City Hospitals Sunderland NHS Foundation Trust
South Tyneside NHS Foundation Trust

South Tyneside and Sunderland Healthcare Group

Appendix 5.2:

Five Reconfiguration Tests' Self-assessment (Path to Excellence Phase 1a)

Version 1.0 March, 2017	Draft – to be updated post-consultation to inform final decision

1.0 Introduction and purpose

A number of “reconfiguration tests” must be applied to all service change proposals, as specified in national policy and guidance. This document sets out the Path to Excellence programme’s (PtPE) self-assessment of compliance with these tests in relation to the Phase 1a service change proposals.

2.0The reconfiguration tests

NHS England guidance on service change is intended to support commissioners and partner organisations in navigating a clear path from inception to implementation. It aims to assist organisations in taking forward their proposals, enabling them to reach robust decisions on change in the best interests of patients. National guidance is set out in ‘Planning, assuring and delivering service change for patients’ (NHS England, 2015).

The guidance includes four tests that must be satisfied. The tests are set out in the Government’s annual mandate to NHS England. The four tests are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from commissioners.

In March, 2017, NHS England’s Chief Executive Simon Stevens announced a new test, to bring further assurance to the service change proposals where significant bed closures are involved. The tests are reflected in Next Steps on the NHS Five Year Forward View and will form part of NHS England’s routine assurance checks from 1 April 2017.

Any service change proposals that will result in ‘significant hospital bed closures’ will have to satisfy one of the following three conditions in order for NHS England support for the proposals to:

- demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

The following sections set out how the CCGs and Path to Excellence programme has responded to each of these tests.

3.0 The four reconfiguration tests

3.1 Strong public and patient engagement

The South Tyneside and Sunderland healthcare partnership organisations are committed to ensuring that they fulfil all of their statutory requirements in relation to involvement and consultation as well as recognising the tremendous value that comes from listening to service users in terms of informing the development of service change proposals. As such, engagement to inform phase 1 of the Path to Excellence proposals has taken place over the last six months. Further detail on the engagement activity undertaken can be found in chapter 4 of the pre-consultation business case (PCBC) and at appendix 4.4.

Engagement activity can be summarised as:

- Engagement on the broad case for acute hospital service change between November 2016 to January 2017 with NHS leader attendance at 21 meetings across Sunderland and South Tyneside and over 500 people directly involved from a range of elected member and council community area forums, voluntary and community sector networks, people's boards, council of GP practices and ward committees.
- Proactive circulation of an 'Issues Document' to build understanding of the drivers for the service change proposals, using a range of multi-media channels
- The development of a comprehensive insight report drawn from surveys and face-to-face interviews with approximately 1,500 previous or potential service users and carers across stroke, maternity, gynaecology and paediatric service pathways and further informed through 3,500 Facebook contributions
- Targeted engagement with Members of Parliament and known local campaign groups
- Regular and proactive attendance at the Joint Health Overview and Scrutiny Committee since September 2016.

3.2 Consistency with current and prospective need for patient choice

Patients' right to choice is embedded in both NHS statute and policy, through both the NHS Constitution (2015) and The NHS Choice Framework (2016). Choice has therefore been assessed as part of the scenario shortlisting process with further

specific analysis as part of individual scenario evaluation, as part of quality, safety and care considerations.

Choice is less applicable for stroke services with the emergency components of the stroke pathway lying outside of the requirement for patient choice, with the exception that every patient must be made aware of their right to refuse treatment.

The non-acute components of the pathway are arguably open to greater patient choice as patients enter the rehabilitation phase of care. However, stroke rehabilitation is not confined to non-acute care with rehabilitation beginning during the hyper-acute stage of care, at the point of admission. Allied health professionals and specialist stroke nurses work across the stroke pathway, presenting workforce considerations for how future stroke services can best be configured to ensure both optimal clinical care and service sustainability.

The stroke proposals within Phase 1a of the Path to Excellence programme has paid due regard to South Tyneside patients' choice rights particularly in the consideration of repatriation scenarios as well as the continued consolidation of the full patient pathway. A number of scenarios will be taken forward to public consultation, including two scenarios which would see South Tyneside stroke patients transferred back to their local hospital for the sub-acute or non-acute parts of their care i.e. after 72 hours or 7 days. Further choice has been incorporated into the semi-elective part of the stroke pathway scenarios through retaining a lows risk Transient Ischemic Attack (TIA) clinic at STDH.

The evaluation of the temporary relocation of the stroke services and any impact of restricted choice will be considered as part of the CCGs' final decision, with evaluation of the clinical effectiveness and patient satisfaction of the temporary move ongoing. The choice availability for South Tyneside patients must also be assessed in relation to that available to Sunderland stroke patients, if CCGs are to ensure equitable service access and choice. Any increased clinical gain from a reduction in patient choice must also be fully considered.

The NHS Choice Framework pays specific attention to choice of maternity services, with choice a core theme of national maternity service policy and service user feedback, as is discussed in chapter 4 of the PCBC. Choice has therefore been considered as part of the impact assessment of the scenarios. Both obstetrics and gynaecology (O&G) scenarios satisfy the NHS Choice Framework requirements of offering four choices of place of birth, which are also core features of the National Maternity Strategy Better Births:

- at home, with the support of a midwife

- in a midwife-led facility (co-located with a consultant-led obstetric unit), with the support of a midwife
- in a midwife-led facility (free-standing), with the support of a midwife
- in hospital with the support of a maternity team. This type of care will be the safest scenario for some women and their babies

Scenario 1 of the obstetrics and gynaecology scenarios retains the greatest level of geographical and Midwifery Led Unit (MLU) type choice due to the proposed availability of two Midwifery Led Units, a free-standing MLU at STDH and co-located MLU at SRH. All other elements of the choice within the maternity pathway, i.e. choice of ante and post-natal care will remain the same. Patients' legal right to choose first outpatient appointments will continue to apply for all obstetric, gynaecology and paediatric activity.

National choice guidance is less applicable to the paediatric service change proposals, particularly for the most seriously ill patients where transfer to hospital is likely to be by ambulance and therefore choice is determined through ambulance pathways and clinical protocols. Choice clearly can be exerted in the case of more minor paediatric urgent ailments. Choice has remained a key consideration in the development, shortlisting and evaluation of the paediatric scenarios. The proposed nurse-led paediatric minor illness/injury service represents a concerted effort to retain local choice for South Tyneside patients and is expected to be able to accommodate a significant proportion of current South Tyneside activity locally.

The NHS Constitutional right to be involved in decisions about treatment and to be given information to help choose the right treatment will continue to apply for all services within the scope of the Phase 1a proposed changes. This will be available to patients under proposed new service configurations through the delivery of public-facing communications and marketing materials to support patients and families in accessing care aligned to whichever scenarios are approved for implementation. This will be particularly important to ensure prompt access to paediatric urgent, or emergency care.

The impact of the proposals on choice has also been assessed in relation to availability of providers, in line with the Procurement, Patient Choice and Competition Regulations (PPCCR) (Monitor, 2013) which creates a framework for procuring NHS health care services that will secure high-quality, efficient services that meet the needs of patients. The framework is relevant whenever commissioners are awarding new contracts or making material variations to existing contracts. It is for commissioners to decide, while acting within the framework of the regulations, what services to procure and how best to secure them in the interests of patients.

No procurement process is deemed applicable or necessary in relation to the Phase 1a Path to excellence proposals however, as CCGs believe that services are currently commissioned from providers who are best placed to deliver the needs of their patients and populations. A partnership approach between CCGs and provider organisations has been achieved throughout the Path to Excellence programme thus far which CCGs are confident can continue to deliver seamless and sustainable care to patients. Nevertheless, this pre-consultation business case, and supporting documentation, demonstrates compliance with a number of the PPCCR regulations in relation to patient choice.

These include:

- Regulation 2 – which says that the objective of commissioners is to secure the needs of patients who use the services and to improve the quality and efficiency of the services, including the services being provided in an integrated way (including with other health care services, health-related services or social care services). All scenarios, including current service configuration scenarios, have been considered to ensure multiple provider scenarios were considered.

- Regulation 3 - which requires commissioners to consider whether services can be improved by being provided in a more integrated way, by enabling providers to compete to provide services and by allowing patients a choice of provider. Although commissioners must consider whether improvements can be achieved through such means, it is for commissioners to decide the extent to which they seek to achieve improvements through these and/or other means. The Phase 1a scenarios are therefore underpinned by robust assessment of need, good predictors of demand and clinically-led proposals on the structure and location of services.

All stroke, obstetrics and gynaecology, paediatrics and directly impacted Special Care Baby Unit (SCBU) proposals, are intended to drive up clinical quality by concentrating clinical skills on to fewer sites. While at face value the choice patients will have if the potential changes are implemented will reduce, the service scenarios proposed also maximise the opportunity for patients to choose between high quality services (delivering the right care in the right place) within the available resources.

With all scenarios, this balance between locally accessible choice and a choice of safe, high quality care will continue to be tested by clinicians and informed by feedback from public and patients, prior to any final decision on future service configurations being made.

3.3 Clear, clinical evidence base

Individual cases for change outlining the service-specific clinical rationale for proposed change are contained within sections 6.2.6.1, 6.3.10.1 and 6.3.10.2 of the PCBC. These are set against the broader national, regional and local strategic cases for change that are embedded in the Five Year Forward View and the recently published delivery plan, the Northumberland, Tyne and Wear and North Durham Transformation and Sustainability Plan and local Path to Excellence documentation.

Service sustainability is a core driver for change with workforce challenges across all three clinical specialities a key element of the clinical evidence base. As noted elsewhere in the PCBC, across both Trusts there are several 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 service continuity, 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 with a limited substantive workforce requires large amounts of energy and resources to sustain. This is certainly true of the services that are under review as part of this business case. There are also an ever-growing number of publications from Royal Colleges, the Department of Health and other bodies in relation to minimum population size that a clinical speciality is recommended to cater for.

Stroke services locally have encountered the greatest workforce pressures that reflect the national and regional shortage of Consultants specialising in stroke care, resulting in the temporary stroke inpatient relocation from STDH to SRH in December 2016. There is currently a substantive vacancy for a stroke consultant at STDH and this has been vacant since 2014. Guidance also exists on the critical mass of patients needed for a stroke unit to ensure the best outcomes for patients and providing a compelling case for greater concentration of care. The research evidence base includes the well-documented London service change which consolidated 32 stroke units into 8 hyper- acute units and a further 24 units providing care after the first 72 hours which achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

The growing national policy around stroke service consolidation was reinforced by a 2015 review of North East & Cumbria stroke services by the North of England Cardiovascular Network which recommended a reduction in Hyper-acute Stroke Units to deliver units that treat strokes of between 600-1500 in number each year. STFT treats less than 300 stroke patients each year. Clinical quality indicators for South Tyneside and Sunderland stroke services also provide clear rationale for

change with both organisations failing to achieve the Sentinel Stroke National Audit Programme (SSNAP) levels that demonstrate a high quality service. A detailed summary of current stroke service quality is incorporated in section 6.

Critical patient mass forms part of the clinical evidence base for the O&G service proposals, with South Tyneside's birth rate currently less than the 2500 recommended from a consultant-led unit by the Royal College of Obstetricians and Gynaecologists (RCOG) (2007). Although both STDH and SRH achieve the required RCOG-advised consultant cover that is proportionate to delivery numbers (40 hours per week at STDH and 68 at SRH), some shortfalls exist in workforce clinical standard compliance. Both hospitals are failing to ensure a minimum of 10 WTE medical staff per rota and one-to-one midwifery care during the second stage of labour, while SRH is also unable to ensure a separate formal elective caesarean list. Locum use to support limited registrar availability is frequent at SRH with a reliance on non-career grade doctors at South Tyneside that leads to service vulnerability as such professionals will naturally wish to seek specialist training roles.

The delivery of gynaecology clinical standards across both sites is also compromised by a limited medical workforce, with not all inpatients reviewed by a consultant on a daily basis. As such, both hospital sites are currently unable to ensure seven-day consultant presence and STDH currently has some rotas with less than the recommended eight staff members.

Paediatric service change proposals are equally driven by workforce challenges and a need to improve clinical quality standard delivery. Not all of the Royal College of Paediatrics and Child Health 'Facing the Future - Acute Standards' (2015) are currently met across both South Tyneside and Sunderland Paediatric ED services. Senior medical cover is not always in line with national standards at South Tyneside with the use of advanced paediatric nurse practitioners used to bolster limited junior doctor capacity. This was highlighted in South Tyneside NHSFT's most recent Care Quality Commission report[1]. Weekend paediatric consultant cover at Sunderland is also only partially achieved. Three coroners' reports in recent years have also expressed concerns about a lack of consultant supervision of paediatric trainees and the lack of assessment for paediatric admissions. The sustainability of a 24-hour paediatric Emergency Department was questioned as far back as 2010 when the now obsolete National Clinical Advisory Team reviewed a range of services as part of the Accelerated Bigger Picture transformation programme.

Clinical leadership has been at the centre of the PtEP from the outset, ensuring that the work has been clinically led and locally appropriate. A clinical services review group (CSRG) – composed of clinicians from each hospital Trust and CCG in South

[1] South Tyneside NHS Foundation Trust Quality Report, Care Quality Commission, December, 2015

Tyneside and Sunderland has overseen the development of the Phase 1a proposals. Clinical service review teams comprising nursing and medical representation across services and organisations have developed the change scenarios. In addition, external clinical assurance has been applied through a range of North of England Clinical Networks and through NHS England's service change assurance process

3.4 Support for proposals from commissioners

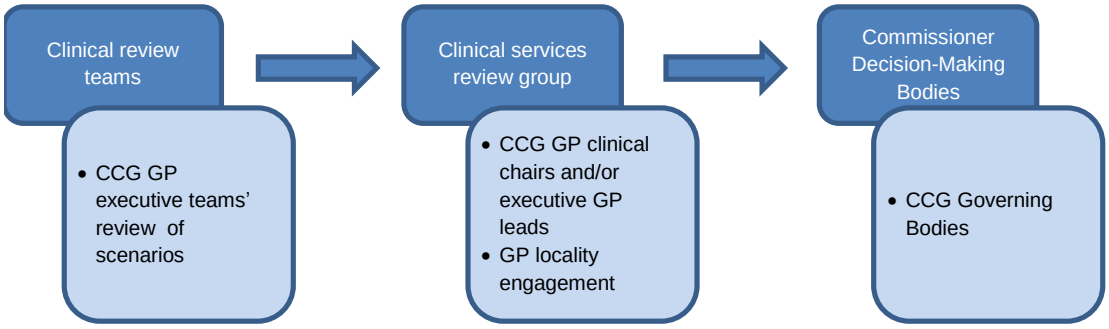
The test for commissioner support was introduced as GP consortia were mobilising as the Health and Social Care Bill progressed through Parliament. With the passing of the Health and Social Care Act 2012, these consortia now exist as Clinical Commissioning Groups (CCGs).

All general practices must be a member of a CCG and on this basis, meeting this test requires service change recommendations to be supported, on balance, by the relevant CCGs. Relevant CCGs in the context of this business case are South Tyneside CCG and Sunderland CCG, however, there is also a case for ensuring support from peripheral CCGs, including North Durham, Newcastle-Gateshead, and Durham, Dales, Easington and Sedgefield CCGs. This is on the basis that some patients from these CCG areas may flow into current South Tyneside and Sunderland services and therefore may be impacted by the change. Neighbouring CCGs will also want to assess the impact of any displaced South Tyneside patient activity flowing into non South Tyneside and Sunderland sites that they commission. Work is ongoing to fully establish any impacts perceived by other CCGs as the programme move into the consultation phase of the service change process.

NHS England's Cumbria and the North East Specialised Commissioning team recognises the inter-dependency of the obstetrics and paediatric service change proposals with the Special Care Baby Unit (SCBU) services that it commissions. The team has therefore delegated consultation responsibility for the proposed changes to SCBU to CCGs. The team has also provided an impact assessment of the Phase 1a proposals and is supportive of the proposals moving to consultation phase. The CCGs will take decisions in relation to stroke, paediatric and obstetrics and gynaecology services and make a recommendation to NHS England in relation to SCBU services. As statutory commissioners of NICU and SCBU services, NHS England's specialised commissioning team will then formally consider these recommendations and take responsibility for overseeing the effective implementation of any approved changes, as required.

It is important that CCGs are able to demonstrate attempts to involve all member practices and enable them to tangibly influence the development of any change proposals, prior to any final decision being made. An overview of GP commissioner involvement in Phase 1a of the PtEP is at figure 5-5.

Figure 3-1: GP commissioner involvement as part of scenario development and approval process.



Clinical commissioning groups have held a range of CCG and GP engagement events such as "time in, time outs" and council of practices and have specifically discussed the Path to Excellence programme and underpinning case for change.

Clinically-led discussions have since been held on a monthly basis through the CCG's executive groups and both CCGs have had multiple senior GP commissioner representation at the Clinical Services Review Group overseeing the programme and providing critical challenge to support the scenario development process. GP engagement has been undertaken and support obtained in line with the CCG's constitutional arrangements. GP engagement will continue as part of a comprehensive clinical and staff engagement programme that will run as a concurrent part of the public consultation process. GP support in those areas most impacted by the proposed service changes will be tested as part of this.

4.0 The 'fifth test'

A high-level analysis has been undertaken against the set of conditions which NHS England recently announced must be applied to any service change proposals that involve significant hospital bed closures.

The tests will form part of NHS England's routine assurance checks and will come into effect from 1 April 2017. Any service change proposals that will result in 'significant hospital bed closures' will have to satisfy one of the following three conditions in order for NHS England support for the proposals to:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it;
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or

- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

The first two conditions are applicable to the Phase 1a PtEP proposed changes if the proposed changes were to be considered to constitute a 'significant hospital bed' reduction. However, the programme does not believe the proposed bed reduction to be either significant nor a risk to increasing either hospital or wider service pressures. Significance has been assessed not by volume of beds but by the risk posed to acute activity flow and the potential implications for medicine, Accidentant and Emergency (A&E) and out of hospital services i.e. maternity beds may close but as they cannot be used by medical patients this is unlikely to pose a risk beyond maternity capacity.

A summary of the proposals' implications for hospital beds can be found at table 5-4 together with narrative demonstrating satisfaction of the conditions.

Table 4-1: Assessment of options against the hospital bed closures test.

Clinical service area	Bed closure implications	Evidence to satisfy conditions
Stroke	20 beds would close at STFT under option 1. Beds will be retained under repatriation models within options 2 and 3	Sufficient alternative inpatient stroke provision (39 beds) is available at SRH to accommodate full annual STFT and SRH stroke activity. Occupancy levels are currently 76%, including stroke mimics, with surplus capacity available for medical boarders. Reconfiguration options will enhance rather than deplete the stroke medical workforce, supporting service sustainability and delivery of improved outcomes in line with national evidence base and regional CVD Network recommendations.
Clinical service area	**Bed closure implications**	**Evidence to satisfy conditions**
Obstetrics	9 delivery rooms and 21 antenatal and postnatal beds would close under option 2. A reduced number of delivery rooms (estimated at 2) and ante/postnatal beds (estimated at 3) would be retained under option 1 as part of a freestanding MLU.	Bed use determined by patient activity and flow therefore future bed numbers are aligned to projected, modelled demand. Patient-facing communication and midwifery education will support right-place patient presentations with cross-site transfer protocols and pathways in place as required. 20 en suite delivery rooms at SRH will be increased

		to accommodate two extra beds to be able to absorb additional high-risk and/or MLU activity under both options. Improved discharge pathway to be implemented to support capacity increase. Options will strengthen medical workforce availability and therefore service sustainability. Obstetric beds could not be used for any alternative service.
Gynaecology	6 female surgical beds that are currently used for gynaecology patients at STFT will be retained as surgical beds. Day case unit facilities will be retained. Pregnancy assessment unit facilities would be retained.	9 inpatient beds currently at SRH with flexibility to increase this to 12 beds with staffing establishment already able to deliver this capacity. Modelling confirms capacity to be sufficient to absorb increased inpatient elective and non-elective gynaecology activity.
Paediatrics	No current paediatric inpatient beds at STDH. 3 CSSAU beds* would be retained at STDH as part of the day-time paediatric service proposed in option 1. The CSSAU beds* would close in option 2. Children's Day Unit beds* x 6 would be retained for paediatric dental surgery. *Not inpatient beds	8-bed Children's Short Stay Assessment Unit (CSSAU) will remain and can comfortably absorb additional activity from STDH. Occupancy currently at 46%. 20 beds (plus 6 escalation beds) on SRH paediatric surgical ward is currently at 50% occupancy with sufficient capacity to absorb small number of additional Children's Day Unit surgical, diagnostic, orthopaedic activity from South Tyneside.
SCBU	6 SCBU cots would close at STDH under both proposed options.	16 SCBU cots at SRH will absorb displaced STDH activity. SCBU capacity is determined by birth rates and obstetrics activity and patient flow. Nursing and medical staffing consolidation will increase staffing ratios and support service sustainability.