University Hospitals Tees (UHT): Case for Change and strategy

Tees Valley Joint Health Scrutiny

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23 July 2026

Aim of the session

- Provide an update on UHT's progress from the December 2025 meeting
- Share the key elements of the case for change
- Describe UHT's overall strategy and potential changes to our model of care, including next steps
- Highlight feedback from UHT's engagement activity in the first half of 2026, and how this will be integrated into our future work
- Get feedback from you on the proposals and process

Progress update since December 2025

Key activities and progress update

In the December Joint Scrutiny meeting, we reviewed the UHT strategy and key drivers for change, alongside an outline of emerging plans to develop services in line with the strategy. We summarised UHT's approach to engagement and our ambition to maintain strong dialogue and input with people living locally, as well as partner organisations. Since that meeting we have:

- Developed a **'Case for Change'** – a requirement for NHS organisations undertaking major service changes. This sets out the rationale for why we need to redesign and develop our model of care in line with our ambition that is set out in UHT's 'Caring Better Together' strategy

- **Gained support** for the direction of travel set out in the Case for Change, and received extensive input and advice from our ICBs in North East and North Cumbria (NENC) and Humber and North Yorkshire (HNY), the NHS England regional team, and the North East and Yorkshire Clinical Senate

- **Engaged extensively** with our local communities over their priorities and feedback on our services

- Carried out further work with clinical teams within the organisation, and with partners, to **plan service delivery** for the next three to five years, and agreed this with commissioners and NHS England

- Begun the development of the **'Pre-Consultation Business Case'** (PCBC), the next stage in the process for major service change. This will set out the specific proposals and options for how we may develop and transform services for patients to address the challenges outlined in our Case for Change

Case for change: Headlines

UHT's case for change sets out the various drivers that necessitate joined-up action to secure the sustainability of clinical services across the North Tees and Hartlepool (NTH) Trust and the South Tees Hospitals (STH) Trust.

The need for fundamental change in the way health services are provided across Teesside, East Durham and North Yorkshire has been acknowledged throughout the system and the region for many years. We need to take this opportunity to consider the case to make radical changes. More than a decade of work with the two individual Trusts led by commissioners and NHS England has shown that services in this region – and its surrounding areas – need to be transformed for the next generation through various means, including:

- **Considering re-shaping specialist delivery of services from our sites.** For example, the 2016 Better Health Programme recommended a consolidation of specialist hospital sites within three years

- **Increasing preventive, community and population health focus.** For example, the 2016 Sustainability Transformation Plan (STP) recommended health and social care hubs being located in communities

- **Structural solutions.** An external review carried out by Carnall Farrar in 2022 set out seven clear benefits for the two Trusts in collaborating more closely, including addressing disparities in provision of care, being better able to tackle poor health and increasing demand, and delivering high-quality and sustainable services for the future. It also recommended structural solutions to enable this collaboration

While we always strive to deliver the best possible standards of patient care, we can do even better by learning and working across UHT.

Demand and capacity

Projections demonstrate that if UHT were to continue operating under the current model, an additional 112 beds would be required across the University Hospital of North Tees (UHNT) and James Cook University Hospital (JCUH) sites within the next 15 years.

Performance variation

Our performance against key metrics show too much variation:

- the four-hour standard for waiting times in Emergency Department performance – 86.2% in NTH and 80% in STH (as at March 2026)
- the 62-day cancer wait standard – 66.6% in NTH and 70.5% in STH (as at March 2026)
- The referral to treatment (RTT) 18-week standard is 70.5% in NTH and 65.2% in STH

Tertiary services

Our tertiary services volumes lack the scale which will enable them to operate efficiently – for example mechanical thrombectomy procedures which are proven to be effective currently operate within restricted hours.

Sickness absence and workforce sustainability

Our sickness absence in both Trusts sit around 6% against the national planning assumption of 4.1%. The lack of resilience in our staffing means that we need to cancel too many procedures and/or employ bank staff (509 WTE in 25/26) and agency staff (34 FTE in 2025/26). By reducing sickness absence we can reduce UHT's reliance on – and the cost of – agency and bank staff.

Across our Medical, Nursing and Allied Health Professional (AHP) workforce, we struggle to recruit into posts across Stroke medicine, Haematology, Microbiology, Paediatrics, Anaesthetics, Histopathology, Radiology, Speech and Language Therapy, Dietetics, Orthotics and Podiatry.

In services such as Stroke and Paediatrics, staffing is currently safe but fragile and, in some areas, we rely on cross-specialism medical workforces. National guidance from Royal Colleges emphasises the case for sub-specialisation of care for increasingly complex cases, and we will take that into account in our future staffing model.

We need to transform and reconfigure our services at a strategic level to meet national and system-wide requirements.

By reconfiguring the way we deliver our services, we will better align with The Government's Ten Year Plan for Health. The national direction says that we must:

- **Shift care away from hospitals and out into the community**, focusing on providing care closer to people's homes and lives
- **Focus on preventing ill health** and empowering the population to stay well
- **Move from analogue to digital** so that care is efficient and easy to access.

Both of our ICBs have set out ambitions which also require us to work differently in order to maximise the impact of our services. For example:

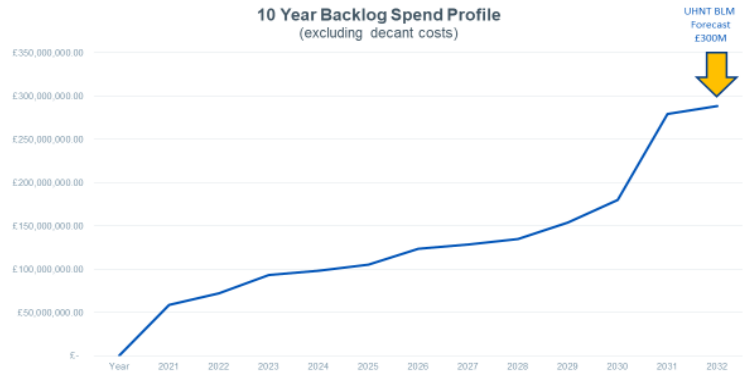
- The **North East and North Cumbria (NENC) ICB** strategy sets out a goal for 'better health and care services' – not just high-quality services, but the same quality no matter where you live and who you are
- The **Humber and North Yorkshire (HNY) ICB** prioritises 'Age Well' which aligns with the increasing demand we are experiencing from elderly and frail patients

Reconfiguring our services will also enable the more effectively delivery of the system-wide proposals outlined within NENC's Strategic Approach to Clinical Services as these begin to emerge, across the identified clinical specialities of gynaecology, neurology, oral and maxillofacial surgery, and cardiology.

We want to seize the opportunity of needing to redevelop our North Tees site in particular to make major changes for the benefit of our population.

Doing nothing is not an option. The backlog maintenance for the University Hospital of North Tees (UNHT) alone is **£126m,** with a total of £194m across UHT in 2024/25. The figure for UHNT has increased since 2015 despite expenditure of around £100m, and will rise sharply over the next few years to around £300m by 2033.

UHNT - Backlog Spend Profile



In light of structural issues set out by a full structural survey in 2020, an intrusive survey is now carried out every three years. The condition of parts of UHNT now represents a major ongoing risk.

The James Cook University Hospital (JCUH) PFI has annual costs of £83m, contributing to a deficit for the Trust. The estate is overcrowded in terms of clinical space and from a patient perspective, meaning transformational change by way of department reconfiguration or movement is not viable, without decompression of the site.

We have over 40 community facilities which, in some cases, are under-utilised. This presents a significant opportunity for wholesale transformation of our service model in line with the NHS Ten-Year Plan, including delivery of care at place, care closer to home and shifting from treatment to prevention through localised education delivery.

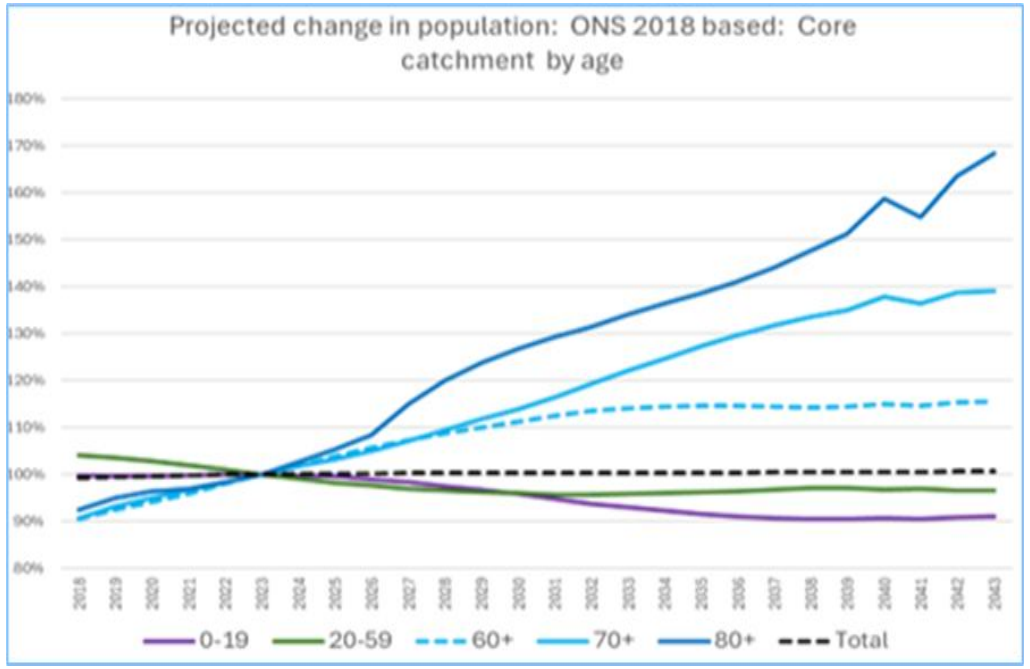
Despite UHT running efficient services, demand for these services - linked to levels of deprivation - has led to expenditure which exceeds our income levels. This has driven higher demand for UHT services, contributing to a need to make efficiencies of £90m in the 2026/27 financial year and £246m in the next three years. We want to develop a new model of care so we can make savings whilst improving service quality.

According to Model Hospital and NHS England metrics, STH and NTH are already operating efficiently and have the lowest opportunities for productivity improvement in NENC so we need to adopt a different model to create a step-change.

Our population is becoming more elderly, and this brings different challenges.

Within the UHT population, the anticipated growth in the proportion of people over the age of 70 is higher than other UK regional projections. There is a predicted increase of 39% in A&E attendances between 2023 and 2040, and a 36.3% increase in inpatient spells between 2023 and 2040 for people aged 70+, with increased complexity given the presence of comorbidities and frailty. By 2040, our inpatient bed requirements for this group will have increased by 41% if we do not change how we deliver healthcare.

Effective support for this population will require transformation of all of our services, with an increased focus on frailty. Diverting care towards community delivery and an increase in Hospital @ Home provision (where appropriate) will naturally reduce the risk of healthcare acquired infections impacting our elderly population – a particular concern due to the vulnerability of this patient cohort.



Activity projections for people aged 70 or over

PoD	2023	Change by 2027		2030		2035		2040	
A&E attends	61,470	4,669	7.6%	9,062	14.7%	17,376	28.3%	23,953	39.0%
IP spells	81,589	5,893	7.2%	11,318	13.9%	21,726	26.6%	29,629	36.3%
Average daily occupied beds	774	64	8.2%	122	15.7%	231	29.8%	325	41.9%

UHT's 'Caring Better Together' strategy and how services may develop in future

UHT's 'Caring Better Together' strategy

Strategy on a page

How we will work towards achieving our vision.

Transforming our ways of working to reform services and create our new offer for the population

Putting in place the right conditions for success

Vision

Caring better together

to continuously improve the lives and wellbeing of the communities we serve

Values

Respect | Support | Collaborate

Strategic objectives

- Consistent high quality care
- Outstanding experience for our people
- Working with partners
- Reforming models of care
- Excellence as a learning organisation
- Using our resources well

Three pillars of reform

Patients and populations

- Clinical strategy: left shift into community
- Clinical strategy: integrating at scale
- Clinical strategy: developing our tertiary services

People

- Continuous improvement
- Workforce transformation
- Leadership and culture

Partnerships and places

- Tackling health inequalities
- Anchor institution
- Education, research and innovation

Enablers

- Quality: effectiveness, experience, safety
- Digital, data and technology
- Estates and the environment
- Finance and productivity
- Operating model

Our three strategic shifts

Our strategy describes three key shifts:

- An increase in activity closer to the homes and communities of our patients
- A maximisation of activity in our surgical hubs at Northallerton and Hartlepool
- A potential consolidation of some specific specialist clinical services at our acute sites

This may mean that:

- Care would be delivered closer to home wherever this is clinically appropriate and convenient for patients
- Patients may be able to access non-emergency and elective surgery more quickly through UHT's two dedicated surgical hubs
- Acute services may be concentrated to deliver increasingly specialist, high-quality care with better outcomes for patients

In order to test this, we will rigorously engage with the public to ensure that their views are front and centre of our proposals, and consider fully the benefits of change and the options for how services might be delivered to ensure the safety and sustainability of care provision.

The need for major redevelopment of UHT estate is recognised within the NHS regionally and a business case has been prepared to align estate redevelopment with clinical options.

Transforming the model of care

Left shift

Delivering ‘left shift’ from acute to community and from community to lower cost models including virtual care and self-care. UHT community services organised in neighbourhoods.

Case Study:

Hospital at Home

When 93-year-old Margaret fell during the night, her daughter found her on the floor in the morning. She called 999, and within 30 minutes a community team arrived, assessed Margaret for injuries, and helped her back into her chair.

Instead of going to hospital, Margaret was safely supported at home. Her medication was reviewed, she received a walking aid, and therapy visits helped her regain strength.

Thanks to joined-up care, Margaret avoided hospital admission and maintained her independence - unlike her sister, who spent a month in hospital after a similar fall and ended up in a care home. With a small increase in home care, Margaret remains where she wants to be: in her own home.

Transforming the model of care

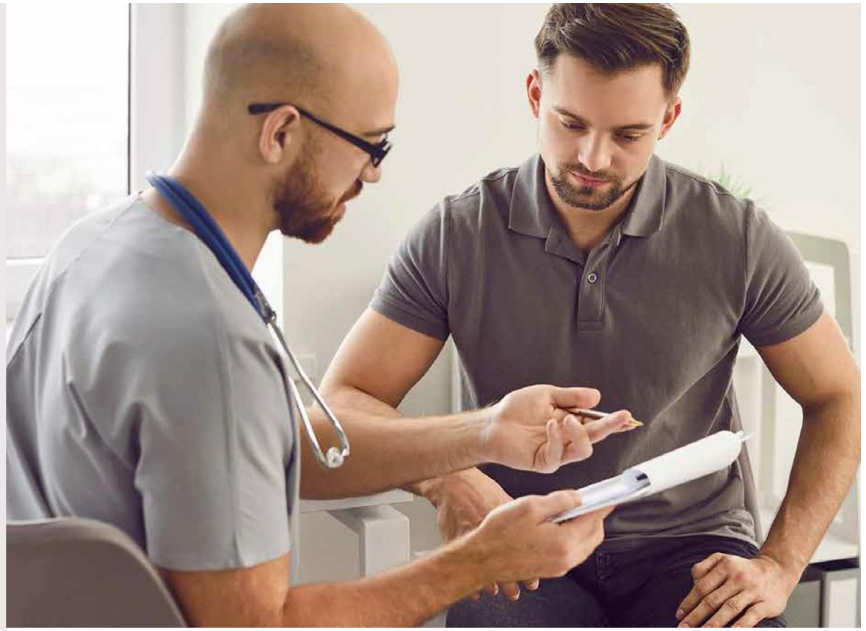
Acute service consolidation

Operating all acute and specialist care as single services across UHT, with consolidation of inpatient care on a single acute site at James Cook or North Tees where appropriate. Transforming outpatients away from an acute hospital-based service.

Case Study:

Patient accessing more specialist care that requires transfer to central “hub” service

Craig, a 43 year old man, initially attended his local hospital with severe diarrhoea and abdominal pain. It soon became clear he needed specialist care, and he was transferred to a Digestive Diseases Centre of Excellence where he was diagnosed with fulminant colitis. Although the transfer added an extra step, it ultimately meant Craig received faster access to the emergency surgery he urgently needed. At the centre, a dedicated surgical team, experienced in complex gastrointestinal emergencies, was ready to act without the delays often faced at smaller acute hospitals. Access to specialist theatres, advanced diagnostics, and coordinated expert care meant Craig’s surgery was performed sooner, improving his chances of a smoother recovery and better long-term outcomes. Despite the transfer, the speed and quality of care at the Centre of Excellence gave Craig the best possible chance of a successful outcome.



Transforming the model of care

Maximising elective hubs

Delivering elective care from our two surgical hubs in Hartlepool and Northallerton, where clinically appropriate.

Case Study:

Patient accessing surgical hub

Lisa, a 56-year-old woman, was informed that her spinal elective procedure could be delivered in one of our surgical hubs. At the hub, her surgery was ringfenced from emergency pressures, meaning it would not be cancelled or delayed by urgent cases. This gave Lisa confidence and peace of mind, allowing her to plan her recovery and rehabilitation without stress and uncertainty.

The surgical hub offered her a calm, focused environment with experienced staff and dedicated supportive services to allow the process to be straightforward and give Lisa reassurance that despite not being on an acute site she is in the right place for her care.

Our clinical boards identified potential transformational opportunities for change in major service areas.

This has been based on evidence of best practice, performance and activity data for our services, study visits to other providers, and extensive engagement with our clinical teams.

Community services	• Develop community services to deliver left shift through Neighbourhood Health Systems with partners • Expansion in Hospital at Home to equivalent of 500 beds • Work in collaboration with system partners to introduce a Tees Valley Care Coordination centre
Women and children's services	• Develop children's and young people's Hospital at Home offer • Explore single service for complex obstetric and neonatal care • Explore consolidation of children's and young people's services to develop a specialist Children's Hospital • Develop a hub and spoke model for fertility services
Urgent and emergency care	• Maintain two emergency departments at UHNT and JCUH • Develop a consistent urgent treatment centre (UTC) model across the places • Review and develop critical care to support future changes in other services
Medicine	• Explore specialist services at JCUH: stroke, haematology, cardiology, neurology • Explore further consolidation of services at UHNT in general medicine, gastroenterology, endocrine & diabetic medicine, chest medicine and elderly medicine
Surgery and anaesthetics	• Maximise activity through elective hubs in Hartlepool and Northallerton in all specialities • Explore specialist services at JCUH: urology, spinal, non-ambulatory trauma, paediatrics • Explore further consolidation of services at UHNT in general surgery (all sub-specialties)

We also need to confirm opportunities to build our scale and remit as a provider of specialist and tertiary services.

Tertiary service leaders have identified their strengths and plans for development. Our overarching strategy is to ensure we minimise the need for our patients to travel outside Tees Valley for specialist care.

Cardiovascular Services	• Regional heart attack centre and vascular hub • Specialist centre for valve intervention: minimal access valve surgery, TAVI, mitraclip • Heart failure service –seamless community and hospital offer across 1º/2º/3º care • Academic centre for CV research
James Cook Cancer Institute	• Bowel, breast and lung cancer screening and advanced diagnostics • Specialist cancer surgery – robotic access to pelvic, colorectal, upper GI and thoracic • Provider of NSO and radiotherapy to wider population of > 1M
Neurosciences	• Integrated neurology, stroke, neurosurgery, neuroradiology/MT and neurorehab service • Comprehensive skull base surgery programme with multidisciplinary care across five specialties • Neurovascular intervention – surgical and endovascular intervention for AVM and cerebral aneurysms • Intraoperative brain mapping and awake brain tumour resection • Integration spinal surgery service with intraoperative spinal cord monitoring and navigation
Major Trauma Centre	• Adult and paediatric major trauma to large geographical population • Early access to speciality multidisciplinary surgery and rehabilitation • Only MTC with on-site Spinal Cord Injury centre – lowest waiting times in UK; immediate access to specialist support and surgery • Academic Centre for Surgery – research active across all trauma pathways

Outpatient transformation: Enabling a modern, patient-centred model of care

Outpatient transformation will play a key role in UHT's supporting wider service reconfiguration and long-term system sustainability. We anticipate that by 2035, outpatient services across UHT will operate through a coordinated, digitally enabled model that maximises patient choice and improves access to specialist care.

UHT's outpatient transformation will be delivered through four initial integrated programme priorities:

1. Single Point of Access (SPoA) – providing ease of access to services
2. Patient Initiated Follow-Up (PIFU) – empowering patients to access care when they need it
3. Clinic Template Redesign – speeding up and simplifying communications and administration
4. Partial Booking – allowing more flexibility for patients

By reducing reliance on appointments being delivered face-to-face away from acute hospital settings and enabling more care to be delivered closer to home or virtually, we will improve patient access, reduce health inequalities and support a more efficient and resilient model of care.

Next steps: The major service change process

Some of the changes that we may make could be designated as being major service changes requiring formal public consultation. National guidance sets out the process we need to follow in order to do this. This has three phases:

A **case for change** setting out why change is needed (this builds on several system-led reviews which have said the current services are not sustainable for the future)
Summarising this today

A **pre-consultation business case** which builds up options of how that change could potentially be delivered for the next generation
This is in development

A **decision-making business case** which sets out the final proposal

Given the interdependency of any proposed changes with our Estate footprint, we have developed a Strategic Outline Case for funding and will follow this process in parallel to the major change process. We know that any major transformation will take time to achieve, but equally we want to drive delivery forward so that we can bring about the benefits for our population.

It is important to note that, at this stage, UHT is still actively considering how it may transform and deliver its services in future, and that no decisions have been made on this as yet. Any proposed changes would be subject to the appropriate assessment and approval protocols, alongside appropriate engagement and consultation.

Major service change: Progress and timetable

Case for Change:

- Completed February 2026
- Approved internally within UHT
- Approved externally by ICB, NHS England
- Stakeholder engagement through NEY Clinical Senate and relevant Scrutiny Committees

Pre Consultation Business Case:

In progress

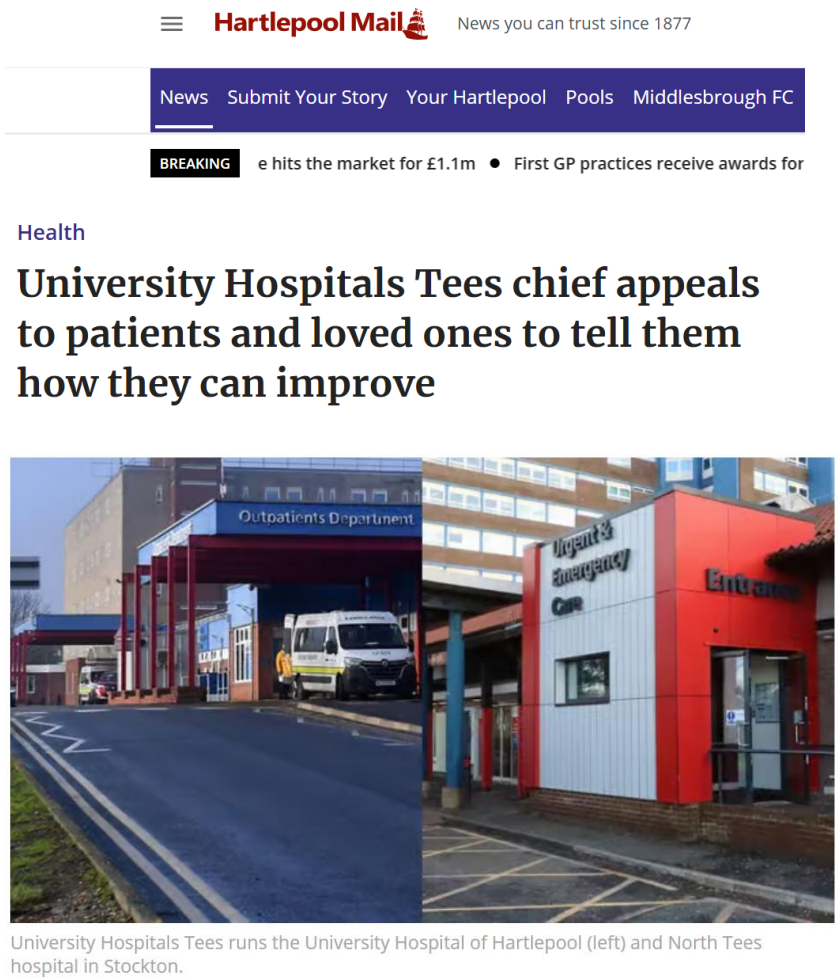
- Internal and external governance approvals from July 2026 onwards
- Proposed public consultation to be agreed once approvals secured (likely to be after Autumn 2026)

Decision Making Business Case:

- To be finalised after public consultation – likely to be early 2027
- Consultation feedback shapes final proposals
- Final proposal submitted for internal and external governance approvals

Engagement and timetable

We have actively engaged with the communities we serve to better understand how they experience our services now, and seek their input into hospital and community-based healthcare provision in the future.



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Health

University Hospitals Tees chief appeals to patients and loved ones to tell them how they can improve

University Hospitals Tees runs the University Hospital of Hartlepool (left) and North Tees hospital in Stockton.

We have met our communities where they are, for example at Stockton Wellbeing Hub, Hartlepool College, Middlesbrough Central Library and Redcar Library and Community Hub, as well as providing an ongoing online survey so they can share their feedback with us.

Since March 2026, we have captured more than 2,000 individual pieces of feedback, both online and from our in-person listening events. Two key themes have come out:

Transport

Given the rurality of some of communities for example in East Cleveland and East Durham and the existing public transport infrastructure, patients are worried about how they reach healthcare appointments or access services in-person. There are also pockets of low car ownership, something that is particularly prevalent across the Hartlepool area.

Communication

This feedback focused on patient pathway management, for example where they have co-morbidities and need to attend various appointments under two different specialties. Patients are frustrated that their care isn't always joined-up and they need to travel to attend multiple appointments on different days, rather than attending all of their appointments on the same day, in the same place.

We also heard that they want us to work on a more joined up approach between GPs and UHT on diagnostic tests and to improve the time it takes for the appointments to come through.

Finally, we've heard their frustrations around response times to correspondence, for example complaints.

Our 2026 listening survey was completed by 1,300 people living across the Teesside, East Durham and North Yorkshire area. Their overall sentiment of their NHS experience was largely positive.

Overall, around three in four people rated their experience of using NHS services in the last 12 months as being ‘good’, ‘very good’ or ‘excellent’.

Respondents identified a number of aspects of care that people feel has worked well. Kindness, empathy and compassion of colleagues who go above and beyond for their patients was a strong sentiment, alongside the professionalism of colleagues and quality of clinical care provided. The efficiency and accessibility of services also scored strongly. Patients told us they particularly value being treated with kindness and respect, clear communication, timely provision of care, access to services provided locally to them, and scenarios where clinical teams listen to and involve them.

Respondents were also happy to share where they felt we have opportunities to improve the way we provide care, identifying that they want to see a more consistent, better organised and more accessible healthcare system across Teesside, East Durham and North Yorkshire. Access to services and lengthy waiting times was a dominant feedback theme, alongside poor communication about their appointments and any follow-up aftercare, and co-ordination of care pathways. Parking and travelling to major hospital sites was identified as being a practical barrier to care provision, as well as recognition that staffing and system pressures are evident in multiple areas. Some also felt unheard in their care interactions.

Patients are primarily asking UHT for respect, clearer communication, more joined-up, timely care, and access to services that are provided closer to their homes.

We also asked people what matters to them most, which is outlined overleaf.

RANKING POLL 1,166 votes

What matters most to you?

(please put these in order of what matters most)

We will use all of the feedback that has been captured through this survey, and our wider engagement activity, to help shape our future change proposals.

In direct response to the clear feedback that has been shared with us on travel and patient communication, we will pay specific attention to a number of areas as part of our work to develop our major change proposals. These include:

- Detailed consideration of the impact of any proposed changes for less advantaged patients to ensure their needs continue to be met
- Detailed engagement with a wide range of partners, including Primary Care, on any options as they are developed so as to ensure the development and provision of joined-up care, making the patient journey as smooth as possible
- An evaluation of the travel impact of any change being considered for each patient cohort, and the wider population as potential future patients. This will include public transport use, and options for advocating for improved transport links given that there is low car ownership across some of our communities
- A commitment to ongoing, detailed engagement with patients and the wider population using a variety of channels as we continue to develop any proposed services changes, and where we may implement any changes. This will include a mixture of on-site meetings, using existing forums wherever possible, as well as digital and online options.

Feedback