Path to Excellence Phase Two

Review to restart the programme (Autumn 2020)

Contents

1. Purpose

The purpose of this report is to consider how COVID-19 has interrupted the process and impacted the drivers for change for the South Tyneside and Sunderland Hospital transformation programme, the Path the Excellence phase two.

This report is the first element of a situational analysis in order to inform the next steps for the programme and provides a high level review the issues in relation to the Path to Excellence transformation programme as a whole – and supports the programme's business continuity plan. It takes into account the need to follow a lawful change process as set out in Planning, assuring and delivering service change for patients, NHS England 2018.

This report reflects the issues and themes raised by key clinical leads and senior managers in relation to the strategic timeline position the programme was in from March 2020 compared to September 2020, and how the local NHS response in dealing with COVID-19 has impacted the original objectives and the working ideas developed to date.

This situational review provides a starting off point for wider discussions within the overall programme governance (Clinical Services Review Group and Programme Governance Group), providing an important audit trail about how issues are being considered and how these inform the next steps in order to meet the programmes objectives.

2. Methodology

The method adopted in this paper is informed by key questions asked as part of classic situational analysis methodologies used in transformation and business processes.

It involves asking key questions, listed in appendix 1, to a range of key contacts involved in the programme, contained in appendix 2.

3. Background

The main objective of Path to Excellence is to create outstanding future hospital services which provide the best working environment for staff, offer the highest quality of safe patient care and clinical excellence for local people in South Tyneside and Sunderland, and wider into parts of County Durham for those who consider Sunderland Royal to be their local hospital.

The key clinical areas under consideration in phase two are:

- Emergency care and acute medicine
- Emergency surgery and planned operations
- Planned care and outpatients
- Clinical support services

The main drivers for change are closely interlinked with each other and have been identified from involvement activity with staff, patients and stakeholders. They are:

- Workforce
- Quality Improvement
- Future demand
- Financial constraints

The programme has to date published three key documents setting out a developing case for change. In July 2018 the programme published an initial issues document which set out the main reasons why services need to change.

As work on the programme progressed via the clinical services review group, an updated case for change published was in February 2019 set out the early thinking and 'working ideas' so far.

In October 2019 the programme published an update with a specific focus on how patient and staff feedback gained through the engagement activity was being used to make improvements and inform working ideas.

In March 2020, phase two of the programme was in the process of drafting the pre-consultation business case which reflects the process that has been followed to date in developing ideas/proposals for change.

In line with the programme strategic timeline, it was anticipated that regulatory assurance would take place in May and June 2020 with a view for public consultation to start from September 2020, allowing decision making in early 2021.

However, the COVID-19 pandemic led to suspension of the programme and clinical services review and governance aspects, as set out in the programme's business continuity plan.

4. Summary of findings

This section is a summary of findings from the more detailed section below.

Situation

The reasons that made P2E are more relevant as a consequence of the pandemic, not less and accelerate the need for transformation – with participants commenting that the trust merger had already brought about minimal consolidation from the working ideas.

Pandemic had brought many positive working solutions with new ways of working established extremely quickly which might have taken a longer time in the past. There was an appreciation that the CSR process and the trust wide relationships which had been developed were extremely helpful in doing this.

People felt that there was a more positive political environment and support for keeping beneficial changes made to services and ways of working, and there was a need to identify these clearly and explain them to stakeholders with stories and supporting data.

But many felt the true impact of elective recovery had not yet been realised and there is a general concern about the impact of winter and a second wave of the pandemic. People felt the need to understand better the process to temporarily suspend the provision of a particular service or use of a particular site on the grounds of clinical safety.

There is a need to consider how the South Tyneside and Sunderland Hospital transformation programme fits within the wider Integrated Care Partnership footprint.

Objectives

In terms of objectives, the general feeling was that the programme objectives were valid, in fact they are now even more pressured – and a universal view that COVID-19 needs to be factored into the programme objectives.

A major theme is the need to include specific objectives and think differently around health inequalities which have been widely exposed through the pandemic experience.

Proposals

Feedback was that the proposals developed so far in the working ideas were probably the same. Reviewing the scope would mean reviewing the original long list to consider what might now be included, for example a new hospital under the Health Infrastructure Programme or alternative funding.

Target audience

All participants highlighted the need to work closely with staff to understand their experiences of the pandemic, more close working with community and primary care partners – in particular GPs. There was also the view to redouble efforts to engage with communities who suffer health inequalities to ensure services were designed to support their needs.

Resources

There was a concern that given the ongoing response and recovery C19 work, staff and clinical capacity may be an issue in relation to the delivery timescale of the programme. There was a view that more operational resources are likely to be needed to support the programme manager at workstream level.

Impact

There is a need to take stock in terms of data and feedback, and the first is to ask staff and internal engagement first. But to answer this question more fully, most

participants felt that more work was needed to understand the current position as the current position is the new starting position for the programme.

5. Recommendations for next steps

This paper is shared with members of the clinical services review for consideration and discussion. In particular in relation to proportionate and practical actions for the programmes next steps.

6. Feedback section

6.1 Themes for the programme as a whole

6.1.1 Situation

This section considers if the clinical, political or policy environment that made Path to Excellence necessary has changed in any significant way.

In relation to clinical, there was universal agreement from all the participants that the impact of COVID-19 has made the reasons for P2E more relevant not less and accelerated the need to transform services and highlighted where we need to do more.

Generally people felt that the engagement and development of working ideas, the trust merger resulting in bringing teams together and the continued development of relationships with key partners has been extremely important in dealing with COVID-19.

In particular, the clinical engagement through the process of developing working ideas has been helpful in terms of thinking differently and knowing that there was worked through options/ideas that could be used in the face of significant service pressures.

There was a clinical view around an increasing need to run the two hospitals as two separate hospitals to take account of infection control measures, the social distance between people and beds, and get back to full/normal elective capacity, as required by the phase 3 planning guidance.

A number of participants commented about rethinking the need for acute beds in the future to meet demands for future COVID-19 waves.

There was a general concern about not yet having a full view of the consequences of stopping elective care and how in the electives could be managed in a second wave and winter pressures. This concern was also around the slow restart of elective care

and reassuring patients it was safe to come to hospital, while also managing a message around not coming into hospital if it is not needed.

There has been a significant reduction in people coming into hospital (although in September 2020 emergency department numbers were rising) and people feeling they don't want to go into hospital because they might come into contact with COVID-19. It was highlighted that is it a difficult message to get across, reminding people that hospitals carry a high risk of healthcare associated infections so encourage people not to come into hospital if they don't need to (offering alternatives in the community) but also saying it was safe to come for planned elective care.

There was also comments around how to keep some of the beneficial changes such as outpatients and virtual consultations have increased significantly which gives the opportunity to shift service locations into local communities, from hospital, and build on the out of hospital and community services transformation. People felt the need to understand better the process to temporarily suspend the provision of a particular service or use of a particular site on the grounds of clinical safety and how an immediate suspension would need to be justified in terms of the level of risk involved (for current and for potential future users of the service).

Several mentioned the positive development of the ICP clinical pathways recovery group, and a good example of out of hospital provision in the phlebotomy service which moved from hospital locations and is now being run in community venues.

Another example is Sunderland Eye Infirmary telephone service, talk before you walk, which addresses concerns raised from engagement around people having to travel.

These are all considerations happening currently.

In terms of the wider political environment, participants felt that there was a higher widespread political appreciation of the NHS, with no critical or negative scrutiny of hospital services during the crisis. But there would be a need to explain to elected representatives through data and stories how the NHS has made changes to deal with the pandemic, for example, out patients virtual appointments (travelling is a major issue highlighted in pre-consultation and in phase 1).

In relation to working ideas around elective and emergency care, this remains a highly sensitive issue and it’s important how this is explained to key political stakeholders.

In terms of policy considerations, feedback related to the need to continue to move towards integrated care partnership arrangements and a wider strategic planning foot print to include County Durham. While all acknowledged Durham patient flow issues, a key consideration is around how to maintain the pace needed for South Tyneside and Sunderland hospital transformation. A key question was around gaining clarify in relation to the wider specialist interdependent clinical services footprint across the full ICP geography: What is South Tyneside and Sunderland dependent and what would require involvement with County Durham and Darlington NHS Trust services?

Finally, there has been a large range of new and updated policy directions since March 2020 and these will all need to be considered. These include: Phase 3 planning letter; ICS recovery plans; Associated impact on five-year plans at ICS/ICP level; COVID-related capital availability; The NHS People Plan; pending Covid Health Inequalities Plan; DHSC delay in publishing social care expectations; Pending review of national service change assurance guidance; Published guide on service change legislation.

6.1.2 Objectives

This question considered the aim of the programme, if they are still the same, or are there now likely to be additional objectives or ones excluded?

There was a general feeling that the ultimate aim of the programme remains the same – provide better health services for the populations of Sunderland and South Tyneside. In terms of the drivers for change these were again felt to be the same, and in all cases even more pressured on staff and workforce, future demand for services, the quality improvements needed and the ongoing financial constraints.

In relation to patient safety, improving quality, reducing health inequalities, ensuring appropriate clinical skill mix and best use of resources all these are still applicable.

There was a view that baseline data needed to be reviewed in light of COVID to fully understand what has changed and consider what were the problems the programme was trying to solve and are these still the problems, for example, emergency department, acute medicine staffing.

There was suggestions around the consideration of a medium-term plan and longer term plan, medium term to deliver business within a COVID-19 environment and longer plan to deliver longer term workforce sustainability.

However it was a universal view that COVID-19 must be factored into the programme objectives.

A major theme highlighted by many participants was how COVID-19 has widened health inequalities and with the continued use of technology there needs to be special consideration about what it means for those groups and that there is not a continuation of widening inequality. The poor data quality around the collection of protected characteristics information was raised and suggestions that a proactive campaign to explain to staff why it was important to ask and to those community to explain why it was important to provide was suggested.

Participants felt if was important to have a wider understanding around Sunderland had a high level of in hospital deaths compared to the national picture, and how this is directly related to the health and the inequalities that there is in the city. A review carried out for both South Tyneside and Sunderland established that high levels of social deprivation and a frail, elderly, multi-morbid population are exactly the target for the virus and has made this visible in a pandemic. A learning From Deaths Collaborative has been set up with specific actions for the Trust and CCG to look to learn further and make tangible clinical pathway changes to tackle the inequalities.

Some participants felt there should be some more specific objectives around health inequalities reduction, BAME workforce and workforce capacity within pandemic.

6.1.3 Proposals

This questions considered the options identification and assessment process that had been carried out to date – and asks if the development of the working ideas were done today would they likely to have resulted in the same? If they have changed, would these changes be significant?

The general view from participants was is the shortlist would probably be same. It was raised that through closer working in teams, better working across sites and the merger of the trust, had naturally implemented the minimal or least change working idea.

Participants said there was still the need to separate elective and emergency care, and there was a continued challenge around medicine and emergency care. There was not a full understanding of the impact of virtual appointments and how this might impact the physical footprint and space available.

Some thought that full consolidation might be too radical if greater capacity to absorb pandemic levels of activity. There were thoughts around how partial consolidation lends itself to hot/cold split and covid/non-covid co-horting as well as contingency bed base in pandemic situations.

There were comments around should the geography be reviewed to include wider ICP acute sites and how would this impact the programme.

Reviewing scope would mean reviewing the original long list and consideration of what could now be included, for example could a new hospital build be a potential with the Health Infrastructure Programme?

6.1.4 Target audience

This question asked if the pandemic experience made it likely that individuals or groups not previously targeted for engagement may now see themselves as potentially impacted and might wish to be involved in the exercise.

Participants felt that in the first instance this was very much about working with staff who have universally supported the emergency pandemic situation, recognising that many have consistently gone above and beyond, have been displaced from usual roles, and been extremely flexible in what they have been asked to do. They was a feeling that a positive benefit is that many now feel they are part of one trust, and a key issue is to fully understand what from an internal change perspective the trust should keep and what should be changed back. This also led to questions about if these were service improvements and what would

There was recognition of positive relationships and closer working out of hospital and with public health, but there was still more to do to engage with primary care and GPs.

In relation to health inequalities which have widened as a result of the pandemic there is a need to reconsider the work done through the impact assessments and if this is robust.

Coupled with this is a renewal of engagement with protected groups and how their lived experiences can be brought to forefront of service design, with the view if it can be right for those groups then it will be right for those who do not suffer inequality.

6.1.5 Resources

This question was about the consideration of resources for the programme. There was a concern that given the ongoing response and recovery C19 work, staff capacity may be an issue in relation to the delivery timescale of the programme. There was a view that more operational resources likely to be needed to support the programme manager at workstream level. There were also comments about being mindful of staff resilience in light of on-going pandemic and a second wave.

The requirement for analysis support was highlighted, especially given a new baseline of data was needed.

In terms of communications and engagement resource is critical and is committed.

6.1.6 Impact

The final question considered impact and if there is a likely change in the impact of working ideas to date. Would it be fair to assume that people who have been involved or engaged so far views would be broadly the same if asked now?

Feedback was that yes there was a need to take stock in terms of data and feedback, and the first is to ask staff and internal engagement first.

But to answer this question more fully, most participants felt that more work was needed to understand the current position which is the new starting point. While the original data may still be valid in some cases, the feeling was the situation has changed significantly and views of people might have. Issues that may not have been significant earlier in the year, may now be bigger issues to consider (and vice versa).

Report author:

Caroline Latta, strategic communications and engagement lead, Path to Excellence programme

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Appendix 1 – key questions forming the situational analysis

Situation – whether the business, political or policy environment that made consultation necessary changed in any significant way?

Objectives – are the aims still the same, or are there now likely to be additional ones or ones excluded?

Proposals – If the options identification and assessment were done today, are they likely to have resulted in the same proposals? If they have changed, are they significant?

Target audience – has the lockdown experience made it likely that individuals or groups not previously targeted may now see themselves as potentially impacted and might wish to be involved in the exercise?

Resources – having considered the above do we need to reassess resources for the programme is there are changes to capability or capacity?

Impact - as we know there will be a change on the likely impact of proposals (travel and transport, out patients being a good examples) but do we need to consider the concept of a secondary baseline if we feel the old status quo has now changed (data validity) – this is around not having the linear perspective but a more triangulated one. A key question on this is fair to assume that consultee views as initially expressed will still be broadly the same if asked now?

Appendix 2 - Interview participants

- Executive Director of Operations, NHS South Tyneside CCG
- Director of Contracting, Planning & Informatics
- NHS Sunderland CCG NHS Sunderland CCG
- Head of corporate affairs
- Director of Communications and Engagement ST&SFT
- Director of Operations ST&SFT
- Medical Director ST&SFT
- Divisional Director Emergency Dare ST&SFT
- Divisional Director Surgery ST&SFT
- Senior Advisor, Integrated Care Systems, NHS England
- Programme manager, Path to Excellence