Join our Journey

North East and North Cumbria

Briefing

Clinical Strategy – Hospital Services

South Integrated Care Partnership

March 2019

Clinical Strategy – Hospital Services

Background

In Darlington, Hambleton, Hartlepool, Richmondshire, South Tees, Stockton and Whitby, NHS organisations have come together, working with local authorities, to lead and plan care for their population in a coordinated way as the South Integrated Care Partnership (South ICP).

The South Integrated Care Partnership is not a new organisation but partners will collaborate and make some decisions jointly, taking forward and building upon the work of the Better Health Programme, and other programmes over recent years to develop proposals for sustainable hospital services in this area.

The Better Health Programme was established in 2015 to develop models of care that could remain clinically sustainable whilst meeting the likely workforce pressures of the future. Learning from the Better Health Programme's public engagement work on what people value from their hospitals and other NHS services has gone on to form the basis of the next phase of work.

This next phase is the development of the Clinical Strategy for Hospital Services for the South of the North East and North Cumbria region, now overseen by the South Integrated Care Partnership.

This involves close working with the following partners:

- NHS Darlington CCG
- County Durham and Darlington NHS Foundation Trust (acute)
- NHS Hambleton, Richmondshire and Whitby CCG
- NHS Hartlepool and Stockton-on-Tees CCG
- North East Ambulance Service NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust (acute)
- NHS South Tees CCG
- South Tees Hospitals NHS Foundation Trust (acute)
- Tees Esk and Wear Valleys NHS Foundation Trust (mental health)
- Yorkshire Ambulance Service NHS Trust

Whilst North Durham CCG and NHS Durham, Dales, Easington and Sedgefield CCG are not included in the scope of the South ICP (due to the population mainly accessing services from the University Hospital of North Durham or hospital services based in Sunderland, Gateshead and Newcastle more often than in Teesside), the South ICP will consider the potential impact of patient flow and service provision on these hospitals within these CCG areas as a result of any new service models.

Clinical Strategy – Hospital Services

At regional level, senior clinical staff from across the North East and North Cumbria are building consensus on the right model to deliver local urgent and emergency medical care,

particularly for the increasing number of frail people, and support the continued delivery of local specialist emergency care where possible.

They have prioritised services facing the most severe challenges and risks, and which would benefit from working more closely together. This is driven mainly by a shortage of medical staff, in terms of continuity of service, pressures on quality and additional financial issues.

The Clinical Strategy for Hospital Services is a programme of service model development where clinical leaders are developing better ways and new ideas to organise health and care services to help solve some of these challenges, by joining up processes to 'do once' and deliver more with the same resources.

They are also taking into account clinical priorities set out by clinical networks across Northern England such as the Northern Trauma Network, the North East Urgent and Emergency Care Network and the Northern England Neonatal Network, and the work of Local Maternity Systems (LMS).

To reflect this work, the Clinical Strategy is split into two phases.

Phase 1 of the clinical strategy looks at the future delivery of a number of key hospital services which are a priority for change - Urgent and Emergency Care, Women's and Children's services (Maternity services , Obstetrics, Gynaecology, Neonatal intensive care and Paediatric services), Frailty and Stroke services, and elective (non-urgent, planned) care for spinal, breast and urology services. It sets out what the shape of the models of care for these services will need to look like.

In particular, we will have more efficient urgent and emergency care by working across emergency departments and urgent care centres, and we will redesign emergency care at front-of-house with other supporting services. This includes ambulatory care (same day emergency care services) where patients who are unwell but who are not seriously ill are assessed, diagnosed and treated on the same day and then sent home, if appropriate, with on-ongoing clinical follow-up as required.

Workstreams looking at each of these areas led by clinicians and managers from the three acute Foundation Trusts developed ideas for models of care using the best available evidence and clinical standards. Each of these groups checked that these met 'must have' criteria such as safety requirements, regulatory requirements and the total amount of money available to provide these into the future. The workstreams continue to work on these ideas.

These services are currently provided at three hospitals:

- Darlington Memorial Hospital
- James Cook University Hospital, Middlesbrough
- University Hospital of North Tees, Stockton

We are proposing to use these hospitals differently and in a more joined up way to benefit patients across a large geographical area.

Note - the three Acute Foundation trusts cover multiple hospital sites which also include:

- The Friarage Hospital

- University Hospital of Hartlepool
- University Hospital of North Durham, Bishop Auckland Hospital and community hospitals in Chester Le Street, Shotley Bridge, Sedgefield, Barnard Castle and Weardale.

The clinical strategy does not directly impact these hospitals.

Phase 2 will look at the development of pathways of care that integrate hospital services across the services and resources that already exist within local communities, bringing care closer to home and reducing an over-dependence on acute hospital services.

Next steps

Clinicians with leadership and management support continue to look at each service and are giving their recommendations as to how they think services could be better organised in the future. Local people, and patients and carers, will also have a chance to say what is important to them about these services.

Both the workstreams and outcomes from listening exercises with patients and the public will form the basis of a case for change which must also take into account a much wider view.

This wider view includes national NHS policy, clinical evidence, consideration of equality impact, a travel and transport review as well as other insights from patients and carers using the services, and staff.

The case for change will be reviewed and concluded by the clinical commissioning groups as it is their duty to ensure the right NHS services are in place for local people. Further scrutiny will also be carried out by NHS England.

A joint health overview and scrutiny committee will review and scrutinise the process for engagement and consultation, as well as form a view on any future options or scenarios for change.

Some changes might not even be noticed by patients, except that they receive an improved patient experience. However, other changes because they are considered to be ‘significant’, such as relocating a service may be subject to a formal consultation process required under that Health and Social Care Act (2012), case law and government policy.

This means that a full case for change with different options or scenarios will be published and a summary consultation document made available. Consultation would take place over twelve weeks and would have different ways for people to feed back their views such as public events, surveys and focus groups.

The feedback from any consultation would then be used in the final business case to be reviewed and concluded by the clinical commissioning groups.

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