North Tees and Hartlepool NHS
NHS Trust

Hartlepool NHS
Primary Care Trust

North Tees NHS
Primary Care Trust

PATHWAYS TO HEALTH CARE

THE ROAD MAP TO NEW HOSPITAL, PRIMARY AND COMMUNITY SERVICES AND FACILITIES FOR TEESSIDE

Patient Centred and Clinically Driven

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1. The Opportunity

The Secretary of State's approval to develop a new hospital in the area north of Tees is a once in a lifetime opportunity for the health and health care of the people of Teesside. It will be the catalyst for radical change and improvement in the way that health care services are delivered for the people of Teesside. It will:

- Provide the opportunity to reshape health care services in line with modern, twenty-first century evidence-based models of health care.

- Be designed as a whole health care system encompassing changes and developments to services and facilities across primary, community, secondary and tertiary care services.

- Be the first whole health care system to be redesigned following the publication of the White Paper *Our Health, Our Care, Our Say*. It will embody the principles, policy and direction of that White Paper.

- Have the patient at the centre of the design process. Patients will shape what they want and need from the whole health care system contributing in true partnership to the overall vision and direction of service development.

- Be clinically driven, a partnership across all health care sectors to design the best care pathways that deliver high quality, safe, effective and value for money services.

- Have Primary Care Trusts and Practice Based Commissioners driving a radical change to the way services are provided and leading the development of new services and facilities in settings closer to patients as part of the bigger picture of building strong and sustainable services for the people of Teesside.

- Be state of the art and world class in terms of design of the whole health care system in general and of the new hospital and its services in particular.

- Incorporate LEAN thinking from the outset of the design to ensure the safest, highest quality and cost effective service provision.

- Be part of the wider health care sector on Teesside which encompasses services, facilities and providers in the area south of Tees. It will be designed so that service provision is complementary whilst recognising the government policy direction of plurality and choice.

- Welcome the joint working with the Local Authorities and other agencies both in terms of their contribution to service provision and care pathways and also in respect of the partnership to develop and build the hospital, primary and community care facilities and the associated infrastructure.

- Make a contribution to the economic and other regeneration of the locality.
- End years of uncertainty following numerous reviews of services which have blighted service development and been a source of insecurity and frustration for staff, patients and the public. It will be a springboard to a new and vibrant future.

2. The Context

Teesside is situated in the North East of England and refers to the geographical area covered by the four Local Authority Boroughs of Hartlepool, Stockton-on-Tees, Middlesbrough and Redcar & Cleveland. Hospital services in the north of Tees provide services predominantly to the populations resident in Stockton-on-Tees, Hartlepool and parts of County Durham particularly Easington and Sedgefield.

It is unquestionable that Teesside is desperately in need of a new hospital serving the north of Tees as part of a wider, more developed primary and community health system – for three reasons:

I. The health status and legacy of ill-health in the area merits the provision of the best health care services that England can offer.

II. The outdated configuration of services and poor quality of physical facilities are long overdue for changing and replacing.

III. A uniting cause after years of conflict and controversy will lead to tangible changes to services and the facilities in which they are provided.

2.1 Health Status

In health terms Teesside is paying the price of its industrial past and a more recent history of high levels of unemployment and deprivation following the decline of traditional heavy industry. The local economy is increasingly buoyant but the legacy of the past is the challenge that local public services, private sector partners and the voluntary or third sector are working together to tackle.

Health is influenced by many factors including individual behaviour, access to health services as well as the wider determinants of health such as income, employment, housing and environmental factors. These determinants of health vary across a population depending on a person's social position (whether measured by socio-economic status, ethnicity, and gender of sexuality). The result of this unequal distribution of health determinants is health inequality.

Health experience across Teesside has some of the best and some of the very worst in England. Teesside experiences greater levels of deprivation compared with the national average, and as such experiences a greater burden of poor health within the population. For example, this area has lower than England average life expectancy, greater than England average mortality from cancer and coronary heart disease

Whilst life expectancy continues to increase year on year, life expectancy for both men and women living across Tees is lower than the average for England and Wales. For example the difference is men on Tees can expect to live to approximately 73 and women 79 years. This compares to an England and Wales average of 75.5 years for men and 80.4 years for women. Mortality from common diseases is significantly greater in people living on Tees as compared to the England and Wales average. For example deaths from lung cancer is 50% greater, deaths from colorectal cancer is 30% greater, deaths from circulatory disease is 16% greater, deaths from stroke is 12% greater, and deaths from suicide and undetermined deaths is 42% greater than the England average.

Deprivation levels across the Tees area vary widely. Analysis of deprivation shows that out of 354 local authorities the district of Easington is the 8th most deprived in England, Hartlepool the 14th while Stockton-on-Tees is ranked 75th. Analysis by the Tees Valley Joint Strategy Unit shows that both Hartlepool and Stockton-on-Tees contain wards with very high levels of deprivation – such as Stranton and Owton in Hartlepool and Portrack and Tilery in Stockton. However, both boroughs also contain wards of relatively high affluence, including Elwick in Hartlepool and Ingleby Barwick in Stockton.

The opportunity to redesign services and provide new hospital and primary and community facilities in the area north of Tees will provide an additional boost to the efforts of all partners who are already working together to tackle the ill-health of the area. It will be a tangible and demonstrable commitment to the area and be a focus for further improvement in health and health care. It will also provide opportunities to contribute to local regeneration.

2.2 Outdated Configuration and Poor Quality Physical Facilities

Acute care south of Tees has undergone significant change in recent years and has culminated in a large PFI development at the James Cook University Hospital which provides services from first class facilities on one site.

The picture is very different in the north of Tees area. Hospital services are provided from two sites: the University Hospital of North Tees in Stockton-on-Tees with 563 beds and the University Hospital of Hartlepool in Hartlepool with 393 beds. The two hospitals are part of a single NHS Trust. The two hospitals are approximately 13 miles apart.

The physical facilities are not appropriate to 21st century health care. The University Hospital of North Tees was built in the 1960s and consists of two multi-storey buildings and a number of other blocks. The University Hospital of Hartlepool is a mixture of early 20th century and more modern 1970s buildings. The backlog maintenance cost for both hospitals is £6.5m of which £1.25m is rated as significant risk. The recent Independent Review Panel report highlighted the need to provide the north of Tees residents with sustainable clinical facilities of high quality comparable to those that exist south of the Tees.

Providing services across two sites, even so closely located, has led to difficulties in sustaining services because of the need to configure them over two sites. The configuration has become unsustainable as a result of:

- Increased medical sub-specialisation means that small hospitals face increasing difficulty maintaining the critical mass of cases required for each sub-speciality to provide a safe, effective and efficient service for patients.
- Any perceived threat to the viability of such units is a major barrier to the recruitment of the highest calibre of recruits.
- European Working Time Directive, and cuts to Junior Doctors Hours under the New Deal, means that rotas across two sites are difficult to maintain and are unattractive to doctors. This creates conflict between the numbers of junior staff needed to maintain emergency cover and the numbers required for efficient workforce planning under MMC plans. Short term this often requires the use of “trust grade” rather than training grade staff to maintain the out of hours, an expensive, inefficient and unsatisfactory solution for the medium to long term.
- Medical Technology is getting increasingly specialised and is changing the pattern of health care resulting in fewer patients needing to stay in hospital for lengthy periods of time meaning that maintaining two ever shrinking hospitals across two sites is and will become more difficult and expensive.
- Payment by Results means a national tariff for every procedure and HRG. When the cost base of the Trust is spread across two sites it becomes difficult to provide service efficiently and within the overall income that can be generated from tariff based payments.

The new hospital, the new associated facilities in primary and community settings and the implementation of new and different evidence-based care pathways that lead to only those services that need to be provided in a hospital being done in such a setting will resolve the configuration issues that have beset the north of Tees for many years.

2.3 A Uniting Cause

Teesside has been blighted with uncertainty about the nature and location of acute hospital; services for many years. The endorsement, by the Secretary of State for Health, of the Independent Review Panel's recommendations have brought an end to that uncertainty. Planning can now be taken forward in a spirit of confidence.

The Panel's recommendations in respect of the sustainability of existing services, particularly maternity and paediatric services is being implemented. This road map is setting the direction for the implementation of the following recommendations made by the Panel:

- A modern hospital to replace the existing out of date hospital buildings should be provided on a new site in a well situated location accessible to the people of Hartlepool, Stockton-on-Tees, Easington and Sedgefield. (Recommendation 3)

- The most specialised neonatal services serving Teesside as a whole should be located in the new hospital. (Recommendation 8)

- Other more specialised services serving Teesside as a whole should be provided at the James Cook University Hospital and the new hospital north of the Tees determined by the optimum relationship with other clinical services and where capacity should be found. (Recommendation 9)

- With the North Tees and Hartlepool NHS Trust moving to Foundation Trust status, key community leaders and stakeholders should all give their full support to the successful implementation of these proposals for the benefit of local people and to bring years of uncertainty to an end. (Recommendation 10)

With the launch of this work to develop the new health care system and the new hospital in Teesside, we have an opportunity to unite the people of Teesside in a common cause that will lead to tangible improvements to health and health care.

3. The Road Map

The precise Road Map is dependent on whether the funding required is secured under the PFI route or whether, preferably, public funding was available. Likewise, the timescales for delivering the new hospital would also be influenced by the funding route.

As a publicly funded scheme the Road Map would have five distinct Phases:

Phase One:	Project Launch (April 2007 – June 2007)
Phase Two:	Service Development and Design (July 2007 – December 2008)
Phase Three:	Public Consultation (January 2009 – April 2009)
Phase Four:	Capital Planning, Development and Procurement (Spring 2008 – Summer 2011)
Phase Five:	Building and Commissioning the new hospital and associated facilities (Spring 2011 – 2014)

Underpinning this road map are the following assumptions:

- Public funding would be preferable because the metrics developed for recent Department of Health reviews of major PFI schemes have sought to limit the % of Trust turnover that is contractually committed to a PFI Unitary Payment. Preliminary calculations suggest that for North Tees & Hartlepool NHS Trust the largest scheme that might be approved would be of

the order of £210m. This would be significantly less than the c£400m which would be required to implement the IRP recommendations for a new single site which have been endorsed by the Secretary of State. This may mean that implementing the recommendations is impractical, additionally, would be viewed by Monitor to be unaffordable.

- Both PFI and public capital schemes would need to do comparable levels of design and other work up to get to OBC approval, and would probably entail the same physical solution – it is likely that public funding will prove to be a speedier solution than a PFI route.

- This time period is shorter than other developments of a similar scope and size have taken previously.

- Subject to a more detailed option appraisal, that a suitable brownfield or Greenfield site is available, so avoiding the additional cost, time and disruption associated with both the complicated decanting of patients and services and a phased construction programme.

- That as new care pathways are developed they will as far as possible be implemented, subject to consultation processes as required, and will not wait for full commissioning of the new hospital facility or only inasmuch as implementation requires the new facility. This is particularly the case with respect to work that has already commenced as part of implementing those parts of the Tees Services Review that were not the subject of the referral to the Independent Review Panel, notably urology services.

3.1 Phase One: Project Launch (April 2007 – June 2007)

This is the crucial stage because it sets the tone for the delivery of the overall project. This launch phase has to:

Be Public
Be High Profile
Be Energetic
Be Enthusiastic
Have top level leadership from all key partners but particularly from the Trust and the Primary Care Trusts.

This is the stage where momentum is engendered and where the public and others are reassured and convinced of the NHS, Department of Health and government commitment to seeing through the building of a new hospital along with redesigning pathways.

It has four main objectives:

I. Agree and set the vision and broad framework within which the hospital and health care system will be developed.

II. Establish the process and broad timescales for the redesign, service development and building of the new facilities.

III. Establish the communication and involvement strategy and processes.

IV. Determine the affordability / cost ceilings and funding route for the new hospital and associated primary care infrastructure.

The key processes that will take place during this stage will be:

- A public launch event to start the work and invite partners and public to be involved and shape the process and the end outcome.

- Workshops with key staff and clinicians from the Trust and Primary Care Trusts, partners and patients and public to establish the design principles.

- Research of the best in class in the UK and world wide with respect to both care pathways and the successful management of change programmes and building of new hospitals and associated primary and community care facilities.

- The first meeting of the Project Board.

- Establishing a Project Team made up of dedicated Trust, Primary Care Trust and Strategic Health Authority staff to drive the care pathway redesign and scoping of the new hospital and associated facilities.

The table below highlights the demonstrable outcomes of this phase of the project:

At the end of this Phase the following will have been delivered:

1. An "Olympic Bid" type project vision, project outline and project plan. It will set out the stall for the direction of travel to act as a vehicle for establishing focus and commitment to the project. Audio-visual and other appropriate media will be fully utilised to ensure the widest possible coverage and engagement.

2. An overarching vision and direction for the new hospital in the context of a redesigned health system for the north of Tees encompassing primary and community based care and a complementary relationship with services provided in the south of Tees.

3. Identified potential locations for the new hospital and conducted a preliminary option appraisal and secured options on possible Brownfield / Greenfield sites pending and in preparation for subsequent consultation.

4. Secured local engagement and commitment to the vision and direction including clinicians, Primary Care Trusts, Practice Based Commissioners, staff, public, local councillors, MPs, partner agencies and stakeholders.
5. Prepared a compelling "storyboard" of the journey that we are all embarked upon with a clearly articulated end point that aligns with the vision and direction. Clinical case studies and real examples will be used to illustrate the difference between now and when the development is complete.

6. Identified the preliminary capital costs of the new hospital aspect of the development.

7. Established the Project Management and Project Board arrangements.

8. Agreed the detailed service review and development plan and the methodology.

9. Determined the communications and involvement strategy for the project.

10. Clarification of the funding vehicle for the new hospital development.

3.2 Phase Two: Service Development and Design (July 2007 – December 2008)

This phase is the powerhouse of the project. It is the outcome from this phase that will determine:

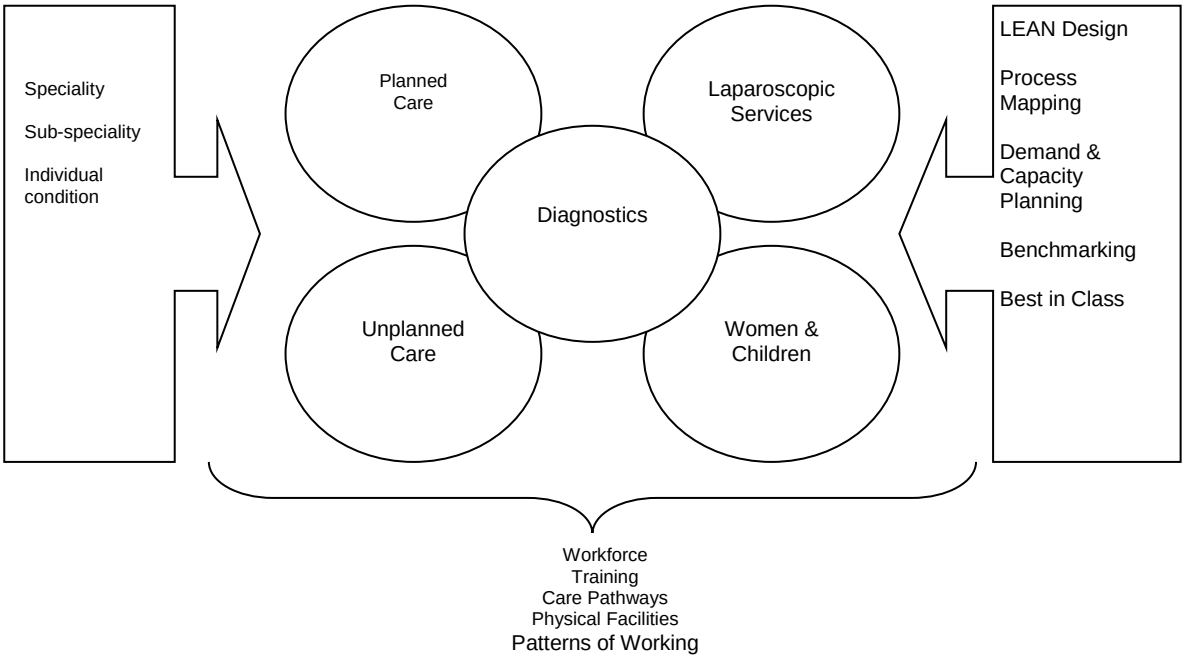
- The model of care across services, specialities and medical conditions
- The parts of the pathways that have to be hospital based because there is no other alternative
- The parts of the pathways that can be provided in settings other than a hospital

- The preferred locations for the provision of those parts of the pathways that are not hospital based
- The complementary relationships of services in the north and south of Tees.

In achieving these outcomes it will be possible to:

- Specify the scope and scale of services to be provided within the new hospital
- Specify the service development and facility development that needs to take place within the primary and community setting
- Identify workforce implications of the new models of care and patterns of provision
- Identify training implications of the new models of care and patterns of provision
- Refine the preliminary costings of both the new hospital and also the associated primary and community service developments.

The methodology that will be employed is illustrated in the diagram below:



The redesign and care pathway modelling work will be approached in the 5 areas illustrated in the diagram above. The approach will be to identify the broad principles that apply to each type of care to set the framework within which then the detailed speciality, sub-specialty or even, in some cases, condition-specific pathways will be examined.

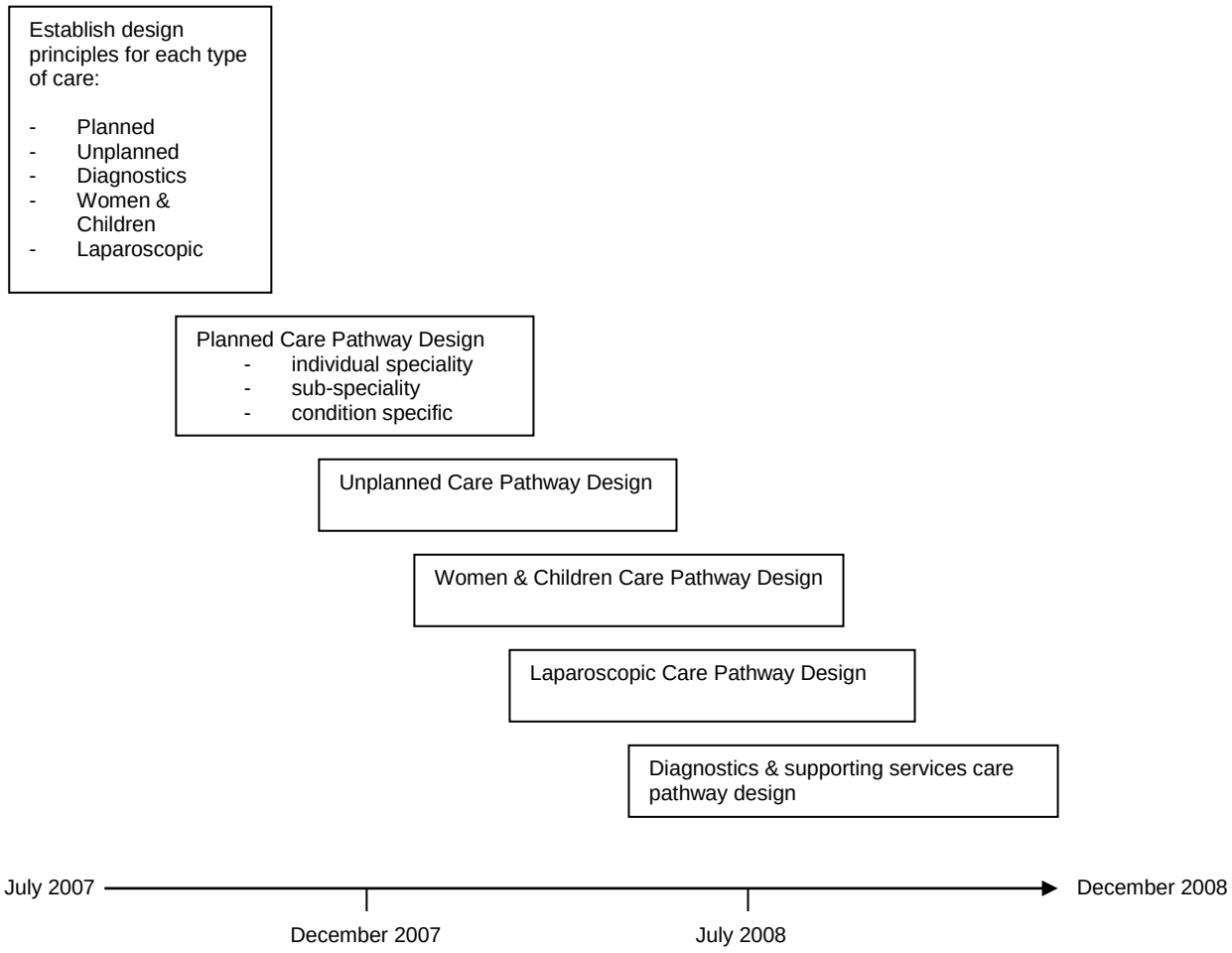
The starting point for each of these areas will be that only those parts of the pathway that have to be provided in a hospital will be done in such a setting. Other options for other parts of the pathway will be actively explored as part of this process.

The timescale for completing this redesign work is tight therefore the intention will be to establish small core groups of clinicians and others to drive the care pathway design assisted by members of the Project Team. The core teams will be time-limited and will work through a process that has the following steps:

- Map the current pathway
- Map the current demand
- Plot the current pathway
- Forecast the future demand on each part of the pathway.
- Translate the future pathway and forecast demand into service and facilities plans.

At the beginning, middle and towards the end of each core teams' consideration of a pathway there will be a workshop approach to sharing and disseminating the work and gaining input and feedback from a wider group of stakeholders, staff, clinicians, patients and public.

The diagram below shoes a schematic of the time line and the work programme:



At the end of this Phase the following will have been delivered:

1. Identification of the model of care and care pathways for services for the people of the area north of Tees.

2. The parts of the pathways that have to be hospital based because there is no other safe or cost-effective alternative will have been identified.

3. The parts of the pathways that can be provided in settings other than a hospital will have been identified.

4. The scope, capacity and scale of services to be provided within the new hospital will have been specified to go forward into the capital planning phase of the project.

5. The service development and facility development that needs to take place within the primary and community setting will have been specified to go forward to be driven by the Practice Based Commissioners and the Primary Care Trusts.

6. The workforce implications of the new models of care and patterns of provision will have been identified so that arrangements can be made in good time to develop the workforce accordingly.

7. The training implications of the new models of care and patterns of provision will have been identified so that arrangements can be made with education and training providers in good time to ensure that appropriately trained and qualified staff are available as and when required.

8. Refined capital and revenue costings to feed into the detailed planning of the new hospital and the capital and service planning for primary and community services.

3.3 Phase Three: Public Consultation (January 2009 – April 2009)

The Secretary of State's approval of the Independent Review Panel's recommendations as set out in section 2 precludes the need to formally consult on the concept of a new hospital. However, formal section 7 public consultation will be required regarding the functional content of the hospital and its location. This will take place when the care pathway redesign and scoping of the new hospital content has been completed.

Throughout the process section 11 informal consultation and involvement will be a key feature. The intention is that by the time formal consultation takes place all of the care pathways and the conclusions of the modelling work will have already been in the public domain.

This will mean that the main consultation issue will be that of location and any implications for other providers of implementing the Secretary of State's decision with respect to the site for neonatal services.

It should be noted that it is expected that primary and community based facilities will be developed as part of the earlier stag of planning during phase two. It is envisaged that consultation on these facilities and services will take place as appropriate at that stage rather than delaying implementing better service and care pathways until the whole package around the acute hospital part of the pathway is planned.

At the end of this Phase the following will have been delivered:

1. A comprehensive informal consultation and involvement process with public, staff, stakeholders, Overview and Scrutiny committees, LINKs groups which fulfils the requirements of section 11 consultation.

2. A comprehensive formal consultation and involvement process with public, staff, stakeholders, Overview and Scrutiny committees, LINKs groups which fulfils the requirements of section 7 consultation.

3.4 Phase Four: Capital Planning and Development (Spring 2008 – Summer 2011)

Elements of this phase need to happen concurrently with earlier phases of the process and before those earlier phases have been completed. This is particularly the case in relation to securing options on possible locations to site the new hospital and especially so if the funding required for the new hospital is to be secured under the PFI route which has very specific process requirements under the Competitive Dialogue Procedure. It is to be noted that if public funding was available then it is anticipated that this would substantially speed up the capital planning aspects of delivering this project.

At the end of this Phase the following will have been delivered:

1. The service scoping and service requirements will have been translated into functional content and capacity for the hospital.

2. Any additional primary and community facilities required as a result of the service design work will have been scoped and translated into facilities design and procurement commenced.

3. Strategic Outline Cases and Outline Business Cases produced and approved as required.

4. SHA approval to the Business cases obtained.

5. Capital and revenue costs and modelling completed.

6. Planning permissions obtained.

3.5 Phase Five: Building and Commissioning the new hospital and associated facilities (Summer 2011 – 2014)

This is the phase that turns all the planning into reality. The new hospital will be built. Any service changes that were not dependent on the new hospital will have been implemented prior to this stage. Any primary and community capital projects will have also been completed prior to this stage to facilitate changes to the care pathways and models of provision.

19 April 2007
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