The path to excellence

NHS
South Tyneside and Sunderland
NHS partnership

Working together

to improve hospital services in South Tyneside and Sunderland

Phase Two of the Path to Excellence programme

Summary of the Draft Case for Change - July 2018

Draft case for change animation video
https://www.youtube.com/embed/RZGrXM2LKcc?rel=0

Why we need to transform all care locally

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Changing hospital care alone will not solve the pressures facing the NHS.

Care in local communities needs to expand and develop as that is where the vast majority of care takes place.

More needs to be done to improve the health and wellbeing of the population with a focus on preventing people becoming unwell in the first place.

This needs to happen while we balance our finances and plan for the future of services to support the growing population demands.

Why we need to transform all care locally cont'd

In order to transform health and care locally there are three main pillars:

Prevention	Out of hospital	In hospital
This is how we work together to encourage everyone living in South Tyneside and Sunderland to take more responsibility for their own health and wellbeing so that they do not become unwell with wholly avoidable illnesses.	This is how NHS, social care and community and voluntary organisations work together to provide more responsive care to prevent avoidable hospital admissions and to get people out of hospital as soon as they are able with more care at home and closer to home.	**This is the Path to Excellence programme which is the subject of the draft case for change document and this summary document.**

Key challenges

Key challenges

1 No change is not an option

We need to achieve sustainability for patient safety reasons.

We have frail, vulnerable services.

We need to address the poor health outcomes of our populations.

We need to address the increasing demands on hospital services when community care is the best care.

We need to address the increasing demands on primary care when self-care is the best care.

Key challenges cont'd

2 Workforce pressures

This is a very common theme throughout our draft case for change.

We face daily challenges to staff wards and departments to a consistently safe level.

We are relying on the goodwill of staff working longer hours or extra shifts - this poses a risk to the health and wellbeing of our staff and they have told us that this cannot continue.

We are relying on employing a temporary workforce (locum/agency staff) which is not only expensive but not good for quality of care.

Having small and separate teams in each hospital means:

- we often face staff shortages and have less resilience
- a number of important clinical quality standards, that really improve outcomes for our patients, cannot currently be delivered
- it is difficult to attract and retain more staff due to poor work/life balance
- we cannot deliver the highest quality of training for junior doctors which reduces our recruitment chances from an already small pool of trainees which all Trusts in the region are competing to recruit from

3 Future demographic changes

The majority of patients admitted to our hospitals are over 80 years old, often with multiple long-term conditions, very poorly and in need of complex care and support from our staff.

Our aging population will continue to grow, increasing the demand on hospital services even further.

We currently have an ageing workforce, which will only exacerbate our staffing pressures as more colleagues retire.

More people living with long-term conditions (e.g. diabetes, breathing problems, dementia) are surviving longer and increasing in number and will only add more demand for services.

Key challenges cont'd

4 Finance constraints

The number of people attending our Emergency Departments at both hospitals continues to grow, with many older people being admitted with multiple health conditions.

Emergency care and acute medicine services in both hospitals currently cost more to run than the funding available and make an annual loss of £15million.

The costs of temporary staff in emergency care and acute medicine amounts to over £11milion each year.

Our overreliance on temporary staffing costs more and limits our ability to make long-term quality improvements to patient care.

Not delivering the right quality of care, at the right time and in the right place means the potential for errors increases which only adds to the financial burden.

5 Quality improvements needed

There is too much unacceptable variation between our hospitals on performance against many clinical standards that are the markers of high quality care.

We are unable to consistently ensure that all emergency patients are reviewed by a consultant in a timely manner.

We do not have consistent availability of senior clinical decision makers seven days a week or wrap around support services available.

Some planned care, for example, going into hospital for an operation or x-ray, is not as efficient as it could be.

There are differences between our hospitals in how often people are referred to specialists and the tests and treatments they receive.

Individually our populations are small, but together we can:

- create the vital critical mass of patients so that specialist teams can maintain and develop their skills
- improve staff retention and increase recruitment as jobs become more attractive
- increase the ability to provide more services locally that traditionally residents have had to travel outside the local area to access previously

How do we plan to address these key challenges?

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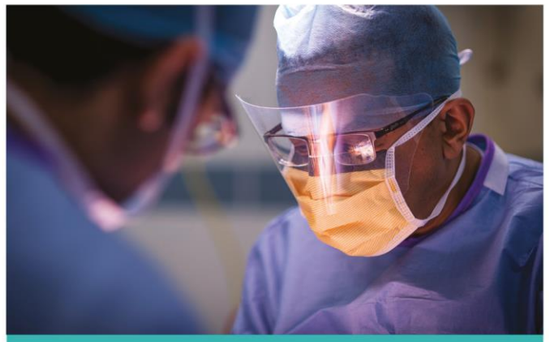
Our work on Phase Two of the Path to Excellence programme covers four broad work streams which are looking at the challenges being faced and thinking about potential solutions for the future:

Emergency care and acute medicine

This is the care we provide when patients arrive at our Emergency Departments or need emergency admission to hospital



Emergency surgery

This is the care we provide for patients who are admitted as an emergency and require an immediate operation

Planned care (including surgery and outpatients)

This is the care we provide after patients have been referred by their GP for a test, scan, treatment or operation

In addition to these areas, we are also thinking about how we improve and develop our various clinical support services across both hospitals such as therapy services (for example physiotherapy, occupational therapy, speech and language therapy), as well as clinical pharmacy and radiology services.

What happens next?

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Clinical design teams continue to work with frontline hospital staff to think about how to solve the challenges and better organise services

Autumn/Winter 2018
Further staff and public engagement

November 2018
Key stakeholder events and staff engagement to set evaluation criteria for any future possible solutions

December 2018
Public listening panel – an opportunity for wider stakeholders to apply to present their evidence and any views on the draft case for change and things for the NHS to consider

Early 2019
Key stakeholder events and staff engagement to apply evaluation criteria to wide range of future possible solutions

Share ideas on future possible solutions and gain feedback to influence final options the CCGs will consider for formal public consultation

Summer 2019
Formal public consultation

Questions and issues about the case for change

Share your views!

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