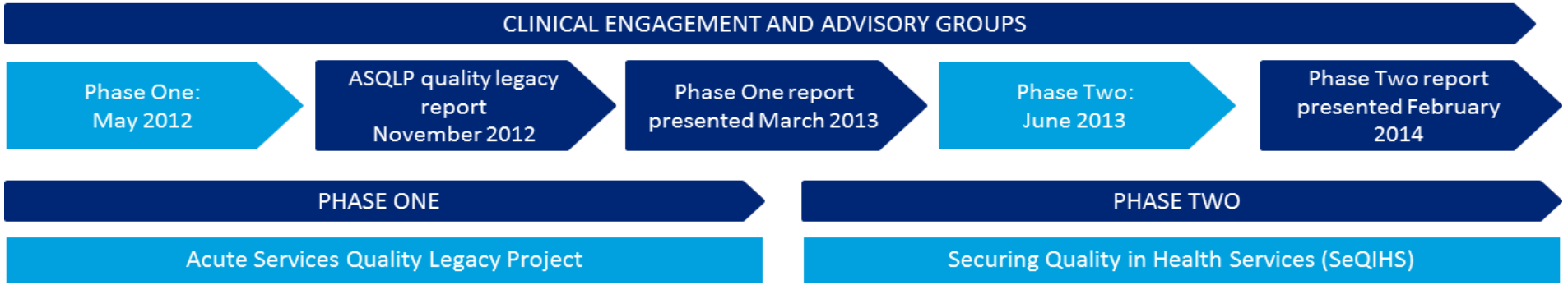
Securing Quality in Health Service (SeQIHS)

November 2014

Background



The project examined routine and specialist hospital care services at County Durham and Darlington NHS FT, North Tees and Hartlepool NHS FT and South Tees Hospitals NHS FT, in five clinical areas:

- Acute Paediatrics, Maternity and Neonatology (Children, Maternity, v young Baby);
- Acute medicine;
- Acute surgery;
- Intensive care; and
- End of Life.

SeQUIHS Feasibility analysis

Having identified the clinical quality standards to be provided, we needed to see what it would mean to put the standards in place and how likely we are to succeed.

We had to:

- Recheck the commitment of the hospital trusts to delivering the standards
- Recheck the commitment of the paying CCGs to wanting the standards to be delivered
- For each of the clinical quality standards, carrying out an independent check at each hospital site of what it would take to put the standard in place, including:
    - checking which standards had been met since the last assessment in 2013
    - checking if it was affordable
    - checking there would be the workforce to do it
    - looking to see if it could be done by 2015 and what were the risks.

The feasibility analysis report shows which clinical quality standards will be met by 2015 and those that cannot be met.

The report sets out 7 key themes or areas which all the trusts are failing to meet now.and will struggle to meet in the future.

A change of funding, collaborative hospital working or a different pattern of services between hospitals will be needed.

Example: Acute Surgery

Expected compliance with Clinical Standards by April 2015:

Ref	Standard	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
5	Senior surgeon on the acute surgical unit to cover at least 10h, 7 days a week. (minimum of 70 hours per week).	✔	✔	✔	N/A	✔	✔
6	All patients to be seen and reviewed by a consultant during twice daily ward rounds, (Especially all acutely ill patients , or others who deteriorate).	✔	✔	✔	N/A	✔	✘
7	All hospitals admitting surgical emergencies to have access to all key investigation services 24 hours a day, seven days a week. Supports clinical decision making: · Critical – imaging and reporting within 1 hour · Urgent – imaging and reporting within 12 hours · All non-urgent – within 24 hours	✘	✘	✔	N/A	✘	✘
8	All hospitals admitting surgical emergencies to have access to special Xray based treatment (Interventional Radiology) 24 hours a day, seven days a week: · Critical patients – 1 hour · Non-critical patients – 12 hours	✘	✘	✘	N/A	✘	N/A
9	Duty rotas to maximise continuity of care for all patients . A single consultant is to retain responsibility for a single patient on the surgical unit.	✔	✔	✔	N/A	✔	✔

Overall Trust expected compliance with key clinical standards

Expected position at April 2015

	CDDFT		NTHFT		STFT		Overall
	UHND	DMH	NTH	HAR	JCUH	FHN	Total
Standards Met (2012)	69	69	87	13	88	64	390
Standards Met (2013)	74	78	107	20	102	72	453
Standards Met (2015 expected)	93	89	132	25	104	73	516
Standards Not Met (2015 expected)	45	49	16	3	59	69	241
% met by Trust	64%	61%	84%	92%	60%	50%	68%
Improvement 2012 – 2015	14%	11%	25%	46%	6%	5%	17%

UHND=University Hospital North Durham
DMH=Darlington Memorial Hospital
NTH= North Tees Hospital
HAR=Hartlepool General Hospital
JCUH=James Cook University Hospital
FHN=Friarage Hospital Northallerton

Key areas failing to meet the Quality Standards

- Full access to diagnostic services (7/7 Hospital);
- Full access to support services (e.g. Physio, Pharmacy, Social Services);
- Access to special Xray based treatment (Interventional Radiology) 24/7;
- Workforce to provide full 24/7 cover (10 WTE) for all middle grade doctor rotas

  (affecting Childrens, Maternity, v young Baby, Surgical and Medicine services);
- Workforce to provide 24/7 (168hrs) consultant cover at Maternity units;
- The majority of End of Life care standards are not met by all Trusts;
- Very young Baby services fail to see enough cases / patients to keep skilled and do not meet staffing standards.

Maximum number of sites based on the workforce capacity - APMN

The overall size of the medical and nursing workforce is forecast to decrease; rota consolidation may be the only viable option to achieve the quality standards.

Maternity

	Current Units:	Future Workforce Allows (2018)
Obstetrics units providing 98 hour consultant cover	5 Units	3.4* Units
Obstetrics units providing 168 hour consultant cover	5 Units	2.0* Units

* Based on current service model

Maternity

Total number of midwives:

2014	2018
415	296

Children (Paediatrics)

	Current Units:	Future Workforce Allows:
Consultant cover	5 Units	4.3* Units
Middle grade cover	5 Units	3.3* Units

* Based on current service model

V small Baby (Neonate)

	Current Units:	Future Workforce Allows:
Consultant cover	2 Units	0.8* Units
Middle grade cover	2 Units	1.1* Units

* Based on current service model

Money:

Key changes facing Durham, Darlington and Tees include:

- Demand growing faster than increase in funding due to ageing population
- Better Care Fund (BCF) transfer of NHS funding for jointly bought health and social care reducing CCG funding by 3% in 2015/16;
- New “Fair shares” CCG funding rules reducing Durham, Darlington and Tees funding by another £50m (or 3.27%)
- On-going cuts to social care budgets can have a knock on increase in demand for health care
- Funding squeeze emerging within some of the individual health organisations

Conclusion from the feasibility analysis

- All providers and commissioners remain committed to achieving the clinical standards;
- Delivery of clinical standards has improved by 17%; but still only 68% achieved;
- Hospital Trusts expect not to be able to achieve the remaining 32% without a big area wide solution;
- Significant extra money would be required to achieve the remaining standards with present ways of working (£9.7m would have 9% improvement .. Still leaving 23%)
- Workforce modelling of Children, Maternity, v young Babies predicts a shortage of clinical staff over next 5 years, particularly in Maternity & Children's services
- The current money situation is extremely difficult for NHS organisations;
- The CCGs need to make a decision to either accept where we are now with clinical standards (and the risk of drop in achievement of these standards as money pressures increase) or to consider options for reconfiguration or changing the way services work together to deliver the clinical standards affordably .

What next?

A burning platform
You Can't do Nothing!

- We want to secure high quality care for the population of Durham, Darlington and Tees (DDT);
- The current levels of hitting the clinical standards (and the risk of deterioration as money pressures increase) means that **Doing nothing is not an option;**
- The CCGs need to look at options for the future pattern of service delivery to meet the clinical standards affordably.
- **Objectives of phase three:**

To explore and agree the range and location of health services that secure high quality care for the population of Durham, Darlington and Tees (DDT)

To carry out independent research with the public to understand what, to the public, is important about hospital services and to check levels of understanding of the balance that has to be struck between quality, access and affordability levels

To establish a clinical leadership group to develop a model of care for Darlington, Durham and Tees that will enable us to meet the clinical standards within the resources we have.

Services In Scope:

The services that will be covered by the SeQIHS programme are:

- Acute Surgery;
- Acute Medicine;
- Intensive Care;
- Children, Maternity, v young Babies (Acute Paediatrics, Maternity and Neonatology);
- End of Life Care; and
- A&E, Minor Injury, urgent care centres etc. (Urgent & Emergency Care).

With the publication of the Five Year Forward View from NHS England in October and the need to ensure the work of the project dovetails with local NHS and social care plans, we are also bringing together information on how each local health community is responding to the changing needs of the population in regards to the development of primary and community care services and how each local health and social care economy is responding to the need to better integrate services.

We will include some of the service options described in the Five Year Forward View within our service modelling and we will take into account

- Specialised services commissioning strategies; and
- Better Care Fund plans.