Appendix

# ACCELERATING THE "BIGGER PICTURE" – THE WAY FORWARD

## A DISCUSSION DOCUMENT

NHS South of Tyne and Wear

CONTENTS

## *Working Together*

Within the South of Tyne and Wear (SOTW) area there has always been a strong track record of partnership working, clinical networks and a general willingness to engage with each other to help overcome the many challenges that arise when working within the NHS.

Building on this history of working together, each of the three Foundation Trusts, Gateshead Health Foundation Trust (GHFT), South Tyneside Foundation Trust (STFT) and City Hospitals Sunderland Foundation Trust (CHSFT) and NHS SOTW agreed to work together on a much wider and bigger scale than previously attempted; this work is known as “The Bigger Picture”.

## *The Case for Change*

Back in 2008, the Strategic Health Authority (SHA) published ‘Our Vision, Our Future’. Before publishing the strategy the SHA reviewed a number of distinct elements, including work undertaken by eight clinical pathway groups each looking at a major area of NHS care with input from over 300 of the north east’s leading doctors, nurses and other clinical staff; therefore clinical engagement and, in particular, the views of clinicians who participated in the clinical pathway groups, were central to the strategy.

The SHA stated:

‘Our vision sets out an agenda for putting the patient at the heart of everything we do and, through a new sense of common purpose, describes systematically how we intend to transform services for the benefit of both patients and our 74,000 staff.

We know that some of the improvements we describe are complex and will take time. Change is always difficult and it is essential that we proceed at the right pace so that everyone affected has the chance to be involved and have their say so we get things right. This includes patients, staff and our partners.’

They also concluded that:

1. We have the worst health in England.
2. Our population both requires and makes more use of hospitals than any other part of England.
3. Our dependence on hospitals limits the resources we have to do more in preventing poor health and we have to do more for patients who have long term problems.

*‘These three features we call the cycle of missed opportunities and we must change the way we do things to break this cycle.’*

The document provided a high level view of the entire health economy, and described some of the unique issues facing the NHS in the North East. Locally, within SOTW there are a number of additional pressures or drivers for change, which are particularly relevant to acute Trusts and these are highlighted below.

## Local Sustainability

Across the three hospitals there are a number of clinical specialties where each organisation may have only one or two consultants or other specialists providing certain services. This poses obvious problems in relation to sustainability, for example covering the service as soon as the consultants take annual leave, go on external courses, or if they were sick for any period of time. Small departments are sometimes not that attractive in terms of recruiting new consultants and are therefore continuously running services which only just keep going and which require large amounts of energy and resources to sustain.

## Critical Mass

There are publications from Royal Colleges, the Department of Health and other bodies in relation to population figures for certain specialties. This guidance is for patient safety, to ensure that when a doctor is treating a patient he or she has enough experience to treat complex conditions. Research shows that something is more likely to go wrong when a patient is treated in a unit where the doctors are not seeing sufficient volumes of certain types of conditions.

It is different for different specialties, but across the three sites there are some specialties, or individual doctors, which don't treat certain conditions frequently enough to maintain their skills (according to published guidance) for certain procedures.

Some of these are discussed later, for example Vascular Surgery, where guidance is suggesting further centralisation based on population figures and minimum numbers of certain operations.

## Quality Standards

Similar to critical mass, over the coming years the NHS will have to achieve numerous quality standards with, for example, the National Institute for Clinical Excellence (NICE) expected to release 150 standards over the next few years. This is good news for patients, as previous quality standards have saved lives across a range of areas.

Commissioning for Quality and Innovation (CQUIN) has been introduced into standard contracts over recent years, and if applied appropriately do set challenging targets each year to improve services.

However, to meet some of these standards hospitals will be required to make significant investments, whether that is new technology, new ways of working or more doctors and nurses. For example, it is expected that hospitals will have to increase the number of senior doctors present at weekends in hospitals as it is a fact that people admitted on a weekend on average have a poorer outcome than those admitted during the week. Other standards exist for example in maternity, where again it is expected that consultants will be required to be present on the delivery suite overnight and on weekends, as again evidence shows outcomes for women are poorer when consultants are not physically present.

For some specialties there are simply not enough senior doctors available for every hospital to implement these standards. For some hospitals the number of patients (depending on the specialty) can be very few, so there could be occasion where there are senior doctors available but no patients in that part of the system to treat.

## Workforce

As highlighted earlier, recruitment to small teams can often be a problem. Newly qualified consultants will often want to work in a large team, which will offer them a number of opportunities to experience the wide ranging aspects of their chosen discipline. Also, issues such as onerous and unsustainable on-call rotas are unattractive for a consultant to work on. For example in a small hospital a consultant may have to be on-call 1 week in every 4 or 5, whereas in a larger unit this is more likely to be 1 week in 6-8 or even more. These are important work-life balance issues that the workforce will increasingly consider when choosing where they will work. This document describes some of the work already undertaken in relation in stroke and breast services, which are two specialties that have small numbers of consultants across the three hospitals in SoTW.

Other changes to workforce rules and regulations are also putting pressure onto the local system. The introduction of the European Working Time Directive (EWTD) meant additional costs and cover arrangement had to be found when junior doctors reduced their working hours. The restrictions on overseas recruitment provides further pressure as this has often been used, in the past, as a way of covering gaps in rotas. With the expectation that training numbers will be reduced over the coming years, all of these taken together, point to a genuine problem facing all the local hospitals.

## Care Closer To Home

The national strategy for the NHS is one of prevention and, wherever possible, trying to keep patients out of hospital. Though there has been mixed success in this area nationally, it is undoubtedly the direction of travel for future years and if successful will have a major impact on hospitals.

Partners in primary care and social care will continue to drive this agenda forward and there are many opportunities to improve upon the existing care pathways, allowing patients to be treated safely in their own environment.

The “patient choice” policy also poses challenges with respect to care closer to home. Across SOTW there are patients who choose to, or are signposted/advised, to have their treatment away from their local hospital, even when the service is available locally. This is completely in line with government policy and all of the FTs support “patient choice”. However, there are certain specialties (and these are different for each FT) where each Trust wishes to work with local commissioners to understand referral patterns and patient decision-making in greater detail.

Each organisation understandably wants to understand why either GPs refer or patient themselves choose alternative hospitals when local services exist. If these issues relate to quality or safety, then each FT will work with commissioners to address these concerns, to ensure patients and GPs have the confidence to use local services.

There are also other specialties, which are only provided by the tertiary hospitals, where there is great potential for outpatient clinics and even daycase work to be provided in each locality, again meaning patients have to travel less.

The ultimate aim of this work would be to attract back local residents into local services (regardless of the provider). There are no financial issues for the wider health system as commissioners are currently paying for this activity and it would provide further financial sustainability for local hospitals going forward.

## Financial

Even though the NHS has been comparatively protected in terms of government spending, the financial challenge facing the NHS is huge. Billions of pounds need to be saved over the coming years, so it can be reinvested into areas such as care closer to home, new treatments, new drugs and technological advances and the changing demographics of the area.

The DH launched Quality, Innovation, Productivity and Prevention (QIPP) 2-3 years ago and this agenda remains very live across all healthcare sectors and is something colleagues in the CCGs will be taking forward.

Simple year-on-year cost cutting will not achieve the required savings and may lead to patient safety issues if each hospital across SOTW continues to try and provide all the services they currently offer on their own.

## What Does This Mean For Our Local Hospitals?

The multiple challenges described above set the scene for the “Bigger Picture” work in SOTW. The collaborative and “Bigger Picture” thinking was setup to look at service integration across the three Foundation Trusts, so that we could genuinely improve the services each hospital currently offers to local people.

“Bigger Picture” is fundamentally a collaborative process, with all organisations being equal partners, working towards a shared vision of how services may look in the future. One thing is certain, if the organisations don’t work together then some services may fail and we will begin to put patients at risk. This work is designed to do the opposite; the aim is to strengthen and improve the services we offer to our patients by building on the different strengths of each partner; we want to create a system where residents across SOTW and beyond will have access to the best healthcare available.

By utilising the strengths of each organisation the aim is to balance healthcare provision across SOTW thereby using all of our resources most effectively to create sustainable quality services for the future. This will mean that one organisation may stop providing some services but provide others; in short, for each of the FTs, there needs to be “a give” and “a get”. Through this approach, the aim is to ensure that hospital services continue successfully in each of the three localities.

You will see from reading this document that work has started in some areas, but not all. The work so far has started to shape how things may look in the future and what this means for each hospital in practice.

The programme is starting to gather momentum and more areas may be affected in the future; this document aims to help to paint the picture so far, so staff working in each organisation and other key stakeholders can continue to contribute to the process.

## *Vision - What Could the Future Look Like – A View From the CEs*

At a time of unprecedented uncertainty and financial pressures across the NHS, the Foundation Trusts and Commissioners across South of Tyne have agreed to set out in one overarching document the future state we believe gives us all the best chance of delivering sustainable quality, and finance.

We agreed that having three primarily acute hospitals is no longer viable going forward so each of the three faces a different future.

For South Tyneside Foundation Trust the future focus will be on delivering world class diagnostic, screening, rehabilitation and out of hospital services for the whole of South of Tyne & Wear and possibly beyond. It will be the prime contractor for these services working together with other Foundation Trusts, Local Authorities and Primary Care.

Within South Tyneside itself local hospital services will move away from complex unplanned surgical care which will be provided as part of wider clinical networks together with other complex care pathways. The population will continue to have local access to emergency medical services including elderly and end of life care supported by the new emergency and assessment centre facilities for adults and children.

For Gateshead, its main surgical focus will be on providing capacity for non-specialist elective activity across the South of Tyne, using the Treatment Centre as a commercial hub to handle high volume contracts for low complexity surgery. It will retain its status as a Cancer Centre for Gynaecology Oncology and will increasingly develop a Breast Cancer Service, and continue to provide and develop a range of national screening services. Gateshead residents will have local access to a full range of emergency medical services, including Elderly Care and Old Age Psychiatry, A&E Services – enhanced by a brand new development locally and supplemented by more same day assessment facilities.

For City Hospitals, its focus will be on becoming the third specialist Centre (or main hub) across the North East and it will increasingly specialise in the more complex/specialised services, both elective and non elective. More complex Colorectal, Vascular and Stroke services will start the beginning of a Cardiovascular, Renal and Metabolic Service being developed to work alongside Primary Care. Its focus as a Trauma Unit will be supplemented by a world class Critical Care unit and it will offer complex diagnostics (a full interventional radiology service for example). Local access to emergency medical services will also be available complimented by a brand new A&E department and admission pathway(s).

CHS will continue to enhance and expand its Medical Education role through its responsibility as the hub for the Wear based (Sunderland, South Tyneside and Durham) educational unit.

An overall model of ‘hub and spoke’ where relevant would make sure that local access is preserved where justified and by prime contracting it will be clear to commissioners where the overall responsibility and governance for service delivery lies against contract. Discussions about tariff sharing will also be handled primarily at provider level. All of the above relates to clinical services, but back of office functions are similarly being reviewed and it is anticipated that these functions (service by service) will be led by one of the Foundation Trusts as agreed.

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## *Reconfiguration Test*

You will see from reading this document, that the actual or proposed scale of change is different depending on the area, with some describing the creation of more formal networks, whilst others describe more fundamental changes, such as altering clinical pathways or service provision.

In 2010, the Secretary of State identified four key tests for service change, which are designed to build confidence within the service, with patients and communities. The tests were set out in the revised Operating Framework for 2010-11 (and still apply now) and require existing and future reconfiguration proposals to demonstrate:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice

These tests will be applied where relevant and have already been used in areas such as Paediatrics. However, the application of the tests will be different in different areas. For example, the creation of a formal stroke network covering all three sites did not go out to formal public consultation but did have patient engagement during the clinical workshops, whereas, given the significant changes proposed in relation to Paediatrics, this went to full public consultation.

The important point to note is that when proposed changes are outlined and examined the above tests need to be considered and acted upon in the appropriate way, but this may be different for different areas.

## *Progress to Date – What Has Been Achieved So Far*

A number of areas were initially looked at, with some not progressing past an early scoping phase, whilst others went further as they appeared that they faced a number of the 'case for change' challenges described above. Below are the areas that have been taken forward to date.

### Paediatrics

Advances in paediatric medicine mean that serious childhood illnesses are very rare and children and young people seldom have to stay in hospital overnight. However, children and young people suffer from more chronic illness now than in the past; for example, conditions like asthma and diabetes. These types of childhood illness can be managed safely and more appropriately in the child's own home with support from healthcare staff. It is often the case that children attend hospital when they could have been treated closer to home by their own general practitioner (GP) or in a walk-in service – for example, children with gastroenteritis.

What's more, some of these children are admitted overnight when their medical needs could actually have been resolved without a hospital stay. We know that unnecessary admissions can disrupt family life and children's education. Last year, more than 12,000 children and young people were admitted to local hospitals. Many of them could have been managed in the community.

At the moment, children and young people who need an overnight stay can use services in Gateshead, Sunderland or South Tyneside. Spreading the paediatric expertise across the region in this way means that we are unable to provide the very high level of care we believe is required. Smaller units are not able to employ a wide range of paediatric staff and some experience difficulty recruiting and retaining doctors and nurses. Having three inpatient facilities in the area also results in a poor use of resources as beds are often unoccupied.

The agreed solution is the implementation of a range of service developments including:

- walk-in services available to children of all ages
- children's community nursing team support for acutely ill and injured children and young people
- children's short-stay assessment units in hospitals in Gateshead, Sunderland and South Tyneside, available for 24 hours each day
- inpatient care available at Sunderland Royal Hospital and the Great North Children's Hospital at the Royal Victoria Infirmary, Newcastle.

### Stroke Medicine

There have been a number of quality standards released with respect to caring and treating patients who have had a stroke. These standards deliver improved outcomes for patients who suffer a stroke but do require teams to work differently compared to their historical ways of working.

One of these standards related to providing a treatment called thrombolysis to patients who have just had a stroke. This requires a stroke consultant to be available 24/7 to review radiology images and make an immediate decision on treatment.

None of three hospitals could have implemented such cover arrangements without working together as a single dedicated stroke team covering each location on the evenings and weekends.

The proposed solution was a network arrangement and a joint rota covering all 3 hospitals and this went live in the summer of 2011 and is delivering genuine improvements to stroke patients across SOTW.

A further development is the provision of a weekend TIA clinic, the clinic will be based at Sunderland Royal Hospital and will serve all residents within SOTW. The service will be delivered by the consultants from all 3 hospitals and form part of the duties of the weekend joint rota.

**Pathology**

In 2006 a national review of pathology services was undertaken by Lord Carter of Coles. The key recommendation of the report was that significant financial savings could be made without comprising on quality if pathology networks were established.

With an increasing amount of technology and automation available in this area of work there is a clear case that savings could be made if pathology laboratories joined together and looked at splitting work between 'hot' (what must be done on a hospital site for patient safety reasons) and 'cold' (more routine work, such as GP samples).

With three laboratories offering similar services across the three hospitals in SOTW it was obvious that opportunities existed locally.

The solution is to have one centre of excellence laboratory working on behalf of the three hospitals, with a 'hot' laboratory on each site. The proposed site for the centre of excellence is GHFT and how this will work in practice is currently being worked through in more detail.

**Breast Services**

Breast Services is an area that has problems in relation to local sustainability. In Sunderland and South Tyneside the teams are very small and both have had problems covering the service in the past and therefore sustainability is a real concern. Also, service provision is different on each site with some residents having access to a wider range of treatment options.

The proposed solution to ensure a high quality, sustainable service is provided going forwards is that the teams come together form one larger team. The proposal is that GHFT would become the hub (main centre) as it already provides the breast screening service across all of SOTW, with existing services in South Tyneside and Sunderland still being provided as normal. This will ensure sustainability and will not alter what is provided locally, and will in fact protect local provision.

## Community Services

Within SOTW and across the country, community services that were provided by Primary Care Trusts (PCTs) had to be transferred to a partner organisation, normally a local acute hospital.

As part of the "Bigger Picture" work, even though each hospital could see elements of the community service that would integrate well with their own services, it was agreed that keeping community services together under one provider would deliver higher quality services to patients in the long term.

It was also obvious that community services have some of their greatest links, not with hospitals (though they clearly exist), but with primary care and other local authority services. It was crucial that the organisation leading community services would be able to strengthen such partnerships and develop more integrated pathways so patients are provided with a smooth care pathway, no matter who is the provider.

Looking ahead and taking into account the vision for SOTW and each hospital within the patch, it was clear that the range of services provided by the community teams had the greatest links to STFT and bringing the community services into STFT will complement and significantly strengthen the future service provision for all healthcare providers across SOTW.

STFT are committed to working with all partners to develop community services and during 2012/13 will look to establish a Partnership Board, where local providers and commissioners have a real say in how these services are taken forward.

It should also be noted that these few words do not begin to cover the breadth and depth of services offered by the community teams which, when brought together with STFT's vision for the future, provide a fantastic platform to tackle the various challenges ahead.

## 24/7 Surgery – Out of Hours

Currently, each of the three hospitals provide an emergency surgery service 24 hours a day, seven days a week. The number of patients who actually require an immediate operation during the night is very small. National guidance states that patients should only be operated on during the night if their life or a limb(s) is threatened.

In STFT, looking across a full year, the number of patients who required an operation out of hours (9 p.m. – 8 a.m.) is extremely small, less than 1 per week. The numbers for GHFT are slightly more, but again very small and not more than 2 per week.

In terms of local sustainability, this is a real issue as some local hospitals have to run rotas where surgeons are covering 1 in every 4 nights. Again, national guidance states the ideal minimum should be 1 in 6-8. This can't be achieved unless teams work together.

Having surgeons, anaesthetists, theatre teams and other support services on stand-by for 1 case per week is also not cost effective due to the number of patients

affected being so small. The proposed solution is to create a hub and spoke model, where those patients who do require an operation out of hours would go to a main centre, which would be CHSFT. As GHFT and STFT will still admit emergency patients, local access for urgent cases would still exist and it is crucial that urgent surgical assessments are available in all locations.

## Vascular Surgery

Currently there are several national initiatives and published guidance that are aimed at driving up quality and safety standards in relation to Vascular Surgery. These cover many of the 'case for change' headings described earlier in this document. For example, a centre providing vascular services should cover a population of approximately 800,000. There is also guidance with respect to minimum numbers of certain operations– for example, 33 aneurysms per year (and this is likely to go up).

Vascular Surgery will also become a separate specialty (it is currently part of General Surgery) in 2013 which will have workforce implications with respect to trainees and this will also have a significant impact on rotas.

In order to achieve these standards, existing teams will have to come together to cover a larger population and to ensure minimum numbers of operations are met.

The proposed solution for Vascular Surgery is slightly more complicated and unclear compared to some of the other areas outlined above. This is partly because of the population figures required, as the population across SOTW is approximately 650,000, slightly short of the required 800,000. Therefore this area of work may require a solution wider than just SOTW, with potential arrangements being established with County Durham and Darlington FT (a working relationship on Vascular already exists between GHFT and Durham).

CHSFT are also committed to providing a Cardiovascular, Renal and Metabolic Service to work alongside Primary Care, therefore there will be clear links to this work, with Vascular Surgery being an integral part of this.

## Trauma

Trauma is an area that, similar to Vascular requires solutions wider than SOTW. A designation process has recently been undertaken across the country, with hospitals having to apply to become 'Trauma Centres' or 'Trauma Units'. Within the North East, due to the range of services provided by Newcastle Upon Tyne Hospitals and South Tees Hospitals, these two hospitals will be the trauma centres.

GHFT, CHSFT and STFT were all successful in applying to be trauma units, but it was recognised by all parties, including STFT, that certain patient groups such as poly-trauma (multiple body parts being severely injured) would have to be managed via a local network, with such patients being transferred to CHSFT for example (as is currently the case).

North East Ambulance Service are also crucial partners in this work, as it will be their protocols and triaging processes that will ultimately dictate where patients are taken for their treatment.

Therefore although work will be undertaken across SOTW on Trauma, this has to be seen as part of a wider change process across the North East.

## Medical Physics

During 2011/12 Newcastle upon Tyne Hospitals served notice on a number of Trusts across the North East that they would no longer be providing a regional Medical Physics service.

For each of the local hospitals this meant a small number of staff being transferred into each FT. With such small numbers it appears there are clear advantages (local sustainability) for the 3 FTs to work together in this area and the creation of a single managed service would provide a more sustainable solution going forwards.

## Back Office Functions

Back office is a term used to describe a number of the administrative functions that support the running of any large organisation. This includes departments such as Human Resources, Finance, Information Technology, Estates and many more.

With each of the organisations generally facing comparable pressures and trying to achieve similar objectives across these areas, there may be an opportunity for these functions to be done once, led by one organisation on behalf of all three.

The proposed approach, therefore, is to look at each area, the current ways of working and to consider whether standardisation of processes or implementing a single managed service is appropriate in a number of such departments.

## *Other Areas – Could They Be Affected?*

A number of other services/specialties have not been taken forward as part of the "Bigger Picture" work programme. This does not mean that they could not change in the future. A number of areas not already covered will face or are currently facing some of the challenges outlined in the 'case for change'. This section describes the potential challenges facing some of the other specialties/services and how they may change in the future.

### Maternity

The Clinical Innovation Team (CIT) have discussed the provision of maternity services for some time and a further clinical engagement event (accelerated solution event) has been undertaken across the entire North East looking at some of the quality challenges facing Maternity and how this may lead to a reconfiguration of services.

Some of the challenges ahead include workforce issues with respect to the potential reduction in Obstetric trainees, quality and safety issues, which are likely to request an increase in consultant presence on labour wards and the move to 1:1 midwifery care, as well the general pressure on NHS funding.

If national standards dictate (or local agreement is reached) that extended consultant presence is required, the current configuration of three consultant led units is not viable, as there simply won't be enough consultants to deliver this level of cover on each site.

No work has started in this area, however, various options and configurations have already been discussed across the North East and it may be an area that being pro-active and agreeing the best model for SOTW would stop intervention from outside the local patch at a later date.

### Gynaecology

Obstetrics and Gynaecology are intrinsically linked, with the majority of the consultant workforce working in both specialties. Similar clinical engagement events have been held in relation to Gynaecology and the emerging view is that some of pressures outlined for services above, also exist for Gynaecology.

Quality standards may be introduced in relation to minimum standards for certain procedures such as VVF, workforce issues may mean on call arrangements will have to cover a number of hospitals and linked to the above, emergency gynaecology may only be provided by those units that have consultant led maternity cover.

Gynae-oncology is provided by GHFT for all three hospitals and this service will continue to be provided by GHFT.

Undoubtedly, if any work in relation to maternity is taken forward then Gynaecology services would also have to be looked at as well.

## Neonates

With the obvious links to maternity, clinical engagement events have also been held across the entire North East looking at some of the quality challenges facing Neonates and how this may lead to a reconfiguration of services. The challenges ahead for neonatal services include workforce issues with respect to the potential reduction in trainees, the number of middle grade staff available for rotas and the move to ensure neonatal cots are staffed to certain quality standards (BAPM).

In SOTW, all hospitals offer neonatal services, but to different levels of care, with GHFT and STFT providing special care beds and CHSFT offering intensive care. At present there is increasing pressure from outside SOTW to reconfigure neonatal services throughout the North East which could result in a loss or reduction of services on any of the sites.

At present, no work has started in relation to neonates, however, similar to maternity, various options and configurations have already been discussed across the North East and it may be an area that being pro-active and agreeing the best model for SOTW would stop intervention from outside the local patch at a later date.

## Medical Specialties

Currently each site provides a range of medical specialties, including Elderly Medicine, General Medicine, Gastroenterology, Thoracic Medicine and each has an A&E department.

Looking to the future, quality standards may be introduced into certain medical specialties that identify that additional consultant presence is required later in the evenings or on weekends. This is to reduce the variation of outcomes that exist for those patients who are admitted at weekends compared to those admitted Monday-Friday.

Similar to some of the surgical specialties, joint on-call arrangements may also be necessary for areas such as Gastroenterology, to manage GI bleeds and other conditions.

New ways of working in relation to A&E attendances and emergency admissions (front of house) are being taken forward in each location and in partnership with primary care. If these projects are genuinely successful by improving outcomes and increasing patient satisfaction, whilst reducing demand for inpatient beds, then further work may be required with respect to the medical specialties. However, at this stage the **planned, long term** view is to maintain three A&E departments with the supporting medical specialisms.

To date, no formal work has been undertaken with respect to the medical specialties, though clinical discussions have started in some areas about how joint working could deliver improvements to the current ways of working.

This area of work will also closely link to planned developments within primary care and CCGs and therefore will require close working relationships going forward.

## Surgical Specialties

A number of surgical specialties are already part of the "Bigger Picture" workstreams, with separate work ongoing in relation to Breast and Vascular. Out of hours ways of working in Trauma and Orthopaedics and General Surgery are also being picked up as part of the 24/7 workstream and the Trauma workstream. At this stage no work has been undertaken with respect to the elective elements of these specialties.

However, as described in the vision, GHFT may play a key role in some of the physical provision, i.e. theatres and beds in the future for elective surgical patients. With the North East Surgery Centre, GHFT have an excellent facility for elective patients and one option is to take certain procedures which are high in volume and relatively low in terms of complexity to this facility from across SOTW. Concentrating on a small number of procedures, which have large volumes, would allow the centre to develop pathways for patients that have world class outcomes and are extremely efficient at the same time. Evidence is available from similar setups around the country that patient feedback is extremely positive and the clinical outcomes can be some of the best in the country.

## Diagnostics

Diagnostics play a crucial role in many of the workstreams listed above and have already had/or will have to implement new ways of working in areas such as Stroke, Vascular, 24/7 etc.

The demand for high quality diagnostics tests will only increase over the coming years and there is likely to be an increasing shift towards rapid turnaround of performing the test and reporting the results, particularly if ambulatory care pathways are successfully implemented. Primary care may also increase their demands over the coming years, supporting the move of care closer to home and keeping people out of hospitals.

The only area of work in relation to diagnostics that is being looked at is Medical Physics, which is due to the service moving out of Newcastle and back to each of the local hospitals and it appears there are clear advantages (local sustainability) to working together in this area.

Looking at the vision described earlier, there is strong support for STFT developing more diagnostic services, specifically for patients who are on planned (elective) pathways, whether that is from GP or secondary care referral. From a patient experience and capacity/demand point of view this makes sense, as for example if CHSFT is providing an increasing amount of trauma services on behalf of the patch, then their diagnostic equipment will be increasingly used for emergency patients.

If STFT develop services which are significantly protected from the demands of emergency patients then the quality of the patient experience, with respect to waiting times, parking and environment should be significantly enhanced.

## Rehabilitation

Care closer to home will undoubtedly increase the focus on creating a world class rehabilitation service for many clinical pathways – both elective and non-elective. Rehabilitation services can be provided in a range of ways and settings which includes a person's home, in outpatient facilities, daycare, as well as rehabilitation beds.

Allowing one organisation to focus their efforts on creating such a service for all partners seems a sensible way forward, otherwise each hospital may 'dabble' in certain aspects of rehab, but never address the full system and service.

In the future and given the obvious links to the community services STFT now operate, the natural choice to take forward these developments would be STFT. Working with the community services they provide and other partners in primary care and local authorities, fully integrated rehabilitation pathways could be developed delivering better outcomes for patients and their families across SOTW.

## Screening Programmes

Over the past few years a number of screening programmes have been established across the country. Within SOTW, GHFT currently provide the screening service for Breast, Bowel and AAA. GHFT have a strong track record in delivering successful screening services, therefore going forwards GHFT should continue to provide and develop screening services for the population of SOTW.

Where existing screening services are already working well and there is no obvious pressure for change, for example in community services or specialties such as Obstetrics and Gynaecology there are no plans to alter the current service provision.

## Interventional Radiology

Interventional Radiology (IR) refers to a range of techniques which rely on the use radiological image guidance (X-ray fluoroscopy, ultrasound, CT or MRI) to precisely target therapy. Most IR treatments are minimally invasive alternatives to open and laparoscopic (keyhole) surgery. The range of conditions which can be treated by IR is enormous and continually expanding. IR supports a number of specialties, with particular links to Vascular Surgery, Nephrology, Oncology and Obstetrics and Gynaecology.

At present, no hospital within SOTW has a comprehensive IR service and providing such as service in many localities is proving a significant challenge across the country. Having a comprehensive IR service available 24/7 would be significant step forward and provide a genuine improvement to the quality of care offered to local residents. To have any chance of making this happen, IR would have be centred on one site and given the strong links to specialties such as Vascular and Nephrology, this would logically be CHSFT.

## Chemotherapy and Radiotherapy

Presently, patients have access to Chemotherapy in all three hospitals and, going forward, there is a strong commitment from all partners to maintain this provision. However, one area that may change would be access to Radiotherapy.

Currently all patients who require Radiotherapy have to travel to Newcastle for any Radiotherapy treatment. Apart from Newcastle, only one other centre provides Radiotherapy in the North East – South Tees Hospital. For a number of years the cancer network has recognised there is sufficient demand for a third centre to provide Radiotherapy in the region and their own analysis (based on population figures and travel times) suggests this would be somewhere in SOTW. A procurement exercise will be undertaken by the North East Cancer Network during 2012 to address this.

It is important to note that for those residents who would prefer to be treated at Newcastle due to travel, patient choice will always be at the forefront of discussions and patients will be able to choose where they are treated.

## Specialist Services

Specialist services which require larger populations (critical mass) are already provided by a smaller number of hospitals. Within SOTW, CHSFT is the main provider of acute specialist services, operating services such as Ophthalmology, Urology, Oral Surgery, ENT, Haematology and Renal Medicine. A number of these services already work closely with partners in GHFT and STFT and clinics are provided locally.

The vision in this document supports a continuation and further enhancement of this arrangement, with CHSFT potentially expanding the range of services they provide, but most importantly continuing to provide local services across all three localities. Future developments would not include those areas where it is already recognised that GHFT provides a first class service – for example, in areas such as Breast and Gynae-Oncology.

Other specialist services which have strong links to the acute sector such as Palliative Care, Pyschology and Pyschiatry will need to continue to provide an integrated service to those specialties that require it.

The important point to note in relation to specialist services is the commitment that wherever possible and practical in terms of patient safety there is a genuine commitment to providing services in each locality, so local residents have good access to care in settings such as outpatient clinics and daycase theatres.

## Critical Care

Currently, all three hospitals provide critical care to local patients, at both HDU and ITU level. Looking ahead, this may change. With more of the specialist work potentially being done at CHSFT and large volumes of elective work being undertaken at GHFT on behalf of the other units then the use of critical care facilities may have to be examined in the future.

## Other support services

If changes are made to current patient pathways, then services which input heavily into certain pathways will also need to change around the needs of our patients. It is difficult to state at this stage how such services will look in the future, but where proposed changes are outlined above and these heavily rely on services such as Physiotherapy or Occupational Therapy for example, then changes to these service may also occur.

These will be different, depending on the area, but the work described above is about creating networks, new clinical teams and new ways of working across the traditional geographical and organisational boundaries and therefore support services, as with all the other services/specialties described above may also change.

## Other Opportunities

Partnership working could be taken forward in other areas as well. In terms of Research and Development combining the three hospitals' R&D functions together, may make it viable to open a clinical trials unit; the population served by the patch would mean that the SoTW area could contribute more to the R&D arena.

With CRLN funding decreasing, more units are looking to commercial trials as a viable way forward and again setting up such as unit would enable the hospitals to compete as a collective for such work. In terms of future recruitment such a setup would also make jobs more attractive for potential employees.

Junior doctor training could also be enhanced, as some of work described above may provide opportunities for greater exposure for juniors and increase their learning. The juniors could rotate and have blocks of time focussing purely on emergency work in one location, with another rotation at a different location looking at purely elective pathways.

## *Does This Mean Merger?*

The question of whether GHFT, STFT and CHSFT should merge and become one organisation has been asked many times over many years. The honest answer is – maybe.

As you can see from the work described above, partnership working does not necessarily require a merger and the three FTs already have a strong tradition of collaborative working and this already exists in a number of areas.

It is well documented that mergers are often unsuccessful, productivity decreases, mistrust increases and people actually behave in ways that are damaging to all. Therefore forcing each organisation into one may actually be counter-productive and make the current situation worse. A merger can create a negative culture of perceived 'winners and losers', which takes years to be broken down.

A counter argument is that one organisation can create economies of scale (if managed appropriately) and may be able to cope with future financial challenges more successfully. One organisation may deliver some of the work described above more swiftly and provide greater clarity over many practical issues. It is also important to note that a number of the Trusts in the North East have recently joined together with their respective community services or in the case of Northumbria, with another Trust, therefore, the FTs in SOTW are becoming smaller in comparison to their neighbours and competition is likely to increase from these organisations in the future.

However, the most important issue for the immediate future is sustaining and developing high quality services for all of our patients. It may be appropriate to form one or more organisations once the majority of the work described above is complete, this would be because many of the teams would be working as one service or department across the three locations. There also may be other models of organisational partnership working that could be explored using the freedoms that each hospital has with their foundation status.

It may also become apparent that each organisation was so dependent on each other that a merger was the natural next step and people felt positively about it, rather than anxious and suspicious as would probably be the case now. It is clear from the visions set out at the beginning that each organisation needs the others to be a success going forward.

A decision about merger could then be taken based on solid evidence, as hopefully, clinical teams and other departments have successfully integrated together and are providing first class services to all our patients. This would give people the confidence that one organisation would be a success based on the work our clinical teams had achieved.

## *Timescales*

The work described above is complex, and is often inter-linked with other issues. For example changing Paediatrics may have a knock-on into maternity, changing the Breast service may impact on rotas for General Surgery etc etc. Therefore each area is working to different timescales agreed by the people leading the work. The work that has already started is at various stages, with some already implemented, some just about to start, others have agreement in principle and a few are just starting to be explored.

In terms of the case for change, some of those drivers are already upon us - quality standards are gradually being introduced, more and more guidance highlights certain figures in relation to critical mass of populations and some of the consultant teams are no longer viable as they stand. The financial outlook is certainly not going to improve in the short to medium term, therefore it can be argued that doing nothing is no longer an option and time is of the essence.

## *Your views*

What a number of people have raised over recent months is where all of the “Bigger Picture” work will end up; what is driving this work and what will things look like in the future? This document attempts to paint a part of a possible future picture, so that all stakeholders can start to understand how things may change, why they need to change and what that means for future service provision at each hospital. This document cannot answer all the questions as many areas are still unclear and work has not yet started in a number of other areas.

However, as work is now starting on more and more areas and is beginning to gather momentum, it is important to share these thoughts and plans with people and to seek views. To help understand and gather views in more detail a number of engagement events will be held over the coming weeks in each of the three hospitals and with local Clinical Commissioning Groups and Health and Wellbeing Boards, followed by a SOTW wide clinical engagement event at the beginning of October.