.

11

Cutting waiting times has ranked high on the public agenda for many years now. We are pleased with the progress we have made in Y&H, though there is still more to do.

Reason three
The quality and safety of care needs to improve – it is unfair that some people get access to better services than others.

Variation in local services

12

Local services are just that: services that reflect the needs of local people, designed for and with the communities they serve. So we should always expect to see some variation in the design of care.

13

What is unacceptable in a nationally-funded health system is the level of unexplained and unnecessary variation in care where that leads to different outcomes for patients. This review has shone a spotlight on variations which need clear attention in Y&H.

14

All eight CPGs found variations in care that were unrelated to clinical or social needs and these are highlighted in the chapters that follow. For example:

- We have very high hospital admissions for children with asthma.
- If you are thought to have suffered a stroke in Y&H, the likelihood of being referred for a scan to confirm diagnosis straight away – a key step in getting you well again – can vary significantly: see figure 9 opposite.

Figure 8. Which services need a lot of improvement?
Source: SHA analysis from Deliberative Event, September 2007

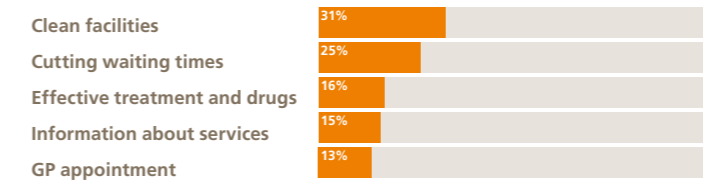
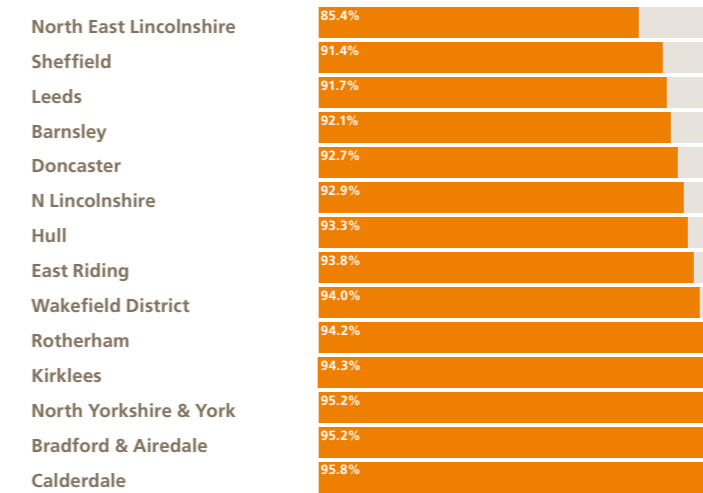
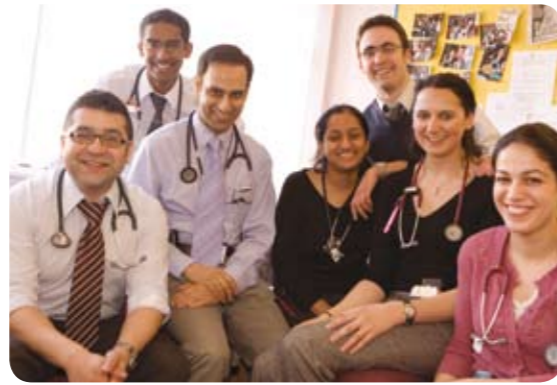


Figure 9. New patients with presumptive stroke referred for further investigation



Reason four
To enjoy the advances in research and science, we need to change how we deliver services.



Technology and scientific advances

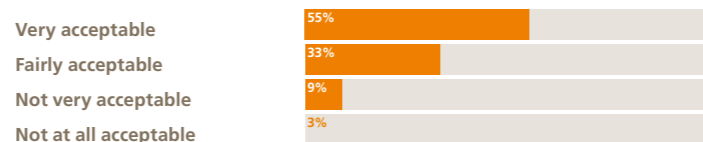
15
Life in Y&H is very different from sixty years ago. All around us we can see signs of change, and the advances of technology. Even twenty years ago, the potential of computers and mobile phones was not realised in everyday life.

16
This is just as true, if not more so, in health care. There is an exponential rise in technological advances. We need to ensure we exploit the full potential of the knowledge and tools we now have, or will have in the future, to deliver better outcomes.

17
National and international research tells us that, for some services, there is a link between the volume of treatment and the outcome, ie that to improve outcomes, a centre needs to treat a larger number of patients. Nowhere is this more evident than in the surgical treatment of many cancers.

18
Clinicians tell us, based on the best evidence available, that we could see improvements in the chances of survival for some conditions, if the appropriate services are centralised into much larger units. The public have told us that they would support this approach – see figure 10 opposite.

Fig 10. Planned care
How acceptable is it that complex operations (eg. some cancers and vascular conditions) or procedures for people with complex medical problems (those requiring high dependency and intensive care) are centralised to a smaller number of appropriately staffed and equipped hospitals? / Source: SHA Invitation to Influence Event, March 2008



In 2002, you could wait up to 15 months for inpatient treatment. In March 2008, 85% of patients were treated within 18 weeks of referral. The total number of people waiting for treatment has fallen by over 40% since 2002 – 40,000 fewer people.



Reason five
 Advances in science mean we have to change the way we deploy our clinical expertise.

19

Equally, advances in science mean that hospital care is often no longer necessary. Treatment can be provided closer to home, or in different ways such as drug therapy or day case surgery. There are now increasing examples of how technology can support people to take care of themselves at home.

20

We need to make sure that people living in Y&H don't suffer poorer care or poorer health because the local NHS has not made the changes to the pattern of care to exploit these advances in technology.

New skills and knowledge in the workforce

21

The impact of scientific and technological advance on the types of skills our workforce needs is often under-appreciated.

22

Sixty years ago, a surgeon would be trained as a general surgeon, ready to operate on any part of the body, for most conditions. As the quantum of knowledge increases, it is no longer feasible for one individual to hold all the specialist knowledge needed to operate on every condition to the same standard as specialists. So over recent years surgeons have increasingly specialised in particular areas of the body, such as breast surgery or paediatric cardiac surgery.

23

But increasingly, there is evidence that further sub-specialisation can benefit patients and improve outcomes for care. For example the most complex cases require a range of diagnostic equipment (MRI scanners, gamma cameras, PET scanners) to be available all in one place. To do this means locating high-tech equipment in centres of expertise where trained staff can utilise it and where there are enough cases to justify the cost of the technology.

24

Alongside this, over the past decade, there have been some important changes to the way in which doctors are trained. The one with the greatest impact has been the reduction in the working hours of junior doctors. This has been shown to reduce the risks from fatigued doctors treating patients and to improve outcomes for patients. The Working Time Directive requires doctors to work fewer hours – which means that more are needed to maintain 24/7 services and it can be difficult for smaller hospitals to employ enough consultants to provide continuous cover.

Reason six
 We need to make the best possible use of taxpayers' money.

Value for money

25

We need to make the best use of the money taxpayers give us. Every pound wasted is a pound that could have spent on care elsewhere.

26

The 'demographic time bomb' that we face as a region means that we need to make sure that we are spending money effectively and efficiently, otherwise healthcare spending will consume all the economy's growth.

27

On the face of it, the need to provide care efficiently sounds obvious. But the general public are not always informed about the reasons for change. So, for example, we know that in Y&H we do not always treat patients in a day, but make them stay overnight in hospital for relatively simple procedures. We look at this issue in more detail in the chapter on planned care.

28

The CPGs have not focussed on efficiency as their prime objective – but focussing on quality and systematic delivery of care in line with evidence will lead to a more efficient use of resources and better outcomes for patients.



1
Soljak M, Volumes of Procedures and Outcomes of Treatment, BMJ 2002;325:787-8 and Killeen SD, O'Sullivan MJ, Coffey JC, Kirwen WO, Redmond HP, Provider Volume and outcomes for oncological procedures, Br J Surgery 2005; 92(4): 389-402

2
American Hospital Statistics CSFB; AHA Trendwatch Chartbook, CMS, Office of the Actuary

29

These reasons for change apply to all services. Clinicians want to focus on what really matters: improving the quality of people's experience of healthcare, and improving the overall health and life expectancy in Y&H.

Improved care across the life journey

30

The next chapters set out the care pathways our clinicians advise should be put into practice across Y&H.

31

Each chapter starts by summarising the specific case for change, sets out key recommendations for change, and then goes on to describe in more detail the model of care for each pathway and how this could be put into practice. The chapters also look at the barriers that might get in the way of change and the good practice that already exists across the region.

32

There are some common principles that we believe should apply to all of the pathways.

33

These are that:

- Care should respect the needs of the individual, provide choice where appropriate and be effective best practice.
- There should be extended and simplified access to services.
- Services should be local where possible, but centralised where (or when – e.g., specialist cancer services) necessary.
- Care should be truly integrated – operating through networks which maximise the contribution of the entire workforce and all providers, including social care.
- Prevention is better than cure.
- There should be a clear focus on health inequalities and diversity.

Clinicians tell us, based on the best evidence available, that we could see improvements in the chances of survival for some conditions, if the appropriate services are centralised into larger units.