Working together to improve hospital services in South Tyneside and Sunderland

Phase Two of the Path to Excellence programme

Helping you understand the issues and challenges

Draft Case for Change - July 2018
This document will continue to be updated during 2018/19 and will be republished

www.pathtoexcellence.org.uk
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Introduction

Our NHS celebrates its 70th birthday in 2018 and remains one of our most cherished British institutions. It is woven into the very fabric of our way of life with each and every one of us using services in some shape or form and placing great value on the care, dedication and unwavering commitment of our amazing NHS staff.

In South Tyneside and Sunderland we have an abundance of good health services and thousands of devoted NHS staff working hard every day to go above and beyond to support patients. There is no doubt that we already have much to be proud of and this ‘everyday excellence’ should not be underestimated.

We also know, however, there is still much more we can do to improve our services even further. Unlike in 1948, the NHS of today is facing some of the biggest challenges in its history. Our staff and services are under extreme pressure and this is being felt intensely in our local hospitals, as well as in other parts of the healthcare system.

Our aging population means more people are now living longer with long-term illnesses such as heart disease, diabetes or dementia and often have very complex care needs. The impact of smoking, alcohol and obesity have all put major strains on our healthcare system and as these demands increase, the way we provide services must change.

Like many parts of the NHS, we also face major challenges in sustaining our workforce and we continue to rely heavily on expensive locum and agency support to make sure we can safely staff all of our services, all of the time. This impacts negatively not only on the money we have available, but also our ability to consistently deliver safe, high quality and timely patient care.

Over the past 70 years, new drugs and advances in medical technology mean we can now help people more than ever before, but it also means that NHS costs are rising far faster than the funding available. Even with the extra funding commitment for the NHS nationally, we must continue to think carefully about how we use our money and our staffing resources much more effectively.

Despite these challenges, as NHS partners we share a very strong ambition to make our local hospitals even better and to improve some of the quality gaps we know exist across our services at South Tyneside District Hospital and Sunderland Royal Hospital. We are absolutely clear both hospitals will continue to exist and both will continue to play pivotal roles in our local communities in the future - of that there is no question.

We do, however, need to change the way we deliver care and work much more effectively together, as unified clinical and nursing teams, right across the populations we serve.
Not only does this mean transforming care provided in our hospitals, but also how we work across health and care organisations to transform out of hospital care provided in local communities, making it more responsive so people only go to hospital if they absolutely need to be there.

We must also place an enhanced emphasis on prevention and how we work better together to support people to take more responsibility for their own health so they do not become ill in the first place.

The aim of this document is to help you understand some of the issues and challenges facing us. It also outlines our aspirations for the future as we continue to think differently, change how we do things and work together for the benefit of our patients and our staff.

We look forward to keeping you updated and welcome your feedback and ideas for making positive improvements happen.

Ken, David and David
Local hospital services in South Tyneside and Sunderland provide an abundance of great care delivered by highly committed teams of NHS staff. Phase Two of the Path to Excellence programme aims to build on these strengths and successes, but also make sure we plan and prepare for the tidal wave of pressures we know are facing us. Over the past two years our teams have already been working much more closely together across South Tyneside and Sunderland and this puts us in a very strong position to embrace the opportunities ahead. There are four key challenges which we cannot ignore and which mean no change is not an option:

1. Workforce pressures
Workforce pressures mean we must do things differently. Our NHS staff are a precious resource and they are working under intense pressure. We currently have many gaps in our workforce across both Trusts and many staff who will also reach retirement age in the immediate years ahead. This is also true of GPs and our colleagues working in primary care. We can only truly address these workforce challenges by working together and creating bigger, stronger and more resilient teams across both hospitals which will also help us attract more newly qualified staff coming into the NHS.

2. Future demographic changes
Future demographic changes mean the people we care for across South Tyneside and Sunderland are getting older and living longer with more complex conditions. This pressure on our NHS is expected to grow and grow. The way that many of our local hospital services are currently set up means we are not geared towards the needs of this aging demographic of patients. By working together to organise services in a different way, we will be in a much stronger position to meet this continued rise in demand and ensure patients always get the best possible care.

3. Quality improvements
Quality improvements and advances in medicine, treatment and technology mean hospital stays today are much shorter and our ability to survive illness or injury is much greater. Improvements in the quality of care for NHS patients are simply astounding. Whether you need a planned operation or emergency treatment, care is becoming increasingly specialised and so too are our hospitals with patients often travelling further to get to the right expertise. Only by working together can we keep pace with these advances and create the all-important critical mass of patients needed for our staff to maintain their skills and for us to consistently meet many quality standards around consultant-led care, seven days a week.
4. Financial constraints

Financial constraints are greater than ever before. Whilst the recent national NHS funding boost is very welcome news, we know our local NHS services currently cost more to deliver than the money which we have available. If we keep going the way we are and do not change how we deliver services, we will face a deficit of £127.5 million by 2021. For example, our emergency care and acute medicine services make an annual loss of £15 million and much of this is down to high costs of temporary staff. By sharing our resources and expertise to create joint services across both hospitals, we will be in a much better position to offer patients the best possible quality of care and to create highly efficient hospital services which offer the best value for money.

Why doing nothing is not an option

All of the above factors mean we have to make a plan for the future. Change in the NHS is constant, it always has been and always will be – that is what makes our NHS the envy of the world as we continue to evolve and develop services. Change is not something we should fear and by working together across South Tyneside and Sunderland we want to embrace the opportunities this presents us to create first-class hospital services for the future.
Why do we need to change?

The NHS ‘Five Year Forward View’ is the national vision for the NHS and it highlights three gaps which currently exist and where we must improve. By 2020/21, it aims to:

1. **Improve the health and wellbeing of the population** by focusing on ‘prevention’ so that we all take more responsibility for our own health and wellbeing and do not become unwell with wholly avoidable illnesses.

2. **Improve the quality of care provided** by closing gaps in quality and safety which still exist by reshaping how care is delivered and driving down variations in patient outcomes and experience.

3. **Improve the finance and efficiency of NHS services** by redesigning services to reduce unnecessary duplication, remove organisational boundaries and create better efficiencies across the whole ‘system’.

In South Tyneside and Sunderland we face big gaps in all three of the above areas and although our local organisations already work well together, there is still much more to be done so we can keep pace with the changing needs of our population and make sure local people have access to consistently high quality care which offers the best possible outcomes. If we do not adapt and change the way we deliver care, we risk our good services becoming average and the challenges and difficulties we face becoming worse. We don’t want this to happen which is why we are working together through the Path to Excellence programme to make a plan for the future.

**What is the position in South Tyneside and Sunderland?**

**The health and wellbeing of our population**

Despite having good NHS services, our population is in very poor health. We have above average levels of deprivation with more people smoking, drinking alcohol excessively and not doing enough exercise, than many other parts of the country. This means we have higher levels of mental and physical sickness, poorer health outcomes and, as a result, there is much greater demand on hospitals in South Tyneside and Sunderland.
In comparison to other parts of the country, in South Tyneside and Sunderland we have:

- more emergency hospital admissions
- more alcohol-related hospital admissions
- more cases of cancer
- more people living with long-term conditions such as diabetes, heart disease or breathing problems
- more deaths due to wholly preventable illnesses
- lower life expectancy compared to the England average
- significant gaps in the life expectancy between the least and most deprived areas of South Tyneside and Sunderland

Life expectancy gap between the least and most deprived areas in South Tyneside and Sunderland (years):

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<th>Sunderland</th>
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<tbody>
<tr>
<td>Men</td>
<td>8.4</td>
<td>11.5</td>
</tr>
<tr>
<td>Women</td>
<td>8.1</td>
<td>8.7</td>
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If we do not start thinking more seriously about reducing the damage caused by living unhealthy lifestyles, then we anticipate much further demand on our hospitals in the future. The majority of all patients currently admitted to our hospitals are over 80 years old and they often have multiple long-term conditions which require more complex care and support. We expect this demand to grow even further in the years ahead.
Projected increase in hospital activity (%) by 2025 by age:

**South Tyneside**

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>19%</th>
<th>23%</th>
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<td>65-74</td>
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**Sunderland**

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>15%</th>
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<td>65-74</td>
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The quality of care we provide

The gaps in our workforce are by far the biggest challenge we face in being able to consistently deliver the highest quality of patient care. Our hospitals both face daily challenges to staff wards and departments to a consistently safe level and this often relies on the tremendous goodwill of staff working longer hours and doing extra shifts, as well as the use of temporary staff. This, in itself, poses a risk to the health and wellbeing of our teams and the quality of care being provided.

We are not alone in this challenge and many Trusts across the country also face the impact of national shortages in a number of specialties. By organising our hospital services differently, we are more likely to attract people to come and work with us, especially if we can offer a healthy work / life balance and NHS services which demonstrate improved quality of care and outcomes for patients.

At the moment we face a number of shortfalls in the quality of care we are able to provide:

- there is too much unacceptable variation between our hospitals on how we perform against many clinical standards which are the markers of high quality care
- we are unable to consistently ensure all emergency patients are reviewed by a consultant in a timely manner
- some of our planned care, for example, going into hospital for an operation or having an x-ray, is not as efficient as it could be and there are differences in how often people are referred to specialists and the tests and treatments they receive
- we do not have consistent availability of senior clinical decision makers or wraparound support services seven days a week
- individually, the populations we serve in South Tyneside and Sunderland are small and without working together we do not have the important ‘critical mass’ of patients needed to meet a range of clinical quality standards

Our financial position and efficiency of local NHS services

The financial challenge our NHS faces today is arguably the most difficult ever encountered. Across the local health economy in South Tyneside and Sunderland our services currently cost more to deliver than the money we have available. Even with the extra funding commitment for the NHS nationally, this alone will not solve the problems we face. If we do not think differently and change the way care is delivered, we will face a financial gap of around £127.5 million by 2020/21.

Our staff have made tremendous efforts in recent years to continually deliver millions of pounds in efficiency savings. Our two Trusts working together have delivered significant financial benefits with more efficient ‘back office’ support services and the introduction of a single management team, generating recurrent savings of over £500,000 per year.
Working with both Clinical Commissioning Groups (CCGs), as a group of local NHS organisations we have now collectively signed up to a shared long-term financial recovery plan to help us get back into financial balance in the years ahead. Phase Two of the Path to Excellence programme will play a key part in this and by improving the quality of patient care, we expect to achieve financial gains by running more efficient and effective hospital services. This does mean we must think more radically than ever before about the way we work together, without organisational boundaries and as larger clinical and nursing teams covering both populations. Only by doing this will we be able to make the most of our precious NHS resources and maximise value for money for the tax payer.

Our financial challenges:

- the number of people attending our Emergency Departments at both hospitals continues to grow, with many older people being admitted with multiple health conditions
- our emergency care and acute medicine services across both hospitals currently cost more to provide than the funding that is available to run them and make an annual loss of £15million
- our over-reliance on temporary staff (£11 million for emergency care and acute medicine alone) not only costs us more, but it also limits our ability to make long-term quality improvements to patient care
Working in partnership with health and care organisations across South Tyneside and Sunderland

As the previous sections have already highlighted, health and care is a lot more than what happens in our hospitals. We need to do more to improve the health and wellbeing of the population with a focus on preventing people becoming unwell in the first place.

We also need to continue to expand and develop care in local communities because the vast majority of care takes place outside of hospital. And we need to do this while ensuring we balance our finances and plan for the future of services to support the growing demands.

In order to transform health and care locally, it is helpful to consider them in three main ‘pillars’ which are:

- **Prevention** – how we work together so we can take more responsibility for our own health and wellbeing and do not become unwell with wholly avoidable illnesses

- **Out of hospital** – how NHS, social care and community and voluntary organisations work together to provide more responsive care to prevent avoidable hospital admissions and to get people out of hospital as soon as they are able with more care at home and closer to home

- **In hospital** – this is the Path to Excellence programme which is the subject of this draft case for change document

Already there has been a great deal of work being led by the two council’s public health teams on prevention, this includes helping people to stop smoking, be a healthy weight, take part in health screening programmes, and not drink alcohol at harmful levels. There are programmes to support people to look after themselves and achieve maximum independence whilst living longer, healthier and more fulfilling lives. We call this self-care.

What self-care might mean to you:

- **Having more control over your health and the services you receive**

- **Knowing how and when to seek support if you are having concerns**

- **Having more knowledge and information to be able to manage a health concern or condition at home**

All of this work needs to continue to expand and develop over the coming months and link closely with our in hospital transformation programme as part of the Path to Excellence.
In both South Tyneside and Sunderland, both clinical commissioning groups have been working to transform out of hospital care using innovative ways to ‘join up’ services. The common theme across both South Tyneside and Sunderland out of hospital is based around two key building blocks.

- **Community integrated teams –** health and social care professionals working together around the GP registered list of 30-50k patients to provide proactive, preventative care

- **Unplanned care –** Sunderland have recovery at home services and South Tyneside is looking to align unplanned care to be similar to Sunderland’s over the next year. Both ways of working are able to respond to people who have a short term crisis or change of circumstances in the community, enabling them to be supported by joined up teams of different health and care staff to stay at home, rather than be admitted to hospital or a care home

In South Tyneside, the NHS became the first UK partner of the Canterbury District Health Board (CDHB) in New Zealand, learning from their 10 year journey which has seen a whole health and care system approach to integrated health and social care through collaboration, partnership working and patient-centred design.

The HealthPathways on-line resource has also been introduced to make it easier for GPs to ensure a consistent way to refer patients to the right service for them, with over 140 pathways that have been developed with local doctors and nurses across both GP and hospital services.

In Sunderland, transforming out of hospital care has been led through the All Together Better Sunderland programme which is playing a key role in making services more joined up and person-centred with the aim of helping patients to live with support in the community. This includes recovery at home – rapid response to support patients’ recovery after leaving hospital and prevent returning to hospital in an emergency. Working 24/7, the service provides a single point of access for patients and professionals, with key nursing and care teams based in one building. A community of integrated teams across five localities sees joined up teams of nurses, social care and therapy staff working together to provide care more locally.

There has also been work to enhance primary and community care with GPs and other community health professionals working to provide more services in communities and outside hospital and looking at how new technology can support the best possible care at home. We will engage with professionals in primary care over the autumn and winter in order to gain their input into ideas under development.
Working together across South Tyneside and Sunderland hospitals

There is already a strong and proud history of partnership working, between our local hospitals, to provide the highest quality of care for local people across South Tyneside and Sunderland.

Since 2016, South Tyneside and City Hospitals Sunderland NHS Foundation Trusts have been working together in a strategic alliance known as the South Tyneside and Sunderland Healthcare Group and now share a strategic vision to become one organisation in the future. This will see over 8,500 highly committed and skilled NHS staff working even more closely together and further improving resilience within our workforce.

Over the past two years, there have been many positive benefits for patients and staff as a result of joint working across our hospitals, with more focussed leadership, shared resource and clinical expertise helping to improve quality for patients. We have also been able to attract more doctors and nurses who can see the ambition of both Trusts and recognise the clinical benefits of working together across a greater geography to create an important ‘critical mass’ of patients to be served.

NHS leaders are very clear that both local hospitals in South Tyneside and Sunderland will continue to play vital roles in providing care for local people in the future, however there will need to be changes to the way some hospital-based services are delivered so we can address the challenges outlined in this document.
Key achievements of the South Tyneside and Sunderland Healthcare Group to date:

- Hundreds more patients are now receiving specialist care closer to home in South Tyneside with new cataract and nephrology (kidney) clinics taking place to regularly to prevent people travelling unnecessarily to Sunderland.

- Significant improvements in quality at South Tyneside District Hospital with the Care Quality Commission acknowledging good progress and visible Trust leadership which encourages pride and positivity.

- Key medical appointments across both Trusts including the first ever kidney consultant at South Tyneside District Hospital thanks to links with Sunderland.

- Nurse recruitment on a much bigger scale than ever before - over 50 new Filipino nurses anticipated to join both Trusts in the year ahead.

- Closer working across clinical and operational teams resulting in greater flexibility to manage pressures and service vulnerabilities in order to deliver safe patient care.

- Creating a shared learning culture by encouraging staff to report and share examples of ‘everyday excellence’ they see in the course of their work.

- Closer working between the Trusts’ research and innovation teams and a shared ambition to further expand clinical trials and investment in research.

- £15 million investment secured through the national ‘global digital exemplar’ (GDE) programme thanks to joint working to develop a single patient information system.
Our ambitions for the future
Phase Two of the Path to Excellence programme is the final phase of work and a number of clinical service reviews are currently taking place which cover the following areas of hospital-based care for adults:

**Emergency care and acute medicine**
This is the care we provide when patients arrive at our Emergency Departments or need emergency admission to hospital.

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

**Planned care (including surgery and outpatients)**
This is the care we provide after patients have been referred by their GP for a test, scan, treatment or operation.

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

Emergency care

Understanding the current picture

Both of our hospitals in South Tyneside and Sunderland have a 24/7 Emergency Department (ED) and, together with on-site urgent care centres, saw a combined total of around 150,000 adult attendances in the past year. Of these attendances, just under 75% were considered more serious emergencies and 25% were minor injuries and illnesses, such as stomach aches, cuts and bruises, small fractures, infections or rashes. However we know that around 45% of attendees with ailments categorised as serious are discharged home or to their GP for care.

Patients arrive at our EDs in a number of ways:

- by emergency ambulance after calling 999
- after being referred directly by their GP
- after being advised by NHS 111
- by choosing to attend and walk-in themselves

All patients are assessed within ED and those with minor injuries or illnesses are streamed into urgent care services which are also located on each hospital site. Those with more serious emergencies are seen within ED. At Sunderland Royal Hospital, patients with suspected heart problems can also be admitted or referred directly to a dedicated Chest Pain Assessment Unit which saw almost 2,000 patients during 2017/18.

Emergency opthalmology services provided by Sunderland Eye Infirmary are not included as part of Phase Two of the Path to Excellence programme.
In **South Tyneside**, total ED attendances (for serious emergencies and minor injuries or illness) have remained just above anticipated population growth over the past two years at 3.3% and are significantly lower than national and peer averages\(^1\). This equates to an average of 136 more patients attending ED every single month in 17/18 compared to 15/16. Since the opening of the urgent care hub in South Tyneside in October 2015, the number of adult attendances for minor injuries or illnesses has reduced by 23% in the two years up to September 2017, with an average of 19 attendances per day during the first year (October 2015 - September 2016), 14 attendances per day in the second year (October 2016 - September 2017) and 11 attendances per day for the six months from October 2017 to March 2018.
In **Sunderland**, total ED attendances (for serious emergencies and minor injuries or illness) have increased by 10% over the past two years and this equates to an average of 682 more patients attending ED every single month in 17/18 compared to 15/16. This level of activity is above national and peer averages\(^2\) and attendances for adult minor injuries or illnesses have risen more sharply, by 28%, since 2015. Work underway by NHS Sunderland CCG\(^3\) is looking at different ways to provide access to urgent care across the city to help relieve pressure on our hospital and reduce the number of minor injury or illness attendances in ED.
Over the past two years, around 65% of patients who attended ED with ‘serious emergencies’ in South Tyneside did not need hospital treatment and were discharged back to their GP or home from ED. Only 24% were admitted to hospital for further assessment and treatment with the remaining 11% discharged with a follow up appointment or left ED of their own accord before being seen.

Over the same time in Sunderland, 47% of patients who attended ED with ‘serious emergencies’ did not need hospital treatment and were discharged back to their GP or home from ED. Only 33% were admitted to hospital for further assessment and treatment with the remaining 20% discharged with a follow up appointment or left ED of their own accord before being seen.

Both hospitals have seen a reduction in emergency admissions in the last two years with a 7% drop at South Tyneside and a 2% drop at Sunderland between 2016/17 and 2017/18.
From October 2018, South Tyneside and Sunderland residents stand to benefit from the introduction of an improved regional NHS 111 service provided by the North East Ambulance Service which aims to provide more integrated, clinically-led urgent care. The service will include clinical assessment and involve a range of clinicians such as dental nurses, mental health nurses and palliative care nurses offering online and telephone advice to support patients to get appointments at the most appropriate service.

**Our performance**

Both hospitals perform above the national average for at least 95% of patients attending ED to be seen with four hours of arrival. The significant pressures facing both Trusts during the busy winter period have seen performance dip, however both hospitals remain among the best performing Trusts nationally in 2017/18 with South Tyneside recording a performance of 94.35% and Sunderland 91.25%.

When patients arrive by ambulance, our hospitals must also make sure they are safely handed over within 15 minutes of arrival. While less patients overall are waiting longer for their care to be handed over, there were still more delays between 15-30 minutes at both hospitals in the last year. Ambulance handover delays are more common at both hospitals during the winter period and between December 2017 and March 2018 around 3% of patients at both hospitals waited more than 30 minutes to be safely handed over to hospital staff. Less than 1% of patients in South Tyneside and Sunderland faced handover waits in excess of one hour between December 2017 and March 2018.
Acute medicine

Understanding the current picture

Acute medicine is the care we provide to seriously ill patients who are admitted as emergencies to our hospitals. Both hospitals have a dedicated area near ED where all patients are assessed by acute care doctors to determine if they need to be admitted to a ward or to another part of the hospital for more specialised assessment and treatment. This is known in South Tyneside District Hospital as the ‘Emergency Assessment Unit’ or ‘EAU’ and at Sunderland Royal Hospital it is called the ‘Integrated Assessment Unit’ or ‘IAU’.

Patients with a medical complaint are then admitted to one of eight general medical wards at South Tyneside District Hospital, each of which looks after patients with a range of different medical problems. In Sunderland Royal Hospital, patients are admitted to one of 13 specialist medical wards, each of which looks after patients with specific medical conditions.

Both hospitals also have ‘ambulatory care’ units caring for patients directly referred from ED or by their GP, who require urgent medical treatment but do not need to be admitted to hospital overnight.

Our challenges

Capacity and demand

Our staff at both hospitals have highlighted the increasing demand for hospital services as a major concern. Despite a reduction in emergency admissions over the past two years, both hospitals usually operate at close to full capacity and we are caring for an increasing number of older patients with a number of complex needs. Our aging population means we are likely to see these pressures increase further in the years ahead, not only in the number of older people accessing services, but in the increasing complexity of patient conditions.
There is much research and evidence to suggest services need to adapt to provide early, multi-disciplinary assessment for older people coming into hospital in order to avoid unnecessary admissions which may have a detrimental impact on older people’s wellbeing, recovery and independence.

Both hospitals have such a ‘frailty’ service but there are differences in how these are run and the level of assessment they offer. During its first year, the frailty service in Sunderland demonstrated a reduction in the length of hospital stay, readmission rates and overall mortality amongst those patients who had been seen early by a specialist multi-disciplinary team.

Patient flow

The term ‘patient flow’ describes how all parts of the health and social care system work together so patients receive appropriate, timely care and ‘flow’ effectively through the system – for example, from the ambulance into ED, from ED to medical assessment and then to a ward and through to discharge. We know that when this doesn’t happen effectively it can increase risks to our patients and means they spend longer on the road to recovery. Key to good patient flow is making sure patients receive a timely expert medical opinion, from the relevant specialist in their condition, so their treatment can begin as soon as possible. This includes for example effective access to specialists in dementia care, to make sure our patients receive the timely care and support they need. We know this doesn’t happen as effectively as we would like it to within our hospitals and this is an area we want to improve.
We also face challenges with the number of patients who experience a delay in being discharged from hospital despite being medically fit to leave. In South Tyneside we aim to achieve less than 60 delayed discharges each month and in Sunderland less than 100 delayed discharges each month. This can often be hard to achieve, especially during winter, and requires a system-wide approach working with colleagues in social care and the vital services in place in South Tyneside and through the Sunderland Care and Support Service.

The main reasons we experience delays are due to:

- **waits for care packages or assessments to be completed**
- **waits for community equipment and property adaptations**
- **patient or family choice**

**Senior clinical decision making**

There is now widespread agreement amongst doctors that the quicker emergency patients get to see a senior clinical decision maker, or specialist, the more likely they are to receive the right diagnosis and treatment sooner, ultimately resulting in better clinical outcomes. There is also clear evidence to show that it is better to travel further for this more specialist care than to receive non-specialist care locally.

Making sure patients have consistent and timely access to a specialist consultant opinion is a key driver for change nationally to ensure patients can begin the right pathway of care sooner. There is also a national expectation that patients are regularly reviewed by consultants to help reduce time in hospital and improve flow. This is arguably even more important given the number of frail, older people who attend as emergencies with several chronic conditions and multiple medications, making prompt diagnosis and ongoing care even more challenging.

At the moment, our emergency care and acute medicine services across South Tyneside and Sunderland are not able to consistently deliver care which is led by senior clinical decision makers and this means decisions about care are often taken by those with much less experience.

Senior clinical input is just as critical at the point of discharging patients from hospital, especially to reduce the risk of any unplanned re-attendances for the same condition or complaint. Every month, both of our hospitals currently have more patients re-attending our ED within seven days than the national average of less than 5%:

- **7.4% in Sunderland**
- **8.6% in South Tyneside**

Between October and December 2017, emergency readmissions within 30 days at South Tyneside District Hospital were also above the national average at 9.67%, with Sunderland just under the national average at 7.23%.
Length of hospital stay

Length of stay in hospital is an important quality measure, not only in terms of hospital efficiency and the costs associated with inpatient care, but most importantly in relation to patient experience and clinical outcomes. The more time our patients spend in hospital, the longer their recovery will be, with evidence showing that early rehabilitation, support at home and wraparound services available seven days a week, greatly aiding patient recovery.

We know that some variation exists in the length of time patients stay in our hospitals. Patients in South Tyneside generally experience longer hospital stays with an average length of stay of 7.2 days for all emergency medical patients in 2017, compared to 5.2 days in Sunderland. Older patients in South Tyneside, who require the expertise of an elderly care consultant, stay in hospital almost twice as long as the same group of patients in Sunderland. For emergency cardiology patients in South Tyneside, their average length of stay was four days longer when compared to Sunderland. As part of our work in Phase Two, we want to reduce this variation and ensure all patients have timely access to the care and expertise they need.

Average length of stay across South Tyneside and Sunderland during 2017 (days)
Clinical drivers for change

Although the performance of both Trusts remains strong against national waiting times, we know that our emergency care and acute medicine services are not meeting a number of very important clinical standards and we will need to make changes in order to improve quality of care. By working together and functioning as bigger teams across two sites our ambition is to:

- provide better access to 24/7 consultant-led emergency care seven days a week
- consistently ensure all emergency admissions are seen by the right specialist consultant in a timely way, when they arrive at hospital, throughout their stay and when being discharged home
- provide better access to multi-disciplinary assessments and support services for emergency patients seven days a week
- ensure our specialist consultants do not have conflicting priorities between emergency and planned care
- improve the differences which currently exist in how quickly diagnostic tests take place for emergency patients and how quickly results are interpreted by the right specialist
- create time and space for our staff to carry out continuous quality improvement and work better with GPs to develop alternatives to hospital admission
- improve the capacity across the whole health and care system to better meet the needs of emergency patients
- reduce the cost of temporary locum and agency staff by creating more attractive services for future new recruits and which offer the best clinical outcomes for patients
- improve the experience for emergency patients with cancer and ensure their care is joined up and better co-ordinated with local oncology (cancer) services
Emergency surgery

Understanding the current picture

Both hospitals provide emergency surgery for patients who have arrived via ED, or who have been referred directly by their GP. The main types of emergency surgery undertaken in both Trusts can be categorised as follows:

- **Emergency trauma and orthopaedics** – this is the emergency surgery undertaken for major fractures or broken bones
- **Emergency general surgery** – this is the surgery undertaken for patients presenting with acute abdominal pain, infections or bleeding

During 2017/18 across both of our hospitals we had 8,452 emergency surgical admissions to hospital for these types of conditions – 2,230 at South Tyneside District Hospital and 6,622 at Sunderland Royal Hospital. Of these, around 33% of South Tyneside patients (748) and 25% of Sunderland patients (1,600) needed an emergency surgical procedure.

Emergency surgery admissions vs emergency surgical procedures in 2017/18:

<table>
<thead>
<tr>
<th></th>
<th>South Tyneside District Hospital</th>
<th>Sunderland Royal Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total emergency surgical admissions</td>
<td>2,230</td>
<td>6,622</td>
</tr>
<tr>
<td>Admissions requiring emergency surgery</td>
<td>748 or 33%</td>
<td>1,600 or 25%</td>
</tr>
</tbody>
</table>

South Tyneside District Hospital  | Sunderland Royal Hospital
The most common types of emergency surgery we provide across both hospitals are:

- Surgery to fix badly broken bones
- Removal of the appendix
- Gall bladder removal
- Emergency laparotomy (opening the abdomen to diagnose acute abdominal pain)
- Emergency laparoscopy (keyhole surgery to diagnose acute abdominal pain)
- Hernia repair
- Drainage of abscesses

In Sunderland we also provide a number of specialist services for emergency surgery patients such as vascular surgery to clear dangerous blockages in their arteries.

**General surgery**

In South Tyneside, emergency general surgery patients are nursed in the Surgical Centre which opened in 2016. The hospital has four operating theatres which are dedicated to general surgery (for both planned and emergency operations).

In Sunderland, emergency general surgery patients are nursed in one of five surgical wards which cover a range of specialties and there are multiple theatres which provide general surgery (for both planned and emergency operations).

**Trauma and orthopaedics**

In South Tyneside, emergency trauma and orthopaedic surgery patients are nursed in one surgical ward and in the Surgical Centre which opened in 2016. The hospital has two ultra-clean laminar air flow operating theatres which are dedicated to trauma and orthopaedics.

In Sunderland, emergency trauma and orthopaedic surgery patients are nursed in one of two wards – ward D43 which is dedicated for trauma admissions and D48 which looks after both emergency trauma patients as well as those undergoing planned orthopaedic operations. There are currently five ultra-clean laminar air flow operating theatres dedicated to trauma and orthopaedics (one of which is used exclusively for emergency trauma surgery).

**Our performance**

Whilst both Trusts generally perform well against national waiting times standards for planned care, there are areas where we need to improve care for emergency surgery patients. For example there are many clinical standards, particularly linked to our ability to deliver seven day consultant-led care, that we are currently not meeting for emergency surgery patients and where we need to improve. A good example of this is the emergency surgery we provide to repair broken hips. A broken hip can be a very serious injury with around one in ten patients dying within 30 days. It is particularly common amongst frail older people who have fallen and who need a whole programme of care and support to recover well.
We know that operating quickly, providing early rehabilitation and effective aftercare to prevent further fractures, greatly aids recovery and the National Hip Fracture Database (NHFD) records how well hospitals across the country perform on a number of important measures. The 2017 results show the current position of both hospitals with green indicating where Trusts are performing amongst the best in the NHS.

**Our performance:**

<table>
<thead>
<tr>
<th>% of patients</th>
<th>South Tyneside District Hospital</th>
<th>Sunderland Royal Hospital</th>
<th>Trusts are performing amongst the best in the NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to orthopaedic ward within four hours</td>
<td>46.9</td>
<td>59.5</td>
<td>63</td>
</tr>
<tr>
<td>Surgery on day of, or day after, admission</td>
<td>46.9</td>
<td>85.1</td>
<td>84.4</td>
</tr>
<tr>
<td>Surgery supervised by consultant surgeon and anaesthetist</td>
<td>46.9</td>
<td>92.7</td>
<td>92.7</td>
</tr>
<tr>
<td>Physiotherapy assessment by the day after surgery</td>
<td>73.7</td>
<td>94.8</td>
<td>98.5</td>
</tr>
<tr>
<td>Mobilised out of bed by the day after surgery</td>
<td>73.7</td>
<td>92.7</td>
<td>98.3</td>
</tr>
<tr>
<td>Nutritional risk assessment</td>
<td>73.7</td>
<td>94.9</td>
<td>98.3</td>
</tr>
</tbody>
</table>
Whilst Sunderland has achieved the best practice standards set by the National Hip Fracture Database, there is still work for us to do in South Tyneside. This is something the Care Quality Commission (CQC) outlined in its latest inspection of services at South Tyneside District Hospital, advising that the Trust should continue to work on improving outcomes for hip fracture patients.

**Our challenges**

As pressures on the NHS have grown over the years, much attention has been paid to ensure that people who need planned operations receive them within national waiting time standards. Until recently, emergency surgery has not benefitted from the same level of national scrutiny and we know there are many areas where we need to improve in South Tyneside and Sunderland.

The national ‘Getting it right first time’ (GIRFT) reports, published in 2015 for orthopaedic surgery and in 2017 for general surgery, have looked at services across the NHS and suggested ways to improve pathways of care, patient experience, and clinical outcomes for emergency surgery patients. Key findings highlight a number of potential benefits for patients and staff, for example:

- **separating emergency and planned surgical patients to reduce unnecessary cancellations or delays**
- **reshaping emergency surgical services to ensure consultant-delivered care and rapid availability of senior surgical opinion**

Locally, we face a number of challenges in meeting these standards and currently do not make the best use of the resource available across our hospitals, in particular from a workforce perspective. For example:

**Trauma and orthopaedics**

- **Our emergency trauma and orthopaedic services at both hospitals currently operate separate and generic on-call rotas for any patients who need an expert surgical opinion out-of-hours. This means patients may not always be seen by the relevant expert for their particular injury. Many parts of the NHS have already solved this problem by pooling expert clinical teams and rotas to ensure patients always have access to the right specialist surgeon no matter what time of day or night**
- **The way our current workload is planned in trauma and orthopaedics means our orthopaedic surgeons are regularly having to manage both emergency trauma cases, as well as caring for patients coming into hospital for planned operations such as hip or knee replacements. This means planned patients may often experience delays for surgical treatment as we must accommodate emergency trauma patients during times of peak demand. It also means our surgeons do not get the opportunity to practice their chosen sub-speciality as often (for example knee or hip surgery) and risk becoming deskillled**

- **ensuring that on-call surgical teams, including the consultant, are not listed to deliver any routine planned operations or clinics whilst they are on call**
General surgery

- Emergency general surgery requires very quick access to diagnostics and senior clinical decision making. Guidance from the Royal College of Surgeons (RCS) is clear that outcomes for patients who require out-of-hours emergency surgery at night and at weekends, are comparatively poor compared to those treated within working weekday hours. This is of concern to us as we know there is inconsistency across both hospitals in the current models of Emergency General Surgery and our working practices are no longer operating with optimum safety standards. It is possible, for example, patients may not receive the timely care they need if this falls outside the specialist remit of the surgeon on-call at that time and, consequently, their emergency surgery may be delayed.

- Much like in trauma and orthopaedics, our emergency General Surgery service continues to be delivered using a traditional on-call system whereby one consultant surgeon (who is a specialist in one type of surgery) is available to give advice and assistance to more junior members of the surgical team who are resident within the hospital. If the consultant surgeon on call is not the right specialist, there can often be a delay in the diagnosis and decision to operate.
Clinical drivers for change

There are now many clinical standards expected of the NHS for the delivery of safe, high quality emergency surgery. The need for consultant-led, speciality driven care is now widely acknowledged with clear evidence\(^{15}\) to show that if surgeons are able to regularly carry out their chosen areas of expertise, patients are more likely to have better outcomes. Across both Trusts there is a collective recognition services will need to be adapted in order to improve quality of care. By working better together and functioning as a bigger team across two sites, our ambition is to:

- provide better access to 24/7 consultant delivered care for emergency surgery patients seven days a week
- move from a generalist surgical opinion to specialist surgical advice and ensure emergency surgery patients have quick access to theatre and a specialist consultant-led team at any time of day or night
- consistently ensure all emergency surgical admissions are seen by the right specialist consultant in a timely way, both when they arrive at hospital, during their stay and when being discharged home
- consistently provide timely assessments for emergency surgery patients with support services available seven days a week to aid recovery
- improve our ability to consistently deliver high quality training for surgical trainees
- improve patient and staff experience and satisfaction by separating planned operations from emergency surgery
- provide more ‘ambulatory care’ for emergency surgery patients delivered by senior clinical decision makers and which helps reduce unnecessary hospital admissions (and associated costs)
- improve the efficiency of emergency surgery services and reduce unnecessary duplication and cost by looking at services as a collective across the Healthcare Group
Planned care
(including surgery and outpatients)

Understanding the current picture

Our hospitals provide planned care for patients with a range of medical complaints. In total, every year there are over 420,000 outpatient appointments which take place across South Tyneside and Sunderland hospitals and from other community venues. The table below shows our activity levels for planned care during 2017/18:

Activity levels for planned care during 2017/18:

- **Outpatients – first appointments**: 41,214 at South Tyneside District Hospital and 96,610 at Sunderland Royal Hospital.
- **Outpatients – follow up appointments**: 89,077 at South Tyneside District Hospital and 197,512 at Sunderland Royal Hospital.
- **Planned day case procedures**: 13,228 at South Tyneside District Hospital and 60,330 at Sunderland Royal Hospital.
- **Planned operations with an overnight stay**: 1,152 at South Tyneside District Hospital and 11,448 at Sunderland Royal Hospital.
- **Planned endoscopy procedures**: 4,031 at South Tyneside District Hospital and 13,195 at Sunderland Royal Hospital.
- **Total inpatients with an overnight stay (including ambulatory care)**: 15,158 at South Tyneside District Hospital and 54,402 at Sunderland Royal Hospital.
Outpatients

Both of our local hospitals run a range of outpatient clinics which take place in the main outpatient departments and from community clinics. The following medical specialities are in the scope of Phase Two of the Path to Excellence programme and account for around 200,000 outpatient appointments every year (53,244 in South Tyneside and 146,035 in Sunderland):

- Cardiology
- Respiratory
- Gastrointestinal medicine (including endoscopy)
- Diabetes
- Care of the elderly
- Surgical

Planned outpatient clinics include those patients who have been referred urgently by their GP with suspected cancer who must be seen within two weeks. Demand for assessment and treatment of patients with a suspicion of cancer has grown significantly in recent years, placing more pressure on our teams to achieve the standards associated with cancer pathways.

Many patients who attend an outpatient clinic go on to have planned operations. The overwhelming majority of planned procedures now take place as day-cases, with advances in medicine and technology allowing people to go home much sooner than ever before and recover much quicker.

Both Trusts have an endoscopy department which offer a range of investigative procedures and see a combined total of over 18,000 patients a year:

### Endoscopy patient numbers during 2017/18:

<table>
<thead>
<tr>
<th></th>
<th>South Tyneside District Hospital</th>
<th>Sunderland Royal Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planned Tests</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total:</td>
<td>17,226</td>
<td></td>
</tr>
<tr>
<td>Emergency Tests</td>
<td>845</td>
<td></td>
</tr>
<tr>
<td>Total:</td>
<td>326</td>
<td>519</td>
</tr>
</tbody>
</table>
Patients who need to have a planned operation or procedure will have this in the new purpose built Surgical Centre at South Tyneside District Hospital which opened in December 2016. In Sunderland, patients having a planned operation or procedure will stay on one of five surgical wards depending on the nature of their procedure. All patients coming into Sunderland Royal Hospital for a planned day-case procedure are admitted via the surgical admissions unit. Both hospitals currently have a mixture of planned and emergency patients being nursed in the same ward areas.

**Our performance**

Both of our hospitals generally perform well against a range of national waiting time standards when delivering planned care for patients. Our performance in 2017/18 is summarised below:

### Planned care delivery vs national standards 2017/18:

<table>
<thead>
<tr>
<th>Measure</th>
<th>South Tyneside District Hospital</th>
<th>Sunderland Royal Hospital</th>
<th>National standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients receiving treatment within 18 weeks of referral by their GP</td>
<td>95.87</td>
<td>94.21</td>
<td>92</td>
</tr>
<tr>
<td>% of patients seen within 2 weeks of an urgent cancer referral by their GP</td>
<td>94.99</td>
<td>96.53</td>
<td>93</td>
</tr>
<tr>
<td>% of patients starting treatment for cancer within 62 days of urgent referral by their GP</td>
<td>89.11</td>
<td>83.62</td>
<td>85</td>
</tr>
</tbody>
</table>
Our challenges and clinical drivers for change

Care closer to home

From our early work so far in Phase Two, we estimate there are around 44,000 outpatient appointments currently taking place in Sunderland for patients who live in South Tyneside. This includes patients with cancer receiving oncology treatment who may have had initial treatment at Sunderland. Whilst some of this activity will need to continue in Sunderland for clinical reasons, we believe strongly that as many of these appointments as possible should be taking place closer to home. We are already working with our clinical teams to bring as much of this work into South Tyneside where this is safe to do so.

We also know many of our patients currently travel outside of our area altogether and go to other NHS providers for a number of planned treatments and procedures. We want our local residents to have equity of access to as many local services as possible and by working together we hope to achieve this. A good example of where we know this is happening is for heart patients who need a planned specialist cardiac MRI scan and currently travel outside of South Tyneside and Sunderland to receive this. In future, our ambition is to develop access to such services locally for the people we collectively serve.

The need for consultant-led, speciality driven care is equally relevant for patients receiving planned services and by working together as larger clinical, nursing and therapy teams, our ambition is to deliver:

- much more care closer to home when it is safe, sustainable and appropriate to do so
- improved patient experience by separating planned care from emergency care
- more consultant led ward rounds and senior speciality review to enable patients to get on the road to recovery sooner
- better access to vital therapy and support services seven days a week to reduce unnecessary delays in recovery

We also know many of our patients currently travel outside of our area altogether and go to other NHS providers for a number of planned treatments and procedures. We want our local residents to have equity of access to as many local services as possible and by working together we hope to achieve this. A good example of where we know this is happening is for heart patients who need a planned specialist cardiac MRI scan and currently travel outside of South Tyneside and Sunderland to receive this. In future, our ambition is to develop access to such services locally for the people we collectively serve.

The need for consultant-led, speciality driven care is equally relevant for patients receiving planned services and by working together as larger clinical, nursing and therapy teams, our ambition is to deliver:
Clinical support services

Across our hospitals and community services in South Tyneside and Sunderland we have a number of vital clinical support services with a large number of staff playing a crucial role to help make sure patients get the timely and effective care they need. This includes:

- **Hospital pharmacy services** – in South Tyneside our pharmacy service supports patients at South Tyneside District Hospital, St Clare’s Hospice and those cared for by community services across Gateshead, South Tyneside and Sunderland. In Sunderland our service provides pharmacy support for patients at Sunderland Royal Hospital and Sunderland Eye Infirmary. Both sites offer an outpatient pharmacy facility.

- **Radiology services** – this includes key diagnostics such as X-Ray, CT and MRI scans, as well as ultrasound and fluoroscopy (real-time moving images of inside the body) which are provided from each hospital site and offered at various community venues. At Sunderland Royal Hospital, interventional radiology for vascular and heart patients is also in place – this is where specialist consultants use live imagery of inside the body and minimally invasive surgery techniques to clear blockages in the arteries and heart.

- **Therapy services** – both Trusts offer a vast range of therapy services to help patients on their road to recovery after a hospital stay. This includes:
  - Physiotherapy
  - Occupational therapy
  - Nutrition and dietetics
  - Community stroke rehabilitation
  - Podiatry services
  - Speech and language therapy
  - Hospital to home / interface team (including close working with social care)
Our challenges and clinical drivers for change

Pharmacy

Working together across both Trusts, we need to think about how we provide better hospital pharmacy services in the future so we can improve the inequity of service provision that currently exists. For example, our ward-based clinical pharmacy service in South Tyneside currently only operates five days a week and is not available on weekends or Bank Holidays. This means inpatients requiring pharmacy input before being discharged home may often stay longer than necessary in hospital. In Sunderland this ward-based clinical pharmacy service operates seven days a week. We also face a pressing issue in relation to the aging pharmacy estate at South Tyneside District Hospital which is no longer fit for purpose with major deficiencies highlighted in a recent inspection by the Regional Quality Assurance Pharmacist.

Radiology

Radiology plays a central role in the care pathways of both planned and emergency patients and is pivotal in our ability to meet a number of important clinical standards. Timely access to diagnostics also has a proven positive impact on reducing the length of stay in hospital for patients and in reducing admissions overall. Across the NHS, we have seen the demand for diagnostic imaging grow consistently at approximately 10% per year nationally in the last decade. This is also true in South Tyneside and Sunderland and as this demand continues to grow, we must think about how we prepare meet this challenge for the future. In Sunderland, for example, we are already facing more demand than the capacity we have available, resulting in high costs for offsite CT and MRI reporting using non-NHS providers.

Therapy services

Our therapy services play a pivotal role in helping patients to recover as quickly as possible and there are currently many differences in the way services are delivered across South Tyneside and Sunderland. Some of our biggest challenges are around our ability to consistently deliver these services seven days a week and by working across our two sites together we hope to create more capacity to do this more effectively in future. Our aim is not only to improve the quality of patient care and experience, but also achieve much greater efficiencies and improved productivity by using standardised systems and processes to maximise the valuable expertise of our workforce in delivering direct patient care.
What do our patients say?
To help understand patient views and experiences in South Tyneside and Sunderland, our first step was to carry out a desk review of existing feedback and research. Key highlights from this show:

- The latest available patient experience data from the national Emergency Department Survey (2016) shows that both Trusts are performing ‘about the same’ as most other Trusts across the country when it comes to peoples’ experiences of ED

- Latest data from the national ‘Friends and Family Test’ (March 2018) also asks people specifically about their experience in ED and shows 95% of patients at South Tyneside and 100% of patients in Sunderland were likely or extremely likely to recommended services

- The recently published national Adult Inpatient Survey (2017) has demonstrated a number of quality improvements for both hospitals over the past year with the following areas rated ‘better’ than 2016

Quality improvements from the Adult Inpatient Survey (2017):

**South Tyneside District Hospital**

- privacy when being examined or treated in ED
- members of staff working well together
- involving patients in decisions about their discharge from hospital
- patients receiving sufficient support after leaving hospital
- hospital staff discussing any further health or social care services required

**Sunderland Royal Hospital**

- privacy when being examined or treated in ED
- length of time on the waiting list
- being advised what to expect to feel after an operation or procedure
- discharge from hospital
- getting understandable answers to questions from doctors
To help understand patient experiences more fully, a second round of research took place in February 2018 to gather the views of over 120 patients who had recently attended ED, been admitted as an emergency, or had some planned care or treatment at our hospitals in South Tynside and Sunderland. Face-to-face interviews were carried out to capture real-time views and opinions of patients and help inform clinical service review discussions at the earliest possible stage. All of the patients we spoke to in February 2018 felt satisfied with the care and treatment they had received, with many positive comments being made about the high standard of care and the attentiveness and friendliness of staff.

**Key feedback from patient insight in February 2018:**

<table>
<thead>
<tr>
<th>Emergency care</th>
<th>Planned care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3 most important things for patients when accessing emergency care:</strong></td>
<td><strong>4 most important things for patients receiving planned care:</strong></td>
</tr>
<tr>
<td>✓ getting the right treatment as quickly as possible</td>
<td>✓ quick access to an expert or specialist for their condition</td>
</tr>
<tr>
<td>✓ access to an expert or specialist for their condition</td>
<td>✓ getting the right treatment as quickly as possible</td>
</tr>
<tr>
<td>✓ quick access to the necessary diagnostic tests</td>
<td>✓ quick access to the necessary diagnostic tests</td>
</tr>
</tbody>
</table>

**Also important to patients...**

- ✓ being able to access care close to home was reported by patients to be more important when needing ‘urgent care’, rather than emergency care
- ✓ some patients at both sites reported encountering waits for blood tests, X-rays or scans and some were unsure as to whether they had seen a senior doctor daily
- ✓ patients reported mixed experiences of discharge planning
- ✓ patients recognised the staffing and workload challenges of the doctors, nurses and other health professionals working across the services and wards
A third round of patient insight work took place during May and June 2018 with over 4,000 people invited to share their views and experiences having recently used local hospital services in South Tyneside and Sunderland. Over 1,000 people took the time to provide feedback, representing an overall response rate of just over 25%.

A very high level summary is included below and will help our clinical design teams in the months ahead as they think through potential ideas for the future.

Key feedback from patient insight May / June 2018:

<table>
<thead>
<tr>
<th>Emergency care</th>
<th>Planned care</th>
</tr>
</thead>
<tbody>
<tr>
<td>86.7% of patients rated their emergency care as very good or good</td>
<td>94.8% of patients rated their planned care as very good or good</td>
</tr>
<tr>
<td>76.2% of patients always had trust and confidence in the staff treating them</td>
<td>90.5% of patients always had trust and confidence in the staff treating them</td>
</tr>
</tbody>
</table>

Top three suggestions from patients for quality improvements:

- **Improve staffing** – patients recognised the demands placed on staff and suggested that more staff should be on duty
- **Reduce waiting times** and provide a more seamless process from attendance at ED to discharge or admission
- **Improve communication** and information flow between health professionals and patients as well as between different departments within the hospital.

- **Improve staffing** to provide a more efficient service
- **Reduced waiting times** for appointments / procedures and keep patients better informed as to how long they can expect to wait
- **Improve communication** to ensure patients are fully informed of their treatment / procedure and that they are given the appropriate aftercare information.
What are staff telling us?
As part of the clinical review process, staff in both Trusts have highlighted the many challenges they encounter in their daily roles. Feedback obtained via a survey of over 700 employees across both Trusts between December 2017 and February 2018 highlighted many recurring themes around workload, capacity and staffing, as well as equipment and facilities. These themes were echoed by almost 200 staff who took part in engagement workshops held in March 2018. A high level summary of the key issues and concerns highlighted by staff are summarised below:

**Workload and staffing**

Staffing was identified as a daily issue and staff from both hospitals highlighted how nursing vacancies posed some challenges in being able to continue providing the best possible quality of safe patient care. Recruitment and retention challenges were a major theme with staff highlighting a reliance on both temporary staff and ‘goodwill’ to cover staff shortages in various specialties. Staff reported how this had a negative impact on personal resilience and wellbeing, with an inability to achieve a good work / life balance and risk of ‘burnout’ described. The ability to cover unexpected staff sickness within services which are already carrying high vacancy levels, was also highlighted as a concern, with examples given of clinical managers stepping in to undertake unfilled shifts. Staff described how this had a knock-on effect in other areas of care with the risk of essential quality improvement tasks, such as clinical audit, being forgone.

“Staffing pressures can compromise quality standards”

**Capacity and demand**

There was widespread acknowledgement of the growing and relentless demand on services all year round. This was felt to impact on the quality of service provided and staff described the challenges of caring for more older people with incredibly complex conditions and with rising levels of dementia. Some staff described how running at 100% bed occupancy presented a challenge, particularly during winter when they felt greater capacity was needed to accommodate the seasonal surge of patients. Staff also talked about the need for more efforts across the NHS to avoid hospital attendances and admissions. Suggestions included GPs working in nursing homes, virtual clinics for patients with long-term conditions, more ambulatory care, enhanced specialised nursing outreach
and improved frailty services. Staff also shared experiences of how barriers in accessing appropriate social care support for patients could often delay discharges, impacting on overall capacity.

“It’s not just winter surge anymore, it’s all year round”

**Staff training and development**

Staff also described how pressures on the workforce presented a significant challenge in getting the time to undertake appropriate training or one-to-one supervisory discussions. Ensuring appropriate time to train and support newly qualified nursing staff was also voiced by some staff as a challenge, while the lack of substantive consultants in some services also meant junior doctor training supervision fell to a smaller number of permanent medical staff.

“Support for staff must be paramount”

Staff also highlighted how the high use of temporary staff could result in different skill mixes being available, with a risk to quality and real challenges in ensuring that new staff were familiar with systems and ways of working. They also commented how they needed a ‘consistent consultant’ instead of locums to help support the team and ease pressure.

**Differences between the two Trusts**

Many staff highlighted how the current inequity of service provision between the two hospital sites needed to be addressed, with the limited amount of specialty cover at South Tyneside District Hospital at weekends given as an example. Staff described how medical staffing shortages particularly impacted on the ability to provide the optimal level of senior doctor cover at both sites.

“In some specialities there are huge discrepancies between the two sites / services”

This also extended to cultural differences in ways of working, with differing policies, procedures and protocols, as well as different working patterns, roles and skill mixes of staff within teams. It was recognised services need to be aligned and standardisation is required. A key recurring theme was also around the IT infrastructure and need for unity across both Trusts, which was recognised as a both a major challenge, but also a key enabler, to improve integration of services and cross-site working.

“Changes and improvements need to happen faster”
Communications and engagement

Staff repeatedly emphasised the importance of engaging and empowering people at all levels, in both trusts so they feel part of the Path to Excellence programme and ensuring all communication is timely, open and honest. The importance of staff engagement and regular communication, even when there are no updates to give, was a recurring theme so staff constantly felt kept informed, able to provide reassurance to colleagues and to dispel rumours. It was strongly felt that the success of change depends on the involvement of staff at all levels, with the importance of ensuring that clinical leaders speak positively about the future opportunities. The importance of clear communication also extended to the public, who were recognised to be very sceptical about the future of South Tyneside District Hospital.

“Staff want to know what’s happening and are happy to work together for the good of the people”

As well as sharing their thoughts on the challenges faced, our staff in both hospitals also articulated a number of shared ambitions for the future. There were several recurring themes from staff in attendance at the March engagement events who expressed a universally desire to:

- have a clear, shared vision for each clinical service across both Trusts
- have stable, integrated teams which are sustainable
- deliver standardised care and treatment across both Trusts which offers the safest, most effective care for patients – ‘excellence’
- provide a smooth journey for patients and ensure they are seen by the right specialist, at the right time, in the right place seven days a week
- become an employer of choice offering greater flexibility for staff, a better work / life balance and attractive working conditions
- have fully integrated IT systems
- deliver improved outcomes for patients through continuous learning, innovation and improvement

Engagement with staff across both trusts is continuing throughout the summer, with further events planned for early autumn and into 2019.
Workforce sustainability
The underlying issue of workforce sustainability is a common thread throughout this document. We cannot ignore this and need to think differently about how we work together as larger clinical, nursing and therapy teams across both hospitals.

So many things, from the quality of patient care and experience, to chances of survival and long-term recovery after an illness or injury, are dependent on having a well-trained, motivated and experienced workforce with the right numbers of appropriately trained staff in place. We cannot underestimate the critical importance of a stable, fully staffed workforce and by improving local hospital services our aim is to attract more potential new recruits.

**Our current workforce and pressures**

We currently employ over 8,500 staff across both Trusts with hugely loyal colleagues enjoying long and fruitful NHS careers with us. Our overall turnover rates are broadly in line with the national NHS average of 0.87% - 0.96% at South Tyneside and 0.71% in Sunderland.

Both hospitals experience much higher staff turnover within the highly pressurised area of ‘emergency care and acute medicine’. This is often due to staff working under relentless pressure with poor work / life balance resulting in a number of vacancies across junior and senior medical roles, nursing and allied health professionals. This makes our ability to sustain safe staffing levels a constant challenge and results in high use of locum and agency staff (and associated costs). By improving the way our current services are delivered, we hope to be able to address this problem for the long-term.

As well as our immediate staffing problems, we must also consider the age profile of our current employees which will see our workforce reduce further over the coming decades as more people reach retirement age. We know, for example, that 20% of the NHS workforce in South Tyneside and 16% in Sunderland are currently of retirement age.

**Our workforce pressures in emergency care and acute medicine (end of 2017/18):**

<table>
<thead>
<tr>
<th></th>
<th>South Tyneside District Hospital</th>
<th>Sunderland Royal Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of all permanent roles vacant</td>
<td>8%</td>
<td>20%</td>
</tr>
<tr>
<td>% of consultant roles vacant</td>
<td>5%</td>
<td>16%</td>
</tr>
<tr>
<td>turnover rate among nurses in emergency care</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>turnover rate in medicine and care of the elderly</td>
<td>12%</td>
<td>13%</td>
</tr>
</tbody>
</table>
What is the impact of these workforce pressures?

**Staff wellbeing and morale** - Our staff have told us of the daily pressures they face due to staffing challenges and the risks this presents not only on the continuity of services, but the personal pressures placed on those permanent staff who are constantly going above and beyond to keep services running smoothly. Inevitably this level of sustained pressure impacts the health and wellbeing of the workforce and while our sickness absence rates in Sunderland are below the national average, sickness absence rates at South Tyneside are above average at 5.67%.

**Quality and safety** – Our staffing issues and, in particular, our costly over-reliance on agency and locum staff, compromises our ability to consistently deliver the very best quality of care and can often lead to delays in the assessment, treatment and discharge of patients from our hospitals. Many of our wards rely on temporary nursing staff to achieve required ‘nurse to patient ratios’ and both hospitals regularly report a number of incidents and risks arising from low staffing levels and the issues that arise when new members of staff are not familiar with local policies and processes. The increasing number of older patients with multiple complex conditions also makes it difficult for our staff to have time to provide the same level of high quality care.

**Training and supervision** – We are working hard to recruit newly qualified staff at both of our hospitals, however this brings with it different challenges as newly qualified staff need greater levels of support, training and supervision. Whilst we always try to achieve a good balance of new and more experienced nursing staff across all of our wards on every shift, this is not always possible. In emergency care for example, one third of all nursing staff in Sunderland have been qualified less than five years and 40% in South Tyneside have similar levels of experience. Our consultants also do not have enough time to deliver the vital role of leadership and training for junior doctors with responsibility for supervision falling to the same, small number of senior clinical colleagues. Despite this, both Trusts consistently score very highly in junior doctor feedback.

Whilst there is work underway locally, regionally and nationally to address these workforce challenges long-term, what is absolutely clear is we must think differently and beyond organisational boundaries about how we use the precious skills, expertise and resource available to us across South Tyneside and Sunderland. Our workforce challenges will not be resolved with a simple injection of cash as there is not enough qualified and experienced staff currently available. This is why it is so crucial we make improvements to our local hospital services so they are as attractive as possible to healthcare professionals who want to work in services which:

- give them an opportunity to regularly practice their chosen areas of specialism or clinical expertise
- see a high volume of patients and deliver the best outcomes
- offer a good work / life balance
- provide strong opportunities for learning, research and development
Building a future workforce:

- Innovative new roles such as ‘advanced nurse practitioners’ now allow the autonomous management of increasingly complex patients, enhancing the skill mix and capacity within ED by training up more nurses and allied health professionals to expand their scope of practice.

- The new role of ‘physician associates’ are also helping to support doctors in the diagnosis and management of patients as part of bigger multi-disciplinary teams. Investment was made in a minimum of 650 physician associate training places nationally in 2017/18, with a number of students on the two-year programme at Newcastle University.

- Workforce innovations in other parts of the country have included looking at GP trainees taking on broader roles to care for ‘ambulatory’ patients, as well as allied health professionals, clinical pharmacists and paramedics trained to higher levels.

- The new school of nursing at the University of Sunderland is expected to be a valuable source of new nursing staff in future years and many students are beginning placements at both hospitals. It is hoped this will ensure that newly trained nurses who live locally will also want to work locally, resulting in a more sustained nursing workforce.

- From 2019/20 over 100 more medical students each year will have the opportunity to live and train in the North East at the University of Sunderland’s new medical school. This will complement existing medical provision in the region and provide more opportunities for a new generation of doctors, recruited from the communities in which they live and will eventually practice.

- Our long term success with overseas recruitment in the Philippines has seen hundreds of new nurses welcomed to the North East over the past ten years. New recruits from our first joint recruitment trip will arrive in South Tyneside and Sunderland from October 2018.
The national, regional and local picture
Our local work during Phase Two of the Path to Excellence programme is in line with national and regional ambitions to evolve our NHS to meet the growing health needs of our population, the rising demand on local services and the rising costs of new treatments and technologies. The challenges we face locally in South Tyneside and Sunderland today, are no different to any other part of the country and whilst issues with the workforce exist right across the NHS, they are felt more acutely in the North East of England.

To meet the challenges facing us, there is recognition across the NHS that we must move away from thinking as individual organisations in the way we plan and manage care, to thinking more collaboratively across organisational boundaries to create more joined-up healthcare systems and better experiences and outcomes for patients.

One person, one team, one health and care system

The NHS is adapting to profound shifts in patterns of ill-health

People are living longer than ever

There are half a million more people aged 75 than there were in 2010 - and there will be two million more in ten years’ time

21%

Predicted growth in number of over 65’s between 2015-25
People are spending more years in ill health

50% of all GP visits are due to an incurable long term condition

65% of outpatient appointments are as a result of a long term condition

70% of inpatient bed days are as a result of a long term condition

x2 Between 2015 and 2035, the number of older people with 4 or more diseases will double and 1/3 of these will have mental ill health

Life expectancy

20 years difference in healthy life expectancy for people living in the most deprived areas

Most deprived areas

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>51.8 years</td>
<td>51.9 years</td>
</tr>
</tbody>
</table>

Least deprived areas

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>70.7 years</td>
<td>70.4 years</td>
</tr>
</tbody>
</table>

£7 out of every £10 of total health and care spending in England is spent on long term conditions

65% of people admitted to hospital are over 65

10% A person over 80 who spends more than 10 days in hospital will lose 10% muscle mass
North East system-wide context

Health and social care organisations across North East England have already committed to improving health, wellbeing and the quality of care as part of shared health and care transformation plans which set out a five year vision\textsuperscript{17} to scale up prevention and wellbeing and improve quality of care through increased out of hospital care and more collaboration between hospitals. This work is also intended to close a projected financial gap between the funding we have available and the projected rising costs of services of £641m across our area by 2020/21\textsuperscript{18}.

Our work in South Tyneside and Sunderland also involves close collaboration with NHS partners in North Durham, recognising that many patients already flow into specialist services provided by Sunderland. In some parts of the country, new partnerships are evolving even further to form fully ‘integrated care systems’. These involve even closer collaboration between the NHS, social care and the expertise of local charities and community groups to help people live healthier lives for longer, and to stay out of hospital when they do not need to be there.

The Path to Excellence programme

Our collective work between both hospitals in South Tyneside and Sunderland has already helped forge even stronger relationships across the local NHS over the past two years as we strive to improve local hospital services and create sustainable models for the future. It is important to recognise, however, that this is just one small part of a much wider conversation about how the local NHS needs to collectively improve integration between primary, community and hospital-based care, as well as links with social care. All organisations within the local health economy have a collective desire to reshape the way we work across South Tyneside and Sunderland with an aspiration to:

- deliver a single system wide way of working and more joined up services
- improve health outcomes and patient experience
- drive out unnecessary duplication and waste
- deliver the services patients need within our affordability envelope
- use the capacity and capability we have across our system wisely and to best effect

Key to this wider work is thinking about prevention and how we can help and support people so that they do not become ill in the first place and how we can intervene early and proactively to prevent further deterioration or more serious long-term problems.
Travel and transport
We recognise that when there is potential for changes to local hospital services one of the biggest concerns people have is how they will get to their appointment or how their loved ones will visit them. This was a core area of concern raised by local people during Phase One of the Path to Excellence programme and our independent review of travel and transport for Phase One suggested a number of different measures that could be explored to help reduce the travel impacts of proposed service changes. These ideas included:

- ensuring patients and visitors have accurate, up-to-date information about their travel choices, including public transport information and are aware of journey planning tools and facilities
- ensuring patients and visitors have accurate information about parking choices and costs
- providing patients with information about schemes that offer assistance with travel costs
- providing travel information with appointment letters
- promoting the existing policy of allowing patients to schedule appointment times that ease their travel arrangements
- introducing improved bus services serving the two hospitals sites

Through our consultation during Phase One, the public have helped us understand their concerns and risks in relation to travel and transport and work is now underway to look at some of the issues raised around:

- clinical transport and ambulances
- public transport issues in relation to buses, metro and ticketing
- hospital car parking and travel between the two hospital sites

A travel and transport advisory group is now in place to carry this work forward and includes representation from NHS partners, both local authorities and local travel and transport provider companies. As work progresses in Phase Two, we will also be carrying out further assessment of travel and transport so that we can fully consider the impact on any potential future service models on both staff, patients and visitors.
What happens next and how to get involved
Over the summer our clinical design teams will be busy working with frontline staff to think about how we may be able to solve some of our challenges for the future. They will be looking at how we can better organise services across our two hospitals to give the highest quality of care to patients, maximise the valuable skills and expertise of our staff and ensure best value for money.

Later in 2018, we hope to be able to share some of our early thinking on the emerging ideas for the future and we will be seeking feedback from staff, patients and the public. This will help influence what final options our CCGs may need to formally consult on which is expected during Summer 2019.

Key milestones:

- Understanding the case for change
- Benchmarking against clinical quality standards
- Developing ideas for future potential scenarios
- Evaluating and impact-assessing potential new ways of working
- External clinical and non-clinical assurances of any proposed changes and potential new ways of working
- Formal public consultation anticipated summer 2019 (dependent on extent of proposed change)
How to get involved

Over the coming months we will have lots of ways to get involved and find out more about the challenges we are facing in the delivery of acute hospital services. The best way to find out what is going on is to look at our dedicated website at: www.pathtoexcellence.org.uk which includes up-to-date documents, links to surveys and details of up and coming events. We will also widely promote activities through the media, online and via key partners and stakeholder groups. You can also reach at any time via:

- Website: www.pathtoexcellence.org.uk
- Email us: nhs.excellence@nhs.net
- Call us on: 0191 217 2670
- facebook.com/nhsexcellence
- @nhsexcellence
- Write to us (no stamp required):
  Freepost RTUS–LYHZ–BRLE
  North of England Commissioning Support
  Riverside House
  Goldcrest Way
  NEWCASTLE UPON TYNE
  NE15 8NY

This document is available in large print and other languages. Please call 0191 217 2670.
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https://www.rcem.ac.uk/docs/Policy/The%20Way%20Ahead_Final%20Dec%202011.pdf


Glossary

**Acute medicine**
The care provided to seriously ill patients who are admitted as emergencies to hospital

**Assessment unit**
A unit where clinicians are able to make immediate assessments and decisions about a person’s care when they arrive in hospital

**Cardiology**
The field of medicine which treat diseases and defects of the heart and blood vessels (the cardiovascular system)

**Care of the elderly**
The field of medicine which cares for older people with physical and/or mental illness and aims to improve quality of life and help people maintain their independence for as long as possible

**Clinical service reviews**
Carried out by clinical teams to understand how services should be configured to meet the needs of local communities in the future

**Clinician**
A qualified health professions, for example a doctor, nurse or physiotherapist

**Consultant**
A very senior doctor or surgeon with specialist training and expertise in a particular area of medicine

**Consultant-led**
A consultant-led service is one where a consultant retains overall clinical responsibility for the service, care team or treatment

**Diabetes**
Diabetes is a lifelong condition that causes a person’s blood sugar level to become too high and must be managed

**Emergency admission**
An unplanned admission to hospital (often via the Emergency Department), which occurs when a patient suddenly becomes very seriously ill or injured

**Emergency Department**
This is where all seriously ill or injured people are initially assessed and treated and is the new name for A&E

**Emergency care**
The provision of an immediate clinical service for the treatment of acute and chronic illness and injury

**Emergency surgery**
The care provided to patients who require an immediate operation

**Gastrointestinal medicine**
The field of medicine which investigates, diagnoses, treats and helps prevent all gastrointestinal diseases including problems with the stomach and intestines, liver, gallbladder, biliary tree and pancreas.
**Health outcomes**
Changes in health that result from measures or specific health care investments or interventions.

**Length of stay**
The length of time patients spend in hospital from the point of their admission to being discharged safely back home.

**Occupational Therapy (OT)**
Therapeutic use of self-care, work, and recreational activities to increase independent function, enhance development, and prevent disability; may include adaptation of tasks or environment to achieve maximum independence and optimal quality of life.

**Outpatients**
The part of the hospital which cares for patients who attend for planned appointments or procedures and do not need to be admitted as an inpatient to stay overnight.

**Patient flow**
How effectively patients move through different parts of the health and care system to receive the care they need.

**Physiotherapy**
The treatment of disease, injury or deformity by physical methods such as massage, heat treatment and exercise rather than by drugs or surgery.

**Planned care**
The care provided in hospital for patients who have been referred by their GP for a test, scan, treatment of operation.

**Primary care**
Care provided in community settings, including the home, by a range of qualified health professionals, including GPs and district nurses.

**Respiratory**
The field of medicine which investigates, diagnoses, treats and helps prevent all diseases associated with breathing and the lungs.

**Secondary care**
Care provided in a hospital setting.

**Speech and language therapy (SALT)**
Providing treatment, support and care for children and adults who have difficulties with communication, or with eating, drinking and swallowing.