NHS
South Tyneside
Clinical Commissioning Group

NHS
Sunderland
Clinical Commissioning Group

CATEGORY OF PAPER	✓
For Decision	✓
For Assurance	
For information only	

Agenda item:	5.1
Enclosure number:	2

GOVERNING BODIES MEETING IN COMMON

21 February 2018

Report Title:	Phase 1 Path to Excellence Decision Making Report

Purpose of report

To provide the governing bodies of NHS South Tyneside CCG and NHS Sunderland CCG with the decision making report for phase 1 of the Path to Excellence programme.

Key points

Healthcare organisations nationally have been challenged to work together to adapt local services to address the three care gaps outlined in the NHS Five Year Forward View (FYFV): gaps in health and wellbeing, care and quality and finance and efficiency.

Across South Tyneside and Sunderland there has been a strong history of partnership working between providers and commissioners to deliver the best possible care to the populations they serve. In response to the national challenge, the South Tyneside and Sunderland Healthcare Group, was established as a formal alliance between South Tyneside NHS Foundation Trust and City Hospitals NHS Foundation Trust. Working in partnership with South Tyneside and Sunderland Clinical Commissioning Groups (CCGs), the Healthcare Group jointly review and plan hospital services as part of a strategic transformation programme known as the Path to Excellence.

The fundamental importance and value of having local hospitals providing a range of services is recognised by both hospitals and CCGs. However it is clear that the consequences of continued service duplication across South Tyneside District Hospital and Sunderland Royal Hospital, not least in terms of workforce availability, present challenges to the delivery of safe, high quality services. Stroke, obstetrics (maternity) and gynaecology and paediatrics (children's) emergency

services in South Tyneside and Sunderland are amongst those hospital based services facing the most severe workforce sustainability challenges, driven predominantly by a limited medical workforce resulting in service continuity, quality and financial pressures.

To be categorically clear, retaining the status quo and not making any changes is simply not an option for these services and it is extremely likely that a failure to act now will lead to closures of services across South Tyneside and Sunderland under crisis circumstances, putting patient safety at risk. It should also be noted that, through the consultation process, that there was much public feedback in favour of simply retaining services as they are now. This feedback was given serious consideration by the CCG governing bodies during the decision-making workshops, however the weight of evidence received about the need for change was compelling and unavoidable for each of the services.

To aid the decision making process, this decision making report aims to do five things:

- Provide an overview of Phase 1 of the Path to Excellence (PtE) programme progress to date
- Reiterate the background and case for change for phase 1 of the programme
- Outline the service reconfiguration options including changes made in light of patient, public and staff feedback
- Provide key additional assurances for the decision making process where required
- Assess each option against the decision making categories agreed by the South Tyneside and Sunderland CCG governing bodies in December 2017

Option development

All service change proposals have originated from clinically led discussions within service specific clinical design teams. Each team developed a longer list of potential options which were assessed against hurdle criteria (described in section 2) in line with the aims embedded in the previously published Path to Excellence issues document.

Only options that satisfied the hurdle criteria were developed for further evaluation by the Clinical Services Review Group (CSRG). This was followed by further refinement and eventual endorsement by both the CSRG and CCG governing bodies for formal consultation.

Decision making process and evaluation

Following the public consultation period (outlined in section 3), the decision making categories for evaluating each of the options were agreed. The choice of categories was influenced by feedback from the public and six decision making evaluation categories were agreed at a meeting in common of the CCG governing bodies on 13 December 2017. These are described in detail in section 2.

Impact Assessments

Alongside the clinical design process two external, independent impact assessments (integrated equality, health and health inequalities and travel and transport assessments) have been carried out to ensure the CCGs comply with relevant legislation and public sector duties and ensure the risks of all proposed service changes are fully understood. These impact assessments were in place prior to the public consultation and have been tested, reviewed and strengthened in light of feedback heard.

Risks and issues

As outlined in the pre-consultation business case, unprecedented pressures across the clinical workforce are being experienced by NHS organisations nationally, regionally and locally. These pressures exist in relation to the shortage of qualified nurses, attracting and retaining consultants in certain specialties, a greater number of gaps in rotas for doctors in training, and the introduction of the agency cap. In addition to these, the challenges around overseas recruitment provide further pressure as this has often been used in the past as a way of covering gaps.

Through the public consultation and decision making processes a number of important considerations have been raised in relation to the details required for a successful implementation of options chosen. Whilst these considerations are not required to make the final decision they will need to be explicit in the detailed post decision implementation plan and are detailed in section 9 of the attached report.

Assurances

Through all stages of design and consultation process, external expertise has been sought to ensure that the development of the options put forward and the process for public consultation were as robust as possible. A number of assurances have been received and include:

- The Clinical Services Review Group, including views of local staff and clinicians
- Patients, public and staff through the pre-consultation and consultation processes
- Impact assessments from key partners, including North East Ambulance Service
- Independent Travel and Transport Impact Assessment
- Independent Integrated Equality, Health and Health Inequalities Impact Assessment (IIA)
- External clinical assurances, not least:
  - Northern Cardiovascular Disease Network
  - Northern Child Health Network
  - Northern England Clinical Senate
  - Northern England Maternity Clinical Network
  - Northern Neonatal Network
- External assurance mechanisms with NHS England and NHS Improvement
- External assurance from the Consultation Institute in relation to engagement and consultation

Recommendation/Action Required

The governing bodies of South Tyneside and Sunderland CCGs are asked to formally approve the following recommendations:

- Obstetrics and gynaecology services: approve option 1 for implementation.
  - Option 1 is the development of a free-standing midwifery-led unit (FMLU) at South Tyneside District Hospital (STDH) and medically-led obstetric unit at Sunderland Royal Hospital (SRH).
  - To note implementation will aim to be complete by April 2019
- Paediatrics services - approve option 2 for implementation as the most sustainable long-term model, but recognise it will take a period of time for the requisite work to be done for this to be deliverable. Therefore the governing bodies are also asked to approve option 1 for implementation in the short-term. For clarity, it is recommended that option 1 be approved as a transitionary step towards option 2.
  - Option 1 is for a daytime paediatric emergency department (PED) at South Tyneside District Hospital (STDH) and 24/7 PED at Sunderland Royal Hospital (SRH).

- Option 2 is the development of a nurse-led paediatric minor injury and illness facility at STDH and 24/7 PED at SRH.
- It is recommended that the governing Bodies support the proposed amendment to opening hours under each option, from 8pm to 10pm as the closing time.
- To note implementation of option 1 will aim to be complete by April 2019 as a transitionary step
- Implementation of option 2 should include an independent, external group to review the transition and proceed at an appropriate pace over the medium-term for likely completion by April 2021

• Stroke services: approve option 1 for implementation.
- Option 1 is that all acute strokes are directed to Sunderland Royal Hospital (SRH), with the consolidation of all inpatient stroke care at SRH
- To note implementation will aim to be complete by April 2019

Sponsor/approving directors	M Brown, Director of Operations, NHS South Tyneside CCG S Watson, Director of Contracting and Informatics, NHS Sunderland CCG
Report author	P Garner, Path to Excellence Project Manager

Relevant legal/statutory issues
NHS Act 2006 (As Amended by Health and Social Care Act 2012); NHS Constitution; Equality Act 2010; The Gunning Principles; NHS Mandate 2013-2015 ('the four tests');NHS England guidance

Equality analysis completed	**Yes**	✓	**No**		**N/A**	
Quality impact assessment undertaken	**Yes**	✓	**No**		**N/A**	

Key implications	
Are additional resources required?	Yes – the required resources been identified for each option for obstetrics and gynaecology, paediatrics and stroke services are detailed in the decision-making report.
Has there been appropriate clinical engagement?	Yes – as part of the consultation process
Has there been/or does there need to be any patient and public involvement?	Yes – as part of the consultation process
Has there been member practice and/or other stakeholder engagement if needed?	Yes – as part of the consultation process

South Tyneside and Sunderland
NHS partnership

The path to excellence

Phase 1:

Decision Making Report

21st February 2018

South Tyneside and Sunderland NHS Clinical Commissioning Groups
South Tyneside and City Hospitals Sunderland NHS Foundation Trusts

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Executive Summary

i. The need for change and the aims of the report

Across South Tyneside and Sunderland there has been a strong history of partnership working between providers and commissioners to deliver the best possible care to populations they serve. This has resulted in the formation of South Tyneside and Sunderland Healthcare Group, a formal alliance between South Tyneside NHS Foundation Trust (STFT) and City Hospitals NHS Foundation Trust (CHS). Working in partnership with South Tyneside and Sunderland Clinical Commissioning Groups (CCGs), the Healthcare Group is jointly reviewing and planning hospital services as part of a strategic transformation programme known as the Path to Excellence.

The fundamental importance and value of having local hospitals providing a range of services is recognised by both local commissioners and providers, however it is clear that the consequences of continued service duplication across South Tyneside District Hospital (STDH) and Sunderland Royal Hospital (SRH), not least in terms of workforce availability, present challenges to the delivery of safe, high quality services. Stroke, obstetrics (maternity) and gynaecology and paediatrics (children's) emergency services are amongst those South Tyneside and Sunderland hospital based services facing the most severe workforce sustainability challenges, driven predominantly by a limited medical workforce resulting in service continuity, quality and financial pressures. To be categorically clear, retaining the status quo and not making any changes is simply not an option for these services and it is extremely likely that a failure to act now will lead to closures of services across South Tyneside and Sunderland under crisis circumstances, putting patient safety at risk.

To aid the decision making process this decision making report aims to do five things:

- Provide an overview of Phase 1 of the Path to Excellence (PtE) programme progress to date.
- Reiterate the background and case for change for phase 1 of the programme.
- Outline the service reconfiguration options including changes made in light of patient, public and staff feedback.
- Provide key additional assurances for the decision making process where required; and
- Assess each option against the decision making categories set out at the first decision making preparation workshop of the South Tyneside and Sunderland CCG Governing Bodies, held in December 2017.

ii. Engagement and consultation

The engagement and consultation activities took place during two discrete phases, the first being the pre-consultation (listening) phase and the second being the formal public consultation period itself.

The objectives of the pre-consultation engagement activities prior to public consultation were two-fold. The first objective was to inform stakeholders and the public of the issues facing these services and hence the reasons that changes are needed, and the second was to collect patient experience feedback to inform the development of specific options, which was to be undertaken by clinical design teams for the three service areas.

The public consultation period for Phase 1 of the PtE programme ran for 14½ weeks, from 5th July to 15th October 2017. This was to ensure there was adequate time for the proposals and issues to be considered and responded to, as per Gunning Principle three (that *"adequate time must be given for consideration and response"*). It was acknowledged that these issues are complex, and every effort was made to make information as easily accessible and understandable as possible and to ensure clarity about the basis on which the proposals were being considered, as per Gunning Principle two (that *"sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response"*).

Following the consultation, all of the public feedback was independently analysed and published in a draft feedback report in December 2017. Further dialogue was held with the public to consider whether this report was a fair reflection of the issues and views expressed during consultation, following which a final, amended version was published in January 2018.

Members are requested to note that the consultation exercise received "best practice" status by the independently commissioned Consultation Institute.

iii. Summary of the options

Clinically-led design teams developed potential options for change as part of a service review programme, informed by the pre-consultation process including engagement with previous and anticipated future patients, and overseen by clinical and non-clinical leaders from both CCGs and both Foundation Trusts. A long list of multiple options was developed and assessed against hurdle criteria, which resulted in a minimum of two potential options for each service being supported for formal public consultation.

Maternity services (Obstetrics) and women's healthcare (Gynaecology)

The compelling reasons for change for Obstetrics and Gynaecology are**:**

- To improve the overall sustainability of local obstetrics and gynaecology services, in terms of making the most efficient use of senior medical staff and creating more viable opportunities for future recruitment.
- To deliver quality improvements through greater service integration, more senior substantive medical decision-making availability and compliance with key clinical standards.
- To improve the overall sustainability of the Special Care Baby Unit.
- To support service alignment with national policy delivery around Local Maternity Systems covering populations of at least 500,000[1].
- To ensure affordability of service delivery.

The Obstetrics and Gynaecology options that have been consulted on are:

Option 1: Developing a Free-standing Midwifery Led Unit (FMLU) at STDH to deliver low risk births with high-risk intrapartum care and alongside low-risk midwifery care at SRH.

Option 2: Developing a single medically-led obstetric unit and alongside low-risk midwifery care at SRH, serving both geographical areas.

Due to the critical interdependency of obstetrics and gynaecology from a senior medical workforce point of view, gynaecology inpatient and emergency care would be provided from the SRH site, whilst day case work will be delivered from both the STDH and SRH sites. Each site would also retain outpatient services to deliver care as close to home as possible and retain patient choice. A single community midwifery team across both geographies would be created in either option.

Both options will improve clinical quality by bringing the two consultant teams together in order to increase the total amount of time of consultant delivered care to patients in the higher risk obstetric unit at SRH. They also both improve sustainability from a workforce point of view by consolidating the consultant and middle grade/specialist trainee rotas. Both options satisfy the minimum choice requirements of three options, but option 1 offers greater choice in relation to midwifery-led births as it offers both free-standing and alongside-obstetric MLU choices (in addition to an obstetric unit and home birth).

There is no financial impact for commissioners, but there would be an improvement on the financial positions of £1,200,000 for the provider trusts under either option, in comparison with expenditure in 2016/17.

[1] Better Births: Improving Outcomes in England, A Five Year Forward View for Maternity Care, 2016

Children and young people's healthcare services (urgent and emergency paediatrics)

It is acknowledged by the clinical and managerial teams across both foundation trusts that urgent and emergency paediatric services are significantly challenged in being able to continue to provide a sustainable and safe service as they are currently configured. This is predominantly due to;

- Significant issues in recruiting and maintaining sufficient senior doctors to provide an emergency paediatric care service at STDH, at middle grade level. There are currently only two middle grade doctors working on the emergency rota and there is a reliance on covering the medical rota with agency doctors out of hours.
- Whereas variability caused through the use of agency doctors has been minimised through attempting where possible to make repeated use of the same doctors familiar with the service, this cannot be guaranteed and does raise safety concerns as the middle grade is the most senior doctor within the department at night. When the rota cannot be covered by locum doctors, then consultants are expected to provide resident out of hours cover. If this happens then there is a likelihood that planned work for the following day, such as outpatient clinics would need to be cancelled.
- The National Clinical Advisory Team (NCAT), which was involved in supporting the previous review of Children's Health Services across South of Tyne and Wear in 2012, did share concerns that a 24 hour unit at STDH may become unsustainable in the medium-term based on the collective understanding of national medical staffing issues. This concern has come to fruition and the opportunities to recruit into paediatric middle grade posts both now and for the future are very limited. Consequently, future service models must recognise these shortages.
- Notwithstanding the aforementioned workforce challenges, it must also be recognised that there is a significant financial challenge for both hospitals with regard to maintaining these services, with both services costing in excess of their budgets.

The Paediatric options that have been consulted on are:

Option 1: provision of 12-hour day-time paediatric emergency department (PED) service at STDH with 24/7 paediatric emergency department (PED at SRH). The service would operate at STDH from 8am to 8pm and would continue with full medical support.

Option 2: Development of nurse-led paediatric minor injury/illness service between 8am-8pm at STDH with 24/7 acute paediatric services at SRH.

Under both options outpatient and community based paediatric services would continue to be provided within South Tyneside and Sunderland.

Both options offer the opportunity to maintain 7 day acute services on the South Tyneside site during day-time and peak activity times, whilst transferring all out of hours overnight activity to SRH. Importantly these options offer the opportunity to continue with a local service whereby children who do not require inpatient care can be assessed and treated locally in most circumstances.

Stroke services
The reasons for service reconfiguration are:

- To reconfigure services in a way that would allow investment to improve quality, particularly in terms of additional inpatient therapy capacity. This was also intended to significantly improve the acute audit Sentinel Stroke National Audit Programme (SSNAP)[2] scores for patients from both South Tyneside and Sunderland.
- To improve the overall sustainability of local stroke services, in terms of making the most efficient use of senior medical staff and creating more viable opportunities for future recruitment.
- To improve the overall sustainability of the service in terms of the ability to manage nursing and therapy vacancies on both stroke units.
- Improving financial efficiency to enable investment in key staff to improve clinical outcomes for stroke patients.

The three options that have been consulted on are:

Option 1: Provide all inpatient stroke care at the SRH site and at the same time close the inpatient stroke beds at STDH.

Option 2: For all patients their hyperacute stroke phase would be spent in SRH. Under this option there would be repatriation of South Tyneside patients to STDH for rehabilitation following 7 days for those patients requiring longer stays who are medically stable for transfer.

Option 3: For all patients their hyperacute stroke phase would be spent in SRH. Under this option there would be repatriation of South Tyneside patients to STDH for the acute stroke phase and rehabilitation following 72 hours for those patients requiring longer stays who are medically stable for transfer.

[2] https://www.strokeaudit.org/

Option 1 stands to deliver the greatest quality improvements, estimating that inpatient stroke service would move from a '**D**' to a '**A**' or '**B**' rating in SSNAP, it would also enable investment in a small number of extra Nurse Practitioners and make much more efficient use of the vital therapy resource.

There is no financial impact to commissioners; however, there would be a small improvement in terms of reduction of the Healthcare Group's organisational financial position.

iv. Evaluation against the decision making categories

To evaluate the different options across the three service areas, six decision making evaluation categories have been determined by the CCGs, following feedback through the public consultation, as outlined below:

- Safety and quality
- Clinical sustainability
- Accessibility and choice
- Deliverability
- Health inequalities
- Value for money

For **Maternity services (Obstetrics) and Women's healthcare (Gynaecology)**, both options provided an adequate or high degree of confidence across all the evaluation categories with the notable exception of the accessibility and choice category for option 2. Option 2 only has a low degree of confidence, given that this would require a greater number of women to travel outside of South Tyneside for their care and has less midwifery-led delivery choices.

For **Children and young people's healthcare services (urgent and emergency paediatrics)**, both options evaluated similarly across five out of the six evaluation categories with the difference seen in the accessibility and choice category. There was a high level of confidence that option 1 would meet the requirements as outlined in this category, whereas there was only an adequate level of confidence that option 2 would. This is due to the expectation that a greater number of patients would have to travel to Sunderland or other providers. It is important to note that there were still workforce pressures identified under both options, in terms of medical staff sustainability in option 1 and workforce availability for nurse practitioners in option 2.

For **Stroke services**, option 1 clearly evaluated higher than option 2 or 3, giving a high level of confidence across the majority of the six categories. The evaluation of option 2 and 3 provided only limited confidence of meeting the safety and quality, clinical sustainability, deliverability and value for money categories.

v. Recommendations

For all three service areas, failure to make a change will compromise the safety of these services; therefore retaining the status quo is not an option.

Maternity services (Obstetrics) and Women's healthcare (Gynaecology),

In respect to the options for Obstetrics and Gynaecology services there is no clear consensus for either option expressed by the clinical design team. The evaluation against the six decision making evaluation categories were broadly similar apart from the accessibility and choice category, where there was a high level of confidence that option 1 would better meet the requirements and would enable greater alignment to key national strategies.

It is recommended that Governing Body members of South Tyneside and Sunderland CCGs approve option 1 for implementation. Option 1 is the development of a free-standing midwifery-led unit (FMLU) at South Tyneside District Hospital (STDH) and medically-led obstetric unit at Sunderland Royal Hospital (SRH) with co-located midwifery-led care.

The Governing Body members of South Tyneside and Sunderland CCGs are asked to note implementation will aim to be complete by April 2019.

Children and young people's healthcare services (urgent and emergency paediatrics),

For Paediatric services it is difficult to distinguish between the two options, with both retaining some elements of risk in terms of workforce sustainability (particularly under option 1), and deliverability in the short- to medium-term under option 2. However, it is clear that the current service at STDH is unsustainable and that the status quo cannot remain.

The pressures on the medical workforce in option 1 remain a risk, even if a consultant delivered model can be recruited to, and therefore option 2 may be the correct model for the longer term, however, this option would not be deliverable in the short term.

It is recommended that Governing Body members of South Tyneside and Sunderland CCGs approve option 2 for implementation as the most sustainable long-term model, but recognise that it will take a period of time for the requisite work to be done for this to be deliverable and, hence, also approve option 1 for implementation in the short-term. For clarity, it is recommended that option 1 be approved as a transitionary step towards option 2. This will be necessary whilst the nursing workforce is developed, consideration is given to sustainable medical support and the relevant communications and engagement work is taken forward with the public.

Option 1 is for a daytime paediatric emergency department (PED) at South Tyneside District Hospital (STDH) and 24/7 PED at Sunderland Royal Hospital (SRH). Option 2 is the development of a nurse-led paediatric minor injury and illness facility at STDH and 24/7 PED at SRH.

It is recommended that Governing Body members of South Tyneside and Sunderland CCGs support the proposed amendment to opening hours under each option, from 8pm to 10pm as the closing time.

The Governing Body members of South Tyneside and Sunderland CCGs are asked to note implementation of option 1 will aim to be complete by April 2019, as a transitionary step. Implementation of option 2 should include an independent, external group to review the transition and proceed at an appropriate pace over the medium-term, for likely completion by April 2021.

Stroke Services

In relation to stroke services, the clinical team, supported by the Clinical Service Review Group (CSRG) assessment has a firmly held view that option 1, the centralisation of inpatient stroke care, will provide high quality care for the populations of South Tyneside and Sunderland. It is clear that significant improvements have already been made for South Tyneside residents during the temporary change and the better clinical outcomes that option 1 would produce, once fully implemented, would improve care for both the populations of South Tyneside and Sunderland.

Therefore, it is recommended that Governing Body members of South Tyneside and Sunderland CCGs approve option 1 for implementation. Option 1 is that all acute strokes are directed to Sunderland Royal Hospital (SRH), with the consolidation of all inpatient stroke care at SRH.

The Governing Body members of South Tyneside and Sunderland CCGs are asked to note implementation will aim to be complete by April 2019.

1.0 Introduction and background

Healthcare organisations nationally have been challenged to work together to adapt local services to address the three care gaps outlined in the NHS Five Year Forward View (FYFV): gaps in health and wellbeing, care and quality and finance and efficiency. Part of the response in South Tyneside and Sunderland has been the development of a formal alliance between South Tyneside NHS Foundation Trust (STFT) and City Hospitals Sunderland NHS Foundation Trusts (CHSFT), working in partnership with South Tyneside and Sunderland Clinical Commissioning Groups (CCGs) to jointly review and plan hospital services as part of a strategic transformation programme known as the Path to Excellence.

1.1 Case for Change

The fundamental importance and value of having local hospitals providing a range of services is recognised by both local commissioners and providers, however it is clear that the consequences of continued service duplication across South Tyneside District Hospital (STDH) and Sunderland Royal Hospital (SRH), not least in terms of workforce availability, present challenges to the delivery of safe, high quality services. Stroke, obstetrics (maternity) and gynaecology and paediatrics (children's) emergency services are amongst those South Tyneside and Sunderland hospital based services facing the most severe workforce sustainability challenges, driven predominantly by a limited medical workforce resulting in service continuity, quality and financial pressures. Such challenges were brought to the fore in October 2016, when the presence of only one part time substantive stroke consultant at STDH, together with the reduction in total stroke consultant numbers to staff the out-of-hours stroke services, led to CCGs and FTs taking the difficult decision to temporarily relocate stroke inpatient services from STDH to SRH. These workforce pressures are also felt in the other areas under consideration, as illustrated in the recent temporary closure of the Special Care Baby Unit (SCBU) due to an acute shortage of suitably qualified nursing staff to provide a safe level of staffing.

The broader national and regional strategic context for stroke services presents a case for long term change with an increasing national evidence base to support service consolidation. The North of England Cardiovascular Network has recommended a reduction in the number of hospitals providing hyper-acute stroke services locally to ensure an appropriate critical mass of patients to deliver improved quality. Change is therefore necessary to invoke improvements in the quality of stroke services at South Tyneside and Sunderland, with both hospital sites failing to achieve high quality scores as set out in the Sentinel Stroke National Audit Programme (SSNAP).

Obstetrics, gynaecology and paediatric services are experiencing similar workforce constraints, with senior medical service gaps inhibiting consistent delivery of national clinical standards and the provision of sustainable safeguarding arrangements. National maternity policy is also driving further change, with the requirement to

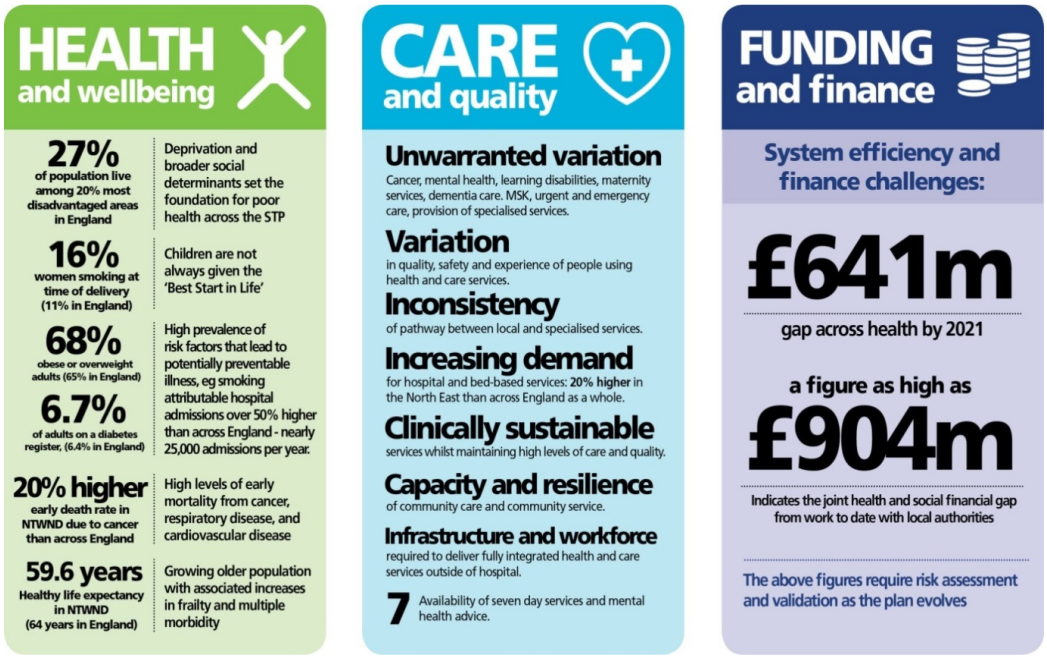
develop Local Maternity Systems of providers working together across populations of 500,000-1.5million.

The financial context for all three service areas is equally as compelling, with both Trusts having significant financial pressures and up to £2,250,000 of potential savings to be made depending on the options implemented.

1.1.1 Regional strategic context

The Sustainability and Transformation Plan (STP) for the region builds on a long history of partnership working and through that collaboration the results have been positive and greater than any individual organisation could have achieved alone. As a footprint, NHS and Local Authority organisations in Northumberland Tyne and Wear and North Durham (NTWND) have come together to work in collaboration on closing the three 'gaps':

Figure 1-1. Understanding the 3 gaps across the NTWND STP footprint.



The STP is built upon established programmes of work within each of the Local Health Economies that make up the STP footprint as well as additional new proposals for transformation over the next five years with common priorities being delivered at an STP level.

Whilst the start of the Path to Excellence (PtE) programme predates the STP for NTWND, it is contained in the plan with particular reference to the 'Optimal Use of the Acute Sector' work stream. The paragraph below is taken from the STP submission in October 2016:

"Our work to date has been to understand existing hospital work programmes in each of our LHEs [Local Health Economies] and explore opportunities for STP-wide alignment across care pathways, services lines, back office sharing, pathology to improve the quality and experience of care and maintain sustainability within a future hospital system. The collaboration between City Hospitals Sunderland and South Tyneside FT exemplifies the opportunities for cooperation across other LHE."[3]

The PtE programme will have a contribution in closing each of the three gaps identified over the lifespan of the programme, with a particular focus on reducing the care & quality and finance & sustainability gaps across South Tyneside and Sunderland.

1.1.2 Clinical safety and quality

Change is also required to improve or maintain clinical safety and quality across the three service areas. For example, a compelling argument for this can be seen in the improvement on some of the quality metrics in stroke for South Tyneside CCG patients since the temporary change was made in December 2016. This is illustrated in the table below:

Table 1-1. Improvement in Stroke metrics.

Indicator	Performance prior to the temporary change	Most recent published data (Apr-Jul 2017)
Percentage of patients receiving a CT scan within 1 hour	34%	51.1%
Thrombolysis rate within 1 hour	0%	63.6%
Percentage of patients who go direct to a stroke unit < 4 hours	17.5%	63.6%
Percentage of patients who spend > 90% of their inpatient stay on a stroke unit	52.5%	95.4%

Improvements in obstetrics, gynaecology and paediatrics are also expected following the implementation of the recommended options.

3 NHS England. 2016. *Sustainability and Transformation Plans*. [ONLINE] Available at: https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/. [Accessed 30 January 2017].

1.1.3 Workforce sustainability

As outlined in the Pre-consultation Business Case (PCBC), unprecedented pressures across the clinical workforce are being experienced by NHS organisations nationally, regionally and locally. These pressures exist in relation to the shortage of qualified nurses, attracting and retaining consultants in certain specialities, a greater number of gaps in rotas for doctors in training, and the introduction of the agency cap. In addition to these, the challenges around overseas recruitment provide further pressure, as this has often been used in the past as a way of covering gaps.

Recruitment to small teams (such as those in STDH) can often be a problem, for example, consultants will often want to work in a large team which offers them a number of opportunities to experience the wide-ranging aspects of their chosen discipline, as well as extend their opportunities to participate in research activity and educational roles. Small teams can often mean onerous and unsustainable on-call rotas that are unattractive to the employee, for example, in a small unit a consultant may have to be on-call 1 week in every 4 or 5, whereas in a larger unit, this is more likely to be 1 week in 6-8 or even less.

It is already understood that 'work-life balance' considerations are key when clinical staff are choosing where to work. The creation of larger, more sustainable clinical teams will help deliver this.

Across both Trusts there are several clinical specialties where each organisation may have only one or two consultants or other specialists providing care. This poses obvious problems in relation to sustainability, for example, covering the service when consultants take annual leave, during training and education sessions or during periods of sickness absence. Small departments are increasingly unattractive in terms of recruiting new consultants and consequently becoming much more challenging to sustain.

As the two trusts work more closely together, the ability to respond to these challenges increases. Through effective workforce planning, there is an opportunity to have a combined focus and consistent and supportive approach to recruitment and retention of staff, skill mix and role review resulting in a reduced need for agency staff. The need for the services to function as one team has been made clear by CCG Governing Body members and supported by the clinical design teams throughout the post-consultation, pre-decision workshops. A clear willingness for the teams to work across both sites has been demonstrated during this time.

In relation to the services contained within Phase 1 of the programme, examples of the workforce challenges are outlined below.

Table 1-2. Illustrative workforce gaps for Stroke, O&G and Paediatrics services.

Service	Workforce gaps
Stroke	• Nationally 40% of consultant vacancies unfilled. • STDH has only 1 permanent part time consultant. National guidance outlines the need for a minimum of 2 full time consultants for day time work (assumes out of hours is covered by networking arrangements). • Ongoing recruitment effort at STDH since 2014.
O&G	• Significant senior doctor gaps, with a third of obstetrics units across the country considering reconfiguration within the next 3 years[4]. • Across STDH and SRH, there are 17 funded middle grade posts established, but only 10.5 posts filled. • Unsustainable use of consultants 'acting down' and expensive locum doctors.
Paediatrics	• Similar problems nationally to those of O&G. • STDH currently has only 2 suitably qualified medical staff working on to the middle grade rota. Royal College guidance recommends each training grade rota should have a minimum of 10[5]. • Acute nursing workforce pressures in SCBU at STDH.

1.1.4 Financial case for change

The financial position that the NHS faces today is arguably the most challenging it has ever encountered. NHS Trusts across the country posted a combined financial deficit of £791 million for 2016/17. The position worsens even further when looking at the collective deficit for the NHS in England, with this being estimated at £2.8 billion at the end of 2016/17 (once adjusted for non-recurrent savings and sustainability funding).

Simple year-on-year cost cutting will not achieve the required savings and may lead to patient safety issues if Trusts individually continue to try and provide all the services they currently offer. As with the rest of the NHS, both trusts have challenging and unsustainable financial positions. If nothing changes, then this situation clearly poses a significant risk to the delivery of healthcare across South Tyneside and Sunderland. The PtE programme, starting with Phase 1, will help to improve the financial efficiency of these services whilst still delivering safe care.

[4] National Maternity and Perinatal Audit (NMPA) Annual Report, RCOG, 2017

[5] Facing the Future: standards for Acute General Paediatric Services, RCPCH, 2015

2.0 Decision making context and progress to date

This report comes to the meeting in common of the governing bodies of South Tyneside and Sunderland CCGs at the decision making part of the Phase 1 process, and follows completion of earlier stages of phase 1 as outlined in the figure below.

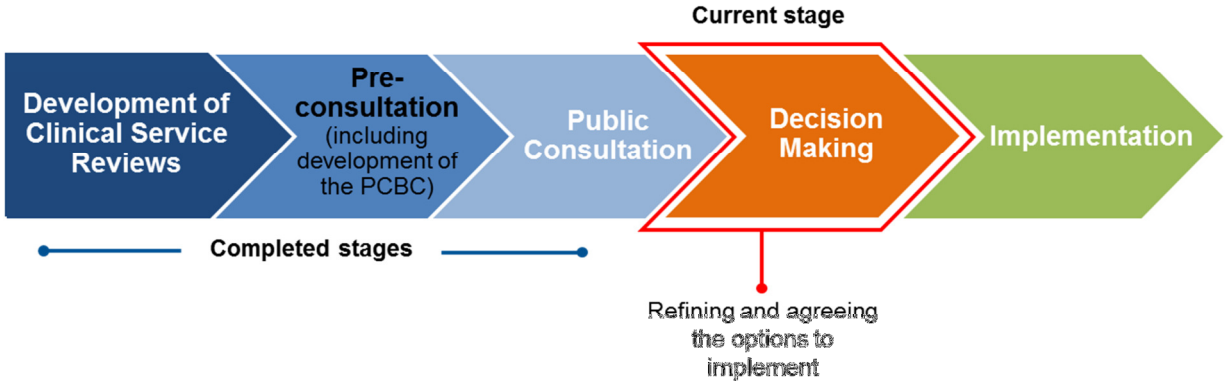
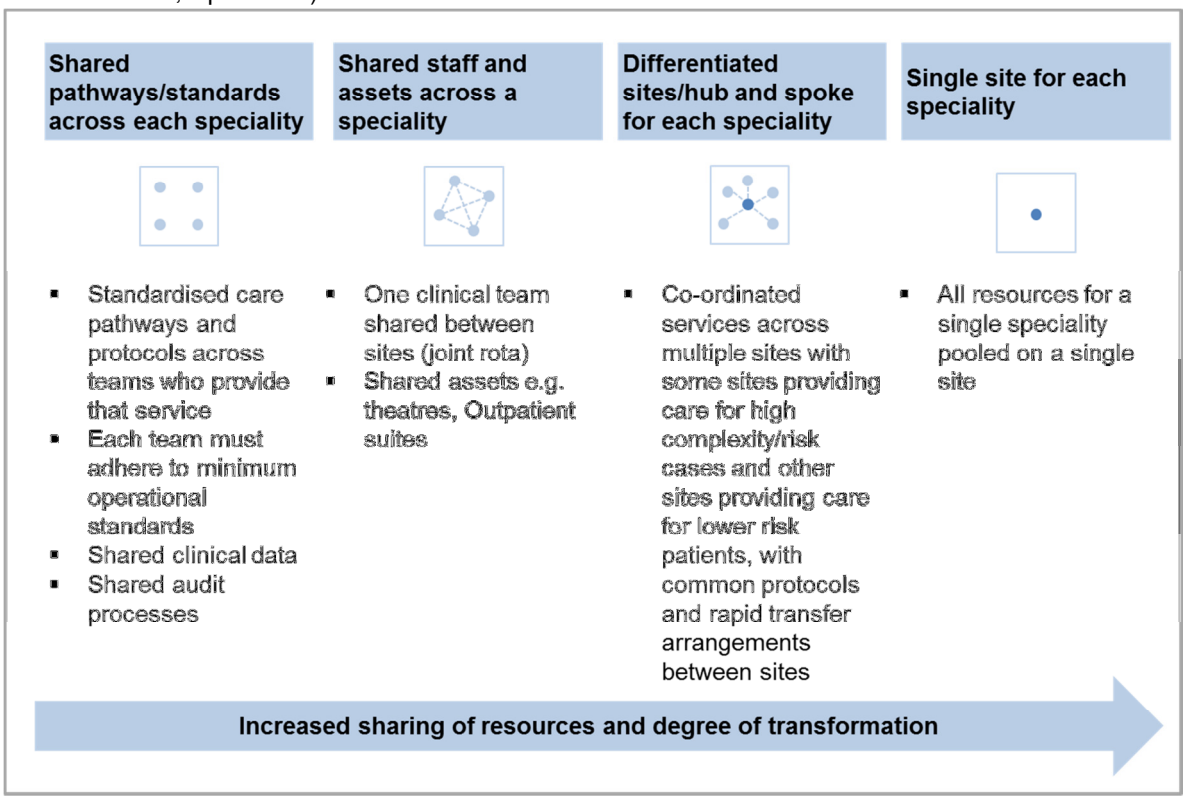


Figure 2-1. Stages in Phase 1 of Path to Excellence programme.

2.1 Types of reconfiguration

The term 'service reconfiguration' can be used to describe a spectrum of service models, which might range from existing clinical teams across the two Trusts and localities simply working to agreed and standardised clinical policies, to the development of a service delivered to patients from a single site. The range of options for service reconfiguration is shown in fig 2-2.

Figure 2-2. Summary of types of reconfiguration (adapted from the City of Manchester Single Hospital Service Review, April 2016).



For Phase 1 of the PtE programme, following significant consideration of an exhaustive long-list, seven different solutions have been articulated across the three services. All these options have been variations of either the 'differentiated site' or 'single site for each speciality' models. The table below summarises this by each service area.

Table 2-1. Summary of the different type of reconfiguration within the Stroke, Obstetrics & Gynaecology and Paediatric options.

Service (number potential options)	Shared pathways/standards across each speciality	Shared staff and assets across a speciality	Differentiated sites/hub and spoke for each speciality	Single site for each speciality
Stroke (n=3)			2	1
O&G (n=2)			1	1
Paediatrics (n=2)			1	1

Other potential options in terms of reconfigurations were considered but these did not pass the 'Hurdle Criteria' as outlined in section 2.2.

2.2 Option development

All service change proposals have originated from clinically led discussions within service specific clinical design teams. Each team developed a longer list of potential options, each of which was assessed against hurdle criteria, i.e. key questions that were applied to establish the high-level viability of options in line with the aims embedded in the previously published Path to Excellence Issues *Document*[6].

The hurdle criteria, agreed by the CSRG, incorporate the national aspirations of achieving service sustainability and high quality care within an affordable financial envelope, associated with the three care gaps within the NHS Five Year Forward View, whilst also reflecting the pressing need to deliver such clinical and financial improvements locally within the next 1-2 years. The hurdle criteria used for short-listing options is summarised at table 2-2.

Table 2-2. Hurdle criteria.

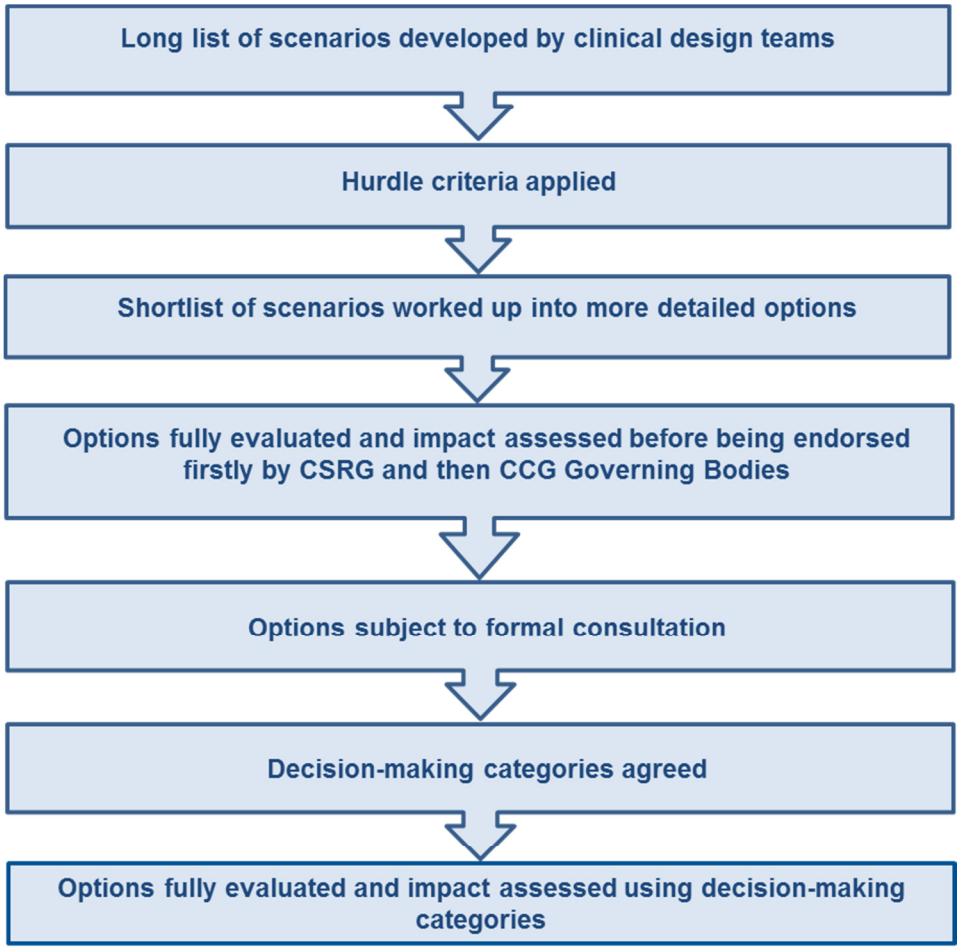
Hurdle criteria	Sub-criteria/ questions
Supports sustainability/service resilience	• Does this option support service sustainability from a clinical workforce perspective? • Does this option support service sustainability from a

[6] Path to Excellence Issues Document (2016) [ONLINE] https://pathtoexcellence.org.uk/wp-content/uploads/2016/11/PathXtoXExcellenceXissuesXbookletXFINALXweb.pdf

	population and activity perspective?
Will deliver high quality, safe care	• Does this option deliver improved quality than that delivered in the current service configuration? • Does this option deliver applicable quality/safety/experience standards and regulatory requirements for service?
Is affordable	• Is this option deliverable without any additional cost impact to commissioners and the wider healthcare system?
Is deliverable	• Is this option deliverable within the next 1-2 years?

How the hurdle criteria process fits in with the wider decision making process is shown diagrammatically in figure 2-3.

Figure 2-3. Flowchart outlining Phase 1 option development and decision making process.



Only options that satisfied the hurdle criteria were developed for further evaluation by the CSRG. This was followed by further refinement and eventual endorsement by

both CSRG and the CCG Governing Bodies. The following configuration options were discounted through this process:

- **Stroke:** Do nothing; centralise on the STDH site; centralise on a wider geographical foot print, i.e. with additional providers.

- **O&G:** Do nothing; centralise on the STDH site; current configuration but single medical team across two sites; removing the service entirely from both South Tyneside and Sunderland.

- **Paediatrics:** Do nothing; current configuration but single medical team across two sites; have a consultant delivered service at STDH overnight; centralise paediatric services in a new hospital build between the two current sites.

In relation to paediatrics, an additional option was put forward prior to public consultation by the paediatric consultant team at STDH. However, due to a number of shortcomings in the proposal, it failed to clear the hurdle criteria referenced in table 2-2 above. This option was reviewed by the Northern England Clinical Senate, which supported this pre-consultation decision.

2.3 Independent advice and assurance

Through all stages of design and consultation process, external expertise has been sought to ensure that the development of the options put forward and the process for public consultation were as robust as possible. This external advice and assurance has included:

1. Clinical assurance to help ensure the best and most sustainable options were being developed for public consultation, this included:

    - Development support and review of evidence by the Northern England Clinical Networks.
    - Development support and review of evidence by STP speciality leads
    - A formal clinical assurance review from Northern England Clinical Senate for Paediatrics.

2. Engagement and consultation assurance from the Consultation Institute – to ensure that engagement and consultation with the public was undertaken effectively and appropriately (this is further outlined in section 3.5)

3. As well as engaging outside expertise and assurance, the programme has met with the requirements of the regulatory processes of both NHS England and NHS Improvement. These processes ensure that national guidance and policy on the assurance of service change was followed by the programme,

including review of clinical models by relevant experts, networks and clinical senate.

The information provided by these independent experts has been summarised in each of the relevant speciality sections (sections 4-6).

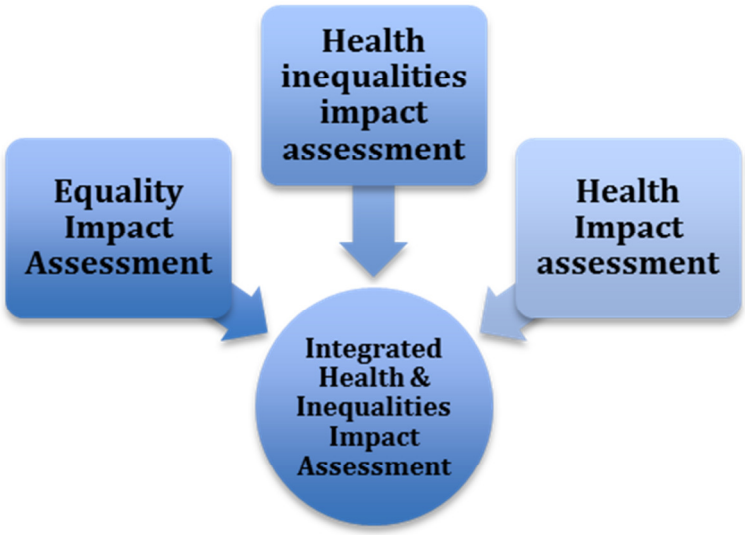
2.4 Risk and impact assessments

Alongside the clinical design process (described in section 2.2) two external, independent impact assessments have been carried out for phase 1 of the programme to ensure the CCGs comply with relevant legislation and public sector duties and to ensure the risks of all proposed service changes are fully understood. These impact assessments were in place prior to the public consultation and have been tested, reviewed and strengthened in light of feedback heard.

2.4.1 Integrated Equality, Health and Health Inequalities Impact Assessment

The purpose of the Inequalities Impact Assessment (IIA) is to examine what each of the potential options may do, positively or negatively, for the populations of South Tyneside and Sunderland.

Figure 2-4. IIA components.



This section outlines the common themes across the three IIAs. A summary of the original IIAs can be found at appendix 2 with a summary of the updated IIAs following public consultation included as appendix 3. A summary of each of the final individual IIAs has also been included in section 4.6 for Stroke, section 5.6 for Obstetrics & Gynaecology and section 6.6 for Paediatrics.

Each of these assessments evaluated what each of the potential options may do, positively or negatively, for the populations of South Tyneside and Sunderland. More

specifically, the health and health inequalities elements of the IIAs were designed to assess the overall health impact and the impact on health inequalities in relation to:

- Service outcomes;
- Service activities;
- Safety of the services;
- Quality of the service;
- Sustainability and resilience of the service (including its ability to respond to projected demographic changes);
- Access to the service;
- Choice for patients, their families and carers;
- The mental, social and emotional wellbeing of patients, their families and carers.

For the equality elements of the IIAs, the assessment was designed to identify what the impact of the potential options would have in relation to patients who fall in one of the protected characteristic groups, i.e.

- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Age.

Common positive impacts of the proposals across all in-scope clinical specialities include:

- More sustainable and consistent high quality care, regardless of the day of the week or the time of day
- Safer care due to improved levels of specialist staffing able to assess and treat patients promptly
- Improved levels of specialist staff and resources able to deal with rising population needs in terms of scale and complexity*
- Cost savings/more efficient or cost-effective service provision in the face of economic austerity
- More efficient and timely treatment of acute illness*
- Less risk of clinical deterioration*
- More specialist skills and services in Sunderland

**Applies to all O&G and all Paediatrics options but only Option 1 of stroke proposals*

The IIAs also highlighted a number of potential drawbacks in relation to the service areas. While the IIA did not demonstrate these to be sufficient enough to outweigh the positive health and health inequalities impacts, they are still potential risks which, where possible, will be mitigated in the future implementation arrangements. A series of recommended actions were included in the IIA for consideration to reduce any potential negative implications and these are included in the relevant sections for each option.

2.4.2 Travel and Transport Impact Assessment

An independent travel and transport impact analysis was commissioned and carried out by Integrated Travel Planning (ITP) Limited, with their full and comprehensive analysis included as appendix 4. An overall summary of the impact is described below with specific speciality impacts summarised in sections 4.4, 5.4 and 6.4.

Whilst acknowledging the issues expressed in the public consultation, general accessibility to both hospital sites is good and is in line with neighbouring communities' access to other local hospitals across the North East. STDH is served by a total of 12 bus services, 10 of which have frequencies of between 10 minutes and one hour and SRH is served by a total of 18 bus services, 12 of which operate at frequencies between 10 minutes and 30 minutes. Both hospital sites are also within 800 metres of a metro station.

Around 80% of South Tyneside residents have access to SRH within one hour. All options collectively present an *average* of either between 20-25 minutes additional public transport travel or 6-7minutes additional car travel for South Tyneside residents who will receive care at SRH under some of the options proposed. The travel impact is more or less depending on where people live. Extensive fieldwork testing has been carried out to validate the public transport and car journey times and this report is appended as appendix 5.

The percentage of the local population anticipated to experience additional travel time is around 4% for South Tyneside residents with zero impact for those patients who currently use SRH. The nature of the services under review however means that the increased annual attendances at SRH are likely to be discrete attendances around infrequent healthcare episodes and therefore the travel impact is neither regular nor sustained.

Public transport travel within 60 minutes is relatively unchanged by the service proposals with only a slight shortfall on the percentage of South Tyneside people able to reach SRH by public transport in an hour when compared to their current access to STDH. Travel by public transport to SRH from South Tyneside within 30 minutes is significantly more challenging however, with only a small percentage of the population likely to be able to do so.

The equality, health and inequalities impact assessment has highlighted positive health impacts of all but options 2 and 3 of the stroke proposals as a result of the workforce consolidation benefits and associated improved clinical outcomes. The improvement in quality and increased clinical sustainability, which evidence strongly suggests will result in fewer deaths and less life-changing disability is therefore deemed to be a sufficient and necessary gain to justify the increased travel to services that can be retained as locally and safely as possible. The negative impact on travel for the relatives and visitors of the c250 patients per annum from South Tyneside is judged to be proportionate to the expected health impacts.

The personal impact on families, patients and carers of additional travel is not underestimated. The deprivation levels across both geographical areas, represents a financial as well as emotional impact. The risk of patients avoiding seeking prompt treatment as a result of increased travel requirements is clearly a risk that needs to be considered and mitigated accordingly.

The independent TTIA recommends a number of measures that could be employed to assist in reducing the travel impact of the proposed service changes, particularly on South Tyneside residents who may be required to travel to SRH. Further information and ideas to reduce the impact were gathered during the dedicated travel and transport public consultation event, considerations include:

- Ensuring patients and visitors have accurate, up to date information about their travel choices, including public transport information, and are aware of online journey planners.
- Ensuring patients and visitors have accurate information about parking choices and costs.
- Providing users with information about schemes that offer assistance with travel costs.
- Providing travel information with appointment letters.
- Promoting the existing policy of allowing patients to discuss and schedule appointment times that ease their travel arrangements.
- Working with local authorities and local transport providers to explore the viability of introducing improved and new bus routes.

Much of this work has already started with a multi-agency Travel and Transport Stakeholder Group with representatives from Health, Local Authorities, Patient User Groups, Transport Commissioners and Providers set up to minimise the travel impact. A paper outlining this group's work in more detail is included as appendix 6.

2.5 Decision making process and evaluation

As outlined in section 2.2, following the public consultation period the decision making categories, for evaluating each of the options needed to be agreed. The

choice of categories was influenced by the feedback through the public consultation and they were agreed following a meeting in common of the CCG Governing Bodies on 13th December 2017. The categories and associated sub-statements are outlined in table 2-3.

Table 2-3. Decision Making Evaluation Categories and sub-statements.

Evaluation Category:	**Quality & safety**	**Clinical sustainability**
Proposed decision-making evaluation sub-statements	• Ability to maintain or improves level of quality and safety that is currently delivered. • Delivery of applicable quality, safety and experience standards and regulatory requirements, including safe workforce standards.	• Workforce model supports long term service sustainability. • Workforce model and associated capacity supports service sustainability.
Proposed information sources to inform RAG rating assessment	• Performance and outcomes assessment against core clinical standards. • Clinical risk assessment of options. • Use of clinical evidence and research to inform models. • External clinical assessment of options. • Consideration of safeguarding impact.	• Workforce model and workforce plan for each speciality. • Heath Education North East view of impact on doctors in training. • External clinical assessment of options. • Updated demand and capacity assessment, including acuity and admissions.
Evaluation Category:	**Accessibility & choice**	**Deliverability**
Proposed decision-making evaluation sub-statements	• Clinical access and transfer times are demonstrably safe. • Non-clinical transport impacts are fully assessed and plans to mitigate impact are developed. • Choice is maintained and promoted where possible.	• Is deliverable by April, 2019. • Strategic alignment with co-dependent services and wider system transformation plans. • Sufficient workforce supply to support timely implementation. • Sufficient system capacity to absorb changes in patient flows.
Proposed information sources to inform RAG rating assessment	• Consultation feedback report. • Final Travel and Transport	• High-level implementation plan and timeline. • Updated workforce model

	Impact Assessment. • Travel and Transport working group plans. • NEAS impact assessment and risk mitigations. • External clinical views on expected transfers. • Refreshed choice impact assessment. • Indicative communications and marketing strategies	and plan. • Co-dependent service assessment, including primary care impact assessment. • Views from other commissioners, providers and strategic transformation programmes. • Updated demand and capacity assessment, including acuity and admissions (and choice impact for maternity).
Evaluation Category:	**Health Inequalities**	**Value for money**
Proposed decision-making evaluation sub-statements	• Service model likely to improve, or at least not worsen, health inequalities. • Accessibility and health impact on protected and vulnerable groups is fully assessed with potential risks identified and mitigated. • Impact on health is fully assessed.	• Ensures best value for money for the taxpayer • Is deliverable within the resource available to the healthcare system in the short and long-term. • Transitional costs can be met where required.
Proposed information sources to inform RAG rating assessment	• Final Integrated Equality, Health and Health Inequalities Impact Assessment and associated recommendations.	• Updated financial modelling and plan, aligned to demand and workforce plans. • Final estates and capital plan

A narrative assessment in terms of the confidence level about how each option would fulfil the requirements of the relevant category has been carried out and is summarised in sections 4.6, 5.6 and 6.6.

3.0 Consultation process

Full patient and public engagement and consultation have been undertaken in line with the CCGs' statutory responsibilities. The Consultation Institute has confirmed that the CCGs' consultation process is in line to earn a best practice award, subject to open and transparent decision-making being undertaken. Details of the engagement, communications and engagement activity undertaken through the service change process are outlined in the Consultation Assurance report which is being considered by Governing Bodies as part of the decision-making meeting. The

consultation feedback report is at appendix 1. The overall response rates to the consultation are listed in table 3-1.

Table 3-1. Public consultation response rates.

Resident street survey	805 interviews
Online and paper based consultation survey	496 responses
Direct mail patient survey (across three service areas)	324 responses
Focus groups	32 groups, 324 participants*
Public, staff and stakeholder events	19 events, 443 participants**
Staff Q&A events	12 groups, 174 participants
Phone, letter, email submissions	57 submissions
Travel and Transport discussion group	1 event, 53 participant

* 144 / **141 completed monitoring forms

4.0 Obstetrics & Gynaecology Services

This section of the decision making report summarises the options that were consulted on during consultation, the information considered as part of the decision making process, and an evaluation of each of the two options for obstetrics and gynaecology.

4.1 Options summary

Both STDH and SRH currently run full obstetrics and gynaecology services. This includes availability for high and low risk births at either site. Both day case and inpatient gynaecology surgery is available at both sites. STDH has a Level 2 special care baby unit (SCBU) and SRH has a Level 3 SCBU and neonatal intensive care unit (NICU).

The two proposed obstetrics and gynaecology options are outlined in tables 4-1 and 4-2.

Table 4-1. Obstetrics and gynaecology Option 1: Developing a free-standing midwifery-led unit (FMLU) at STDH and medically-led obstetric unit at SRH

STDH	SRH
• A free-standing midwifery led unit (MLU) to deliver low risk care • Hospital based antenatal care • Community midwifery care through a single South Tyneside and Sunderland community midwifery team with additional community midwifery resource into the free-standing midwifery-led unit • Day-case and ambulatory care gynaecology services • Gynaecology outpatients	• Medically-led obstetric unit to deliver high risk intrapartum care • Midwifery-led intrapartum care through co-located MLU • Hospital based antenatal care • Community midwifery care through single South Tyneside and Sunderland community midwifery team • All inpatient gynaecology • Gynaecology outpatients • Special care baby unit • Neonatal intensive care

Under option 1, the service would offer obstetric care provision for high risk births or for those women who choose to give birth in the obstetric unit. Women classed as low risk during their first pregnancy and women who book for pregnancy care with their second or subsequent pregnancy (whether at South Tyneside or Sunderland) who are assessed as low risk will be encouraged to book for midwifery-led care in the birth centre at STDH or at SRH. Women would be directed to the type of care that would maximise the chances of them having appropriate and safe care in an environment that supports their needs and reduces the possibility of unnecessary intervention, with no impact on the outcomes for mother or baby as set out in the

Birthplace cohort study[7]. This pivotal extensive and evidence based study will be referred to throughout.

Table 4-2. Obstetrics and gynaecology Option 2: Development of a single medically-led obstetric unit and alongside MLU at SRH, serving both geographical areas	
STDH	**SRH**
• No medical or midwifery-led intrapartum care • Hospital based antenatal care • Community midwifery care though single South Tyneside and Sunderland community midwifery team • Day-case and ambulatory care gynaecology services • Gynaecology outpatients	• All high and low risk intrapartum care delivered in co-located medical and midwifery led units • Hospital based antenatal care • Community midwifery care through single South Tyneside and Sunderland community midwifery team • All inpatient gynaecology • Gynaecology outpatients • Special care baby unit

4.2 Summary of obstetrics and gynaecology services consultation feedback

The independent analysis of the quantitative consultation feedback showed that option 1 was the preferred obstetrics and gynaecology option with 72% of responses in the resident street survey, 35% in the online/paper survey and 47% of the direct patient survey stating that it was closest to meeting their needs. More Sunderland people responding to the street survey favoured option 1. Option 1 showed to be the most likely to meet the needs of pregnant women & women who have children under the age of 2. However women who are pregnant rated this more likely than those with children under two.

Option 1 was preferred by all groups, but more so by pregnant women.

The breakdown of preference by area and consultation shown below -

Table 4-3. Resident street survey consultation feedback on proposed O&G options.

	Closest to meeting needs		Farthest from meeting needs	
Option 1	72%	582	15%	118
Option 2	15%	118	72%	582

*All % figures shown as a percentage of all survey respondents (excludes no response/prefer not to say)

[7] Accessed at https://www.npeu.ox.ac.uk/birthplace/results

Table 4-4. Online/paper consultation feedback on proposed O&G options.

	Closest to meeting needs		Farthest from meeting needs	
Option 1	35%	108	13%	39
Option 2	10%	32	38%	118

*All % figures shown as a percentage of all survey respondents (excludes no response/prefer not to say)

Table 4-5. Direct patient survey feedback on proposed O&G options.

	Closest to meeting needs				Farthest from meeting needs			
	Pregnant or child under 2				Pregnant or child under 2			
	Yes		No		Yes		No	
Option 1	78%	21	77%	87	29%	10	24%	29
Option 2	22%	6	23%	26	71%	24	76%	94

* calculations are based on the percentage of respondents who are pregnant/have a child under 2 (column totals), variances are explained by those who preferred not to say and consequently are not counted.

The independent analysis of the qualitative consultation feedback highlighted how the public shared views on the following:

- The lack of consultants on-site at STDH. Child birth is seen as not a simple, prescriptive event and reducing services would be to the detriment of the residents of South Tyneside, with the perception that this introduced an unnecessary and unacceptable risk.
- Transporting a mother in labour independently to Sunderland was felt to have the potential for detrimental effects. People unfamiliar with Sunderland, its road systems and transport would struggle with transport and extra costs incurred which would in turn create more issues and problems.
- There was a strong feeling that the downgrading of maternity services in South Tyneside would lead to an increase in home births in the borough. There was also concern at the loss of a Special Care Baby Unit (SCBU), particularly amongst recent mothers.
- The ability of the Ambulance Service to respond to pregnancies that become high risk/emergency very quickly. The specific concern was around transporting mothers in distress to Sunderland in time to be safe for both them and their baby.
- Travel to Sunderland from South Tyneside for higher-risk births at night time, particularly amongst communities where there are high levels of employment

in the evening/night time economy, meaning partners are not always available.

4.3 Strategic alignment and external clinical view of the options

For obstetrics and gynaecology services there has been a large amount of national guidance written in recent years describing what constitutes safe and effective obstetrics and gynaecology services. Pertinent national strategy and guidance include:

- *Better Births: National Maternity Services Review* (NHS England, 2016)
- *Providing Quality Care for Women: Obstetrics and Gynaecology Workforce* (RCOG, 2016)
- *Safer Childbirth* (Royal College of Obstetrics and Gynaecology, 2008)
- *Maternity Matters* strategy (Department of Health, 2007)

The 2014 NHS FYFV committed to the development of new maternity service models, including reviewing how best to sustain and develop maternity units across the NHS. This resulted in the *Better Births* - National Maternity Review. The review made a series of recommendations for the sustainability of safe, high quality and personalised care, with improved post-natal and perinatal mental health care and strengthened multi-professional working. It advised that commissioners and providers are asked to work together across areas as local maternity systems (LMS) covering a population of between 0.5-1.5 million, with the aim of ensuring women, their babies and their families have equitable access to the services they choose and need, as close to home as possible. In particular, the role of the LMS is to:

- Bring together all providers involved in the delivery of maternity and neonatal care, including, for example, the ambulance service and midwifery practices providing NHS care locally;
- Develop a local vision for improved maternity services based on the principles of Better Births;
- Co-design services with service users and local communities;
- Put in place the infrastructure needed to support services working together.

Each obstetrics and gynaecology option has been assessed for its ability to deliver improvements against the Better Births recommendations. While the scope of the proposed changes and the focus on intrapartum care means they only partially contribute to the delivery of national strategic expectations, the options do support LMS delivery at a local level and option 1 enables greater patient choice of midwifery-led delivery options particularly.

NICE guidelines also determine standards of clinical service delivery within maternity services, including making FMLU delivery available for women with low-risk pregnancies, hence midwifery led care feature in both future potential service configurations.

At a regional level, the development of a Local Maternity System (LMS) is a core feature of the Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan (STP) for maternity services. The PtE proposals for maternity services have been reviewed and endorsed by the NTWND LMS chair and clinical lead on behalf of the LMS Board and in their formal response to the consultation they conclude *that both options for the future of maternity services within the 'Path to Excellence' are clinically justified, safe, in accordance with national standards of care – and will lead to improved outcomes for mothers and their babies in the local area.* Their full response is included as appendix 10.

The proposals are also strategically aligned with the North East neonatal service review recommendations around future special care baby capacity and the network has confirmed the clinical quality benefits of the proposals.

4.4 Summary of Travel Impact Assessment

The information below summarises the TIA for Obstetrics and Gynaecology services. More comprehensive information can be found appended as appendix 4.

South Tyneside mothers and their visitors will be the population category affected by the obstetric options. Depending on the option that is taken forward, it could be that all South Tyneside mothers will be affected, in the case of option 2, or only those that are deemed to be having a high risk birth (or opt for obstetric-led care), in option 1, and will be required to travel to SRH (or another unit) for the birth.

The analysis of the postcodes of previous maternity patients giving birth at STDH shows that the average public transport journey time to SRH (instead of STDH) increases by 21-25 minutes depending on the time of day and direction of journey. Journeys by car to SRH will take on average 9-11 minutes longer than if the journey was made to STDH. The travel survey indicates that South Tyneside visitors or patients would use broadly similar modes of transport to get to STDH and SRH, although more people would use the metro and less people would walk to SRH.

Under option 1, in which all high risk births would transfer from STDH to SRH, it is estimated that there would be an increase in the demand for parking at SRH of up to around 4 vehicles per day. Under option 2, in which all births would transfer from STDH to SRH for treatment the potential increase in parking demand at SRH is up to around 7 vehicles per day. The impact on the local road network would be small and would be spread across the day.

In relation to gynaecology, South Tyneside inpatients will be affected by the service proposals and will be required to travel to SRH instead of STDH for their treatment. The analysis of the postcodes of previous gynaecology patients living in South Tyneside and treated at STDH shows that the average public transport journey time

to SRH would be on average 20 minutes longer than to STDH. Journeys by car would be on average 12 minutes longer.

The travel survey suggests that 77% of in-patients currently travelling to the gynaecological services at STDH use a car based mode (33% as a passenger and accompanied in hospital, 44% as a passenger and dropped off) and 23% use taxi. If the services were switched to SRH, the survey indicates that a greater proportion (89%) would travel by car (67% as a passenger and 22% would drive themselves), and 11% would use the bus. Additional parking demand at SRH would be negligible due to the relatively small number of patients involved.

4.5 Summary of Inequalities Impact Assessment

As described in section 2.4.1, the baseline IIAs for Stroke, Obstetrics and Gynaecology and Paediatric services were commissioned from an independent consultant in early 2017 to inform the evaluation of the options prior to them being agreed as appropriate options to be taken forward to public consultation. These IIAs have been tested during public consultation for relevancy and addendums produced in January 2018 to reflect further evidence, assessment and findings. Below are the main findings for the Obstetrics and Gynaecology services.

4.5.1 Equality Impact

The pre-consultation IIA identified considerable benefits relating to both obstetrics and gynaecology options (including the impacted changes on Special Care Baby Units) for all equality groups across both CCG areas, with benefits outweighing any drawbacks. All equality groups were found to benefit equally across Sunderland and South Tyneside. The review and update of the IIA identified minimal changes to this assessment.

No new equality groups were highlighted as being potentially vulnerable to the proposed changes. The final IIA concludes the following groups as being most impacted by the obstetrics and gynaecology proposals:

1. Socioeconomic deprivation
2. Disability (physical, mental, learning)
3. Race (BME communities)
4. Age (older women, older and teenage mothers)
5. Women who misuse alcohol or drugs
6. Sensory impairment
7. Women with co-morbid conditions

Both service change options positively affect these vulnerable groups equally, irrespective of CCG area, because these groups are more likely to need consultant-led obstetric led care and the proposals for this type of care are the same in each option.

Following consultation feedback, the review of the IIA included further consideration of the impact of travel arrangements on breastfeeding mothers. Equality impact scores for pregnancy and maternity were therefore amended to reflect an equal impact for both options, as per table 4-6.

Table 4-6. Final Equality Impact Scores (Obstetrics and Gynaecology).

Equality group	Total Equality Impact Scores	
	Option1	Option 2
Sex/ gender	6	3
Sexual orientation	9	9
Gender reassignment	9	9
Race	3	3
Marriage and civil partnership	9	9
Pregnancy / maternity	3	3
Religion or belief	9	9
Disability	3	3
Socioeconomic deprivation	3	3
Age	3	3

The lower equality impact score for option 2 reflects the fact that Option 2 requires more women from South Tyneside to travel outside the borough than Option 1. The scores also recognise the loss of consultant and midwifery care in the South Tyneside area

While the IIA highlights clear benefits of both options for equality groups in both CCG areas, it illustrates that these community groups may be more vulnerable to any associated drawbacks such as increased travel costs.

4.5.2 Health and Health Inequalities Impact Assessment (HIIA) (obstetrics and gynaecology)

The baseline IIA assessed both obstetrics and gynaecology options as having a strongly positive impact on health and health inequalities for both CCG populations, with minimal negative or neutral impacts. While the IIA review and update identified no new health and health inequalities impacts, it identified the need to further consider impacts relating to breastfeeding and to review the scope and scale of ambulance-service related impacts.

Breastfeeding mothers from South Tyneside were highlighted as being particularly disadvantaged due to accommodating additional travel time and inconvenience into feeding schedules. This additional impact led to slightly lower scores for both options; however, the greater impact was equally applied to both options as per table 4-7.

Table 4-7. Health and Health Inequalities Impact Assessment Scores (Obstetrics and Gynaecology).

	Option 1	Option 2
Baseline HIIA total score	**152**	**111**
Update HIIA total score	**148**	**107**

The IIA review and update considered further evidence relating to ambulance response times, the national Birthplace Study, North East Ambulance Service capacity and Care Quality Commission assessments, and concluded that this information did not change the original IIA scores which had fully considered relevant ambulance issues such as the importance of timely transfers, particularly in relation to option 1.

The final IIA continues to demonstrate a higher score for option 1 than option 2. The main difference between scores for the two options recognises that option 2 will result in more women needing to travel outside of South Tyneside for care. The IIA concludes that there is strong evidence that the significant benefits associated with the proposed changes outweigh the drawbacks for both South Tyneside and Sunderland communities. Health and inequalities gains in both areas include:

- More sustainable and consistent high quality care, regardless of the day of the week of the time of day – for women, mothers and babies
- Safer care due to sustained and improved levels of specialist staffing - especially in obstetrics care and neonatal care - able to provide timely intervention and avoid clinical deterioration
- More cost-efficient and cost-effective obstetrics and gynaecology services

The IIA determines that both options will give children a better start in life and could therefore deliver enduring and significant benefits to child health, population health and inequalities across South Tyneside and Sunderland.

4.5.3 IIA considerations for implementation

The baseline IIA highlighted a number of drawbacks to the proposals, although it emphasised that the identified drawbacks were rarely significant enough to offset the strongly positive health benefits identified. Emphasis was placed on supporting

service users to understand the changes, to minimise travel and transport barriers and to ensure continuity of care. The most pertinent suggestions to mitigate these drawbacks are listed below and will be considered through the implementation of whichever option is taken forward.

- Patient and public information campaigns could be developed and targeted to promote understanding and enable service users to adapt to the changes in an elective or emergency situation.
- A cross area 'women's services' user group could be supported to champion the needs of women, their carers, partners, friends and relatives with an emphasis on vulnerable groups.
- Oversight arrangements could scrutinise equity and satisfaction data and ensure that this information is translated into timely and appropriate service developments whenever necessary.
- The pathways for postnatal depression could be clarified and made publically available.
- Introduce arrangements to monitor user satisfaction and critical incidents relating to service continuity and coordination for all users, especially vulnerable groups. These arrangements could ensure that intelligence is translated into service developments as appropriate and necessary.
- Integrated records and information systems could be developed to promote information sharing and communication across service and sector boundaries.
- Introduce arrangements to monitor equity of access audit data for each service and ensure that this information is translated into timely and appropriate service developments whenever necessary.
- Oversight arrangements could scrutinise user experience data and ensure that this information is translated into timely and appropriate service developments whenever necessary.
- Policies and plans to promote breastfeeding initiation and support to sustain breastfeeding could be published with an emphasis on mothers from South Tyneside.
- The travel and transport working group should consider the suggestions made during the public consultations around parking charges and passes for staff, patients and regular visitors.
- The promotion of home births (appropriately risk assessed) could deliver further cost efficiencies while mitigating against the reduced delivery options in South Tyneside.
- Consideration of further local developments to enhance the local non-acute elements of maternity pathway, as per Better Births' recommendations, could ensure the best possible, locally delivered maternity care.
- The proposed health service specifications could include protocols which address how the risks associated with potential delays in transfer and handovers of care will be minimised.

4.6 Evaluation against decision making categories

The following section outlines considerations against the decision-making categories with a specific focus on any additional work that has been undertaken since the pre-consultation stage of the process. This includes where consultation feedback has indicated a need to review previous information or to obtain new information.

A summary of the assessment against the decision making evaluation categories, with a specific focus for the obstetrics and gynaecology options can be seen in the narrative below.

For the safety and quality category both options provide a high level of confidence that these will be improved with the consolidation of all high risk intrapartum care onto a single site, with benefits in terms of being able to increase the number of consultant hours on the high risk unit at SRH and the positives that brings in terms of timely intervention when needed.

The current resident consultant cover is 68 hours for Sunderland and 40 hours for South Tyneside. The intercollegiate document *Safer Childbirth* (RCOG, 2007) advocated a minimum of 40 hours resident cover for units managing between 2,500 and 6,000 deliveries each year and although the existing arrangements are compliant with the minimum expectations of this standard the proposal is to provide consultant cover on the delivery suite to 84 hours.

Providing services for high risk patients on one site would also reduce the number of neonatal or intrauterine transfers currently experienced from STDH due to the co-location of SCBU and NICU on one site.

Whilst there are concerns from some members of the public about the safety of FMLUs, comprehensive research and evidence has also been used in helping inform the option development, with for example the Birthplace Cohort Study, which demonstrates that there is no significant differences in perinatal morbidity observed between obstetric unit and midwifery led units. Adverse outcomes were rare and occurred in both groups. However some additional benefits were seen in MLUs where women were significantly less likely to experience complications such as an abnormal foetal heart rate, foetal–pelvic complications, shoulder dystocia, occipital–posterior presentation and postpartum haemorrhage compared with women in obstetric units. In addition, significant reductions were found for the MLU group in use of caesarean section and instrumental delivery when compared to obstetric units.

In relation to clinical sustainability both options provide a high level of confidence that this will be improved with the consolidation of all high risk intrapartum care onto a single site. The main reason for this is that the proposed centralisation of obstetric care onto a single site will address the longer term problem of non-consultant grade

medical staffing shortages experienced by both services (for example currently 6.5 whole-time equivalent middle grade gaps across both units). The need for the services to function as one team has been made clear by CCG Governing Body members and supported by the clinical design teams throughout the post-consultation, pre-decision workshops. A clear willingness for the teams to work across both sites has been demonstrated during this time.

Centralising high risk services should also make the unit more attractive in terms of staff recruitment and retention of senior medical staff and the midwifery workforce. The midwifery staffing model has also been comprehensively reviewed in both options and there would be no gaps in the establishment required to staff either option.

Assessment of the physical capacity shows that there is enough capacity both within the maternity unit and also on the gynaecology ward at SRH to accommodate the extra activity.

The long term sustainability of the proposed FMLU in option 1 has been raised during the public consultation and, as such, the clinical teams and programme board have given this further consideration. FMLUs continue to feature in national maternity policy and, while it is true that they have not been successful in other parts of the north east, they have proved more successful nationally with a rise in the number of MLUs over the last 10 years. Additionally, Better Births illustrates that FMLUs should be more than just a place to give birth and be a community hub offering a range of additional activities such as antenatal classes, smoking cessation support, breast-feeding support etc. The clinical teams within the FTs have confirmed a commitment to developing the proposed FMLU in option 1 into a vibrant, thriving birthing centre, in line with the national model.

In England the majority of FMLUs have between 200-300 births a year. According to the original postcode based analysis contained in the PCBC it has been assumed that approximately 320 births from Sunderland and South Tyneside would be delivered at the FMLU in option 1. Further analysis to look at the potential catchment population for the FMLU has been carried out to inform the final decision-making assessment. Previous retrospective case mix analysis has shown that the annual number of eligible low risk births at STDH is 19% or 250 births. This is lower than the Birthplace cohort study which estimated that about 50-60% of women meet the NICE ‘low risk’ criteria. However using this same proportion for SRH would give another 610 eligible births. It is also known that 140 women from South Tyneside and 40-50 from Sunderland choose to have their baby at the Birthing Centre at the Royal Victoria Infirmary (RVI) in Newcastle upon Tyne for non-medical reasons. It is assumed that those women opting for care at RVI for non-medical reasons are exercising their choice to give birth in an alongside midwifery led unit (AMLU), and that these women would also be eligible to give birth in the FMLU at STDH. With

these potential births factored in we can see that there are a total of around 1000 eligible low risk women across South Tyneside and Sunderland who would be eligible to give birth at the FMLU under option 1.

An alternative way of investigating the sustainability issue is by looking at what women hypothetically would choose if they were given the full range of birthing choices. Recent patient engagement work done across Teesside, Darlington and Durham as part of the Better Health Programme has looked at this. During this engagement work 889 mums (with children aged 5 or under) and women planning to have children were interviewed with their birthing preferences ranked as follows:

1. Alongside midwife-led unit (52%)
2. Consultant-led unit (27%)
3. Freestanding midwife-led unit (FMLU) (11%)
4. Home birth (10%)

Using the 11% of women expressing their preference to give birth in a FMLU from this regional work and applying it to the total number of births across South Tyneside and Sunderland (4,500) we would have potentially 495 births.

Whilst it is difficult to predict the number of women across South Tyneside and Sunderland who would choose to give birth in a FMLU, we can see by looking at the clinical eligibility and some local comparable engagement work, that both produce a higher estimate of the potential number of women who could give birth in the FMLU than was contained in the previous analysis when developing the options for consultation.

The clinical design teams recognise that ensuring that expectant mothers have informed choice about the benefits and risks of giving birth in an FMLU as key to its future sustainability. Central to this will be sharing the robust national evidence base which demonstrates the positive clinical and patient experience outcomes of a planned birth in a non-obstetric setting. The Birthplace cohort study concluded that such a birth setting was significantly associated with a higher patient satisfaction rate, reduced risk of instrumental delivery, intrapartum caesarean section and a significantly increased chance of 'straightforward' and 'normal birth' irrespective of whether the woman lived in a more or less advantaged demographic area. In particular the Birthplace study measured three ‘positive’ outcomes for mothers and/or babies: immersion in water (i.e. use of a birth pool at any stage during labour), having a normal birth, and whether the mother breastfed her baby at least once. Compared with planned ‘low risk’ obstetric unit births, the results for FMLUs were:

- Immersion in water – four times greater opportunity for births planned in FMLUs.

- Increased chance of a normal birth.
- Initiated breastfeeding - higher for births planned in an FMLU.
- Birth in an AMLU, FMLU or at home was associated with a reduction in caesarean section in both White and non-White women and there was no evidence that the pattern was different for instrumental delivery, 'normal birth' or 'straightforward birth'.

There is no doubt that it will be essential for local system leaders, staff, members of the public and their elected representatives to come together to help support the sustainability of such a unit, and to help develop a vibrant, exciting choice for expectant mothers to make. Key to fully informing women on the benefits and risks of an FMLU would be a communications strategy to ensure women had facts and evidence, rather than anecdote to inform their choice. An example of communications strategy to address this is included in appendix 9.

For accessibility and choice the two options differ in their assessment against this evaluation category. Option 1 satisfies the four choice options (obstetric unit, stand-alone midwife-led birthing unit, alongside midwife-led care/unit and home birth) set out in *Better Births* and in NICE guidance, with greater delivery choices for women opting for a midwife-led birth. Option 2 still offers the choice of a midwifery-led birth but as part of an alongside MLU rather than a FMLU. Option 2 also limits locally accessible choice options for South Tyneside patients. It is worth noting that the National Childbirth Trust (NCT) has previously estimated that over 95% of women in the UK did not have a full choice about different settings for birth and that over 40% of women lived in areas where they were not able to make a choice between having their baby in a birth centre or in an obstetric unit. Choice will still be maintained for both gynaecology outpatients and day case procedures, with delivery of these still planned at both SRH and STDH.

As highlighted in section 4.2 concerns were expressed during the public consultation in relation to South Tyneside residents travelling to Sunderland. However the vast majority of stays in hospital for obstetrics and gynaecology care are relatively short and it should be noted that under both options ante and post-natal outpatient care will continue be delivered in both localities, which will help minimise the travel impact.

The strongest concern expressed through the public consultation period in relation to obstetrics and gynaecology was what would happen if there needed to be an urgent transfer out of the FMLU (developed in option 1) for medical reasons. The direct answer to this is that the first step is in rigorously undertaking risk assessment with expectant mothers, but any emergency transfer from the FMLU would be initiated by the midwives in the unit and would be carried out by an emergency response ambulance. The North East Ambulance Service (NEAS) has been fully engaged in Phase 1 of the PtE programme and the issue of emergency transfers from the FMLU

has been specifically discussed. They have confirmed and provided assurances that an emergency call made by a midwife from the FMLU would be classed as a Category 1, 8 minute response if that was what requested and that the unit would not be classed as a `place of safety` and also that the `blue-light` transfer time between STDH and SRH was 12 minutes. NEAS are currently the highest performing ambulance service nationally for the highest category of call (life-threatening emergencies) and have confirmed that any additional demand from FMLU transfers would be relatively minor in the context of existing ambulance service activity.

Figure 4-1 Map of distances between MLUs and obstetric sites (taken from NMPA Audit 2017).

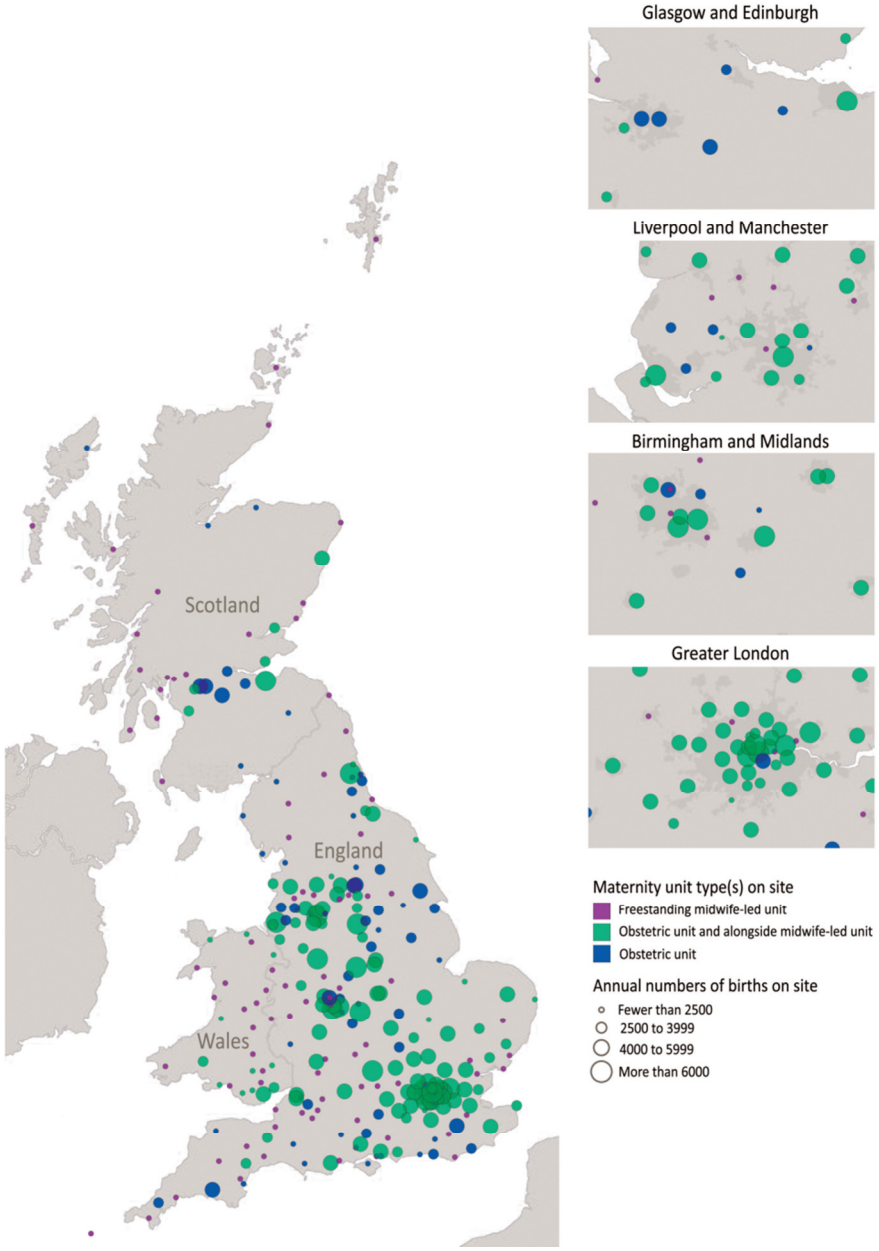


Figure 4-1 is taken from the National Maternity and Perinatal Audit (NMPA) shows the distance between existing MLUs and obstetric units. As can be clearly seen, the distance involved between other units are far in excess of the 7-8 miles between STDH and SRH. Governing Body members will note that time is more relevant than

distance, but that NEAS have confirmed that the added ambulance drive times remain within safe clinical time thresholds for the respective specialty areas.

It also needs to be recognised that the vast majority of transfers out of an FMLU do not occur in acute emergency situations, with continuing risk assessment being carried out by the midwives throughout labour to ensure early transfers where required. The Birthplace study shows that for women having a first baby (primiparous), there is around a 36% chance of transferring to an obstetric unit during labour or immediately afterwards. For those having a second or subsequent baby (multiparous), the transfer rate is around 10%. Further analysis of the Birthplace findings and local delivery data has been undertaken to quantify the future likely risk of transfers.

The main reasons for transfer out of the FMLU are for failure of the labour to progress and for pain relief (epidural). The Birthplace study showed that the average time from a women being transferred to an obstetric unit and them giving birth was 4.5 hours, suggesting that there is a low threshold for transfer to avoid emergency transfers in the later stages of labour.

The number of emergency transfers between the proposed FMLU at STDH in option 1 and the obstetrics unit at SRH would depend on the proportion of first time mothers using the unit, although it is accepted that a greater proportion of women who have already given birth use FMLUs rather than first time mothers. The table below shows the range of expected transfers including emergencies.

Table 4-8. Range of expected transfers between the FMLU at STDH and the obstetric unit at SRH.

Proportion of Primiparous/ Multiparous births	Number of Primiparous/ Multiparous births	Number of transfers
Primiparous 60%	192	57 transfers, of these 5 would likely to be defined as an emergency
Multiparous 40%	128	12 transfers, of these less than 1 would be defined as an emergency
Based on a 60/40 split 69 women would be transferred with **6 transfers** being defined as an emergency		
Primiparous 40%	128	38 transfers, of these 4 would likely to be defined as an emergency
Multiparous 60%	192	18 transfers, of these less than 1 would be defined as an emergency
Based on a 40/60 split 56 women would be transferred with **5 transfers** being defined as an emergency		
Primiparous 30%	96	29 transfers, of these 3 would likely to be defined as an emergency
Multiparous 70%	224	20 transfers, of these less than 1 would be defined as an emergency

Based on a 30/70 split 49 women would be transferred with **4 transfers** being defined as an emergency

As clearly demonstrated the expected emergency transfer rate would be less than one patient every two months. Discussions with other FMLU sites, through the Northern England Maternity Network, have also confirmed total transfer rates to be in keeping with national evidence.

In summary, whilst it is understandable that there are concerns about women requiring the emergency transfers from the FMLU, the evidence suggests the actual numbers requiring emergency transfers are very small. However for those who do require emergency transfer, these would be prioritised for transfer as per the clinical need and there are assurances from NEAS that it would respond based on the clinical need of the transfer as assessed by the midwives within the unit. A midwife would also accompany the woman during transfer.

Within the deliverability category there is a high level of confidence that both option 1 and option 2 would meet the requirements as set out in the evaluation sub categories, this is due to both options being deliverable by April 2019 with no workforce constraints identified that would cause barriers to implementation of either model.

Assurances from the Maternity Network and LMS have been given that both are valid options and align to the wider strategic maternity programme, although recognition that option 1 offers more choice as outlined in the previous category. During the consultation period there has also been confirmation from other local providers (Newcastle-upon-Tyne NHS Foundation Trust and Gateshead Healthcare Foundation Trust) that there is sufficient capacity in the wider system to absorb the modelled changes in patient flows.

Further analysis of anticipated activity levels and flows has been undertaken to test the pre-consultation activity assumptions. This has included reviewing the impact of patient choice during the recent temporary suspension of births at STDH, following the unexpected temporary SCBU closure. This has only been done for option 2 as there was no ability for low risk women to give birth in a FMLU as is proposed in option 1 during this period.

Out of the 1,300 annual births at STDH it had been assumed based on postcode analysis that 780 (60%) births would take place at SRH and 520 (40%) would take place at other providers (Newcastle and Gateshead). In the temporary closure during 4 December, 2017 until 22 January, 2018, there were 123 births, of which 56 women (46%) elected to give birth at SRH, with 67 (54%) giving birth elsewhere (52 at Queen Elizabeth Hospital, Gateshead and 15 at the Royal Victoria Infirmary, Newcastle). This estimate needs to be caveated in terms of this being a small

sample size and that, given the nature of the emergency change, it may be difficult to extrapolate in terms of observed and expected behaviour

In relation to health inequalities, for both options the IIA provides evidence that the proposed changes could have major benefits for the resident populations including vulnerable groups. These include, more sustainable and consistent high quality care regardless of the day of the week or the time of day, safer care due to sustained and improved levels of specialist staffing - especially in obstetrics care and neonatal care, and also being able to provide timely intervention and avoid clinical deterioration. These service improvements could achieve enduring and significant benefits to child health, population health and inequalities across South Tyneside and Sunderland.

For the value for money category whilst both options generate net savings of around £1.2 million compared to what was spent in 2016/17 (once adjusted for the flow of patients to other providers) and therefore providing better value for money, the service as a whole still remains in a deficit position and therefore neither option has been evaluated as having a high degree of confidence of achieving long term financial sustainability.

In summary both options improve the significant workforce vulnerability issues in these services, with option 1 providing more choice options to patients, particularly in South Tyneside.

5.0 Paediatric Services

This section of the decision making report summarises the options that were consulted on during consultation, the information considered as part of the decision making process and an evaluation of each of the two options for emergency paediatric services.

5.1 Options summary

The two paediatric options are described in tables 5-1 and 5-2 below:

Table 5-1. Paediatric Option 1: Day-time paediatric emergency department (PED) at STDH and 24/7 paediatric emergency department (PED) at SRH

STDH	SRH
- Medically-supported paediatric emergency department (PED) available from 8am to 8pm - Medically-supported children's short stay assessment unit (CSSAU) available from 8am to 8pm - Doors closing for both services at 8pm to allow children to be treated and discharged - Paediatric outpatients' clinics with potential scope to provide more sub-specialist clinics, e.g. paediatric epilepsy or asthma. - Children's day unit (dental, orthopaedics, diagnostics and day case activity)	- Medically-supported paediatric emergency department available 24/7 - Medically-supported children's short stay assessment unit available - Children's day unit - Special care baby unit - Paediatric outpatients clinics

Table 5-2. Paediatric Option 2: Development of nurse-led paediatric minor injury/illness facility at STDH and 24/7 acute paediatric ED at SRH

STDH	SRH
- Nurse delivered paediatric minor injuries/illness care available between 8am and 8pm with pathway integration to existing urgent care hub - Paediatric outpatients' clinics with potential scope to provide more sub-specialist clinics, e.g. paediatric epilepsy or asthma. - Children's day unit (dental only)	- All acute paediatric services, including children's short stay assessment unit and children's day unit - Special care baby unit - Paediatric outpatients clinics

5.1.2 Alternative Special Care Baby Unit model

During the consultation period, the senior nursing staff from the special care baby unit (SCBU) at STDH proposed an alternative model for a transitional care unit at STDH regardless of which option was chosen to be implemented for obstetrics. The

unit would have four SCBU cots to provide the ongoing level 1 or transitional care, to point of discharge, for the local population of South Tyneside, thus freeing up cot space in the unit at SRH. Day to day management of SCBU infants would be by advanced paediatric nurse practitioners supported by the team of experienced SCBU nurses at STDH. The view of the nursing staff is as SCBU will be providing care for lower risk babies, medical support could be provided by an on call consultant with one session on site per week to undertake a ward round, supported by telemedicine.

In order to assess whether this option should be considered in the final decision making process the option needs to be assessed against the hurdle criteria by which all other options that progressed to public consultation had been subject to. To help with this assessment comments from the Neonatal Network (NN), NHS England specialised commissioners (NHSE) and the National Quality Surveillance Visit Programme (NQSP) have been taken into consideration. The hurdle criteria assessment is summarised in table 5-3.

Table 5-3. Hurdle criteria assessment for the proposed alternative SCBU model.

Hurdle criteria	Sub-criteria	Assessment of alternative model
Will deliver high quality, safe care	• Does this option deliver improved quality than that delivered in the current service configuration? • Does this option deliver applicable quality/safety/experience standards and regulatory requirements for service?	X Peer review (NQSP) identified serious concerns about medical and nursing staffing support in current unit and the alternative model would not address these √ Would continue to provide local access to transitional care for the local population X Risk of increased transfers of care, should baby deteriorate (NN) X Limited medical support available locally (on call from CHS) should baby deteriorate (NN) X Concerns about ability of staff to maintain clinical skills working in alternative model described (NN) X Limited facilities for parents and carers (NQSP) X Single site SCBU and NICU co-located associated with better clinical outcomes
Supports sustainability/ resilience	• Does this option support service sustainability from a clinical workforce perspective? • Does this option support service sustainability from a population and activity perspective?	X Model unlikely to be commissioned by specialist commissioners as does not meet SCBU criteria (NHSE) X Neonatal Network advise that capacity across the network to absorb STDH activity (NN) – additional level 1 capacity not required X Concern about the ability to recruit and retain suitably trained staff in a model – national shortage of Qualified in Speciality trained nurses (NN)

Is affordable	Is this option deliverable without any significant additional cost impact to commissioners and the wider healthcare system?	X Model unlikely to be commissioned by specialist commissioners as does not meet SCBU criteria – would need additional investment from CCG (NHSE) X Additional investment in nurse staffing required to support the current and alternative model
Is deliverable	Is this option deliverable within the next 1-2 years?	√ Model is deliverable in short term, but question long-term sustainability due to concerns about recruitment and retention
Supported by Neonatal Network		X Based on comments above
Supported by Specialist Commissioning		X Based on comments above

Based on the above assessment the alternative SCBU model will not be considered in the final decision making meeting.

5.2 Summary of paediatric services consultation feedback

The independent analysis of the quantitative consultation feedback showed that option 1 was the preferred paediatrics option with 80% of responses in the resident street survey, 36% in the online/paper survey and 58% of the direct patient survey stating that it was closest to meeting their needs. More Sunderland people responding to the street survey favoured option 1.

Option 1 showed to be the most likely to meet the needs of children and young people.

The breakdown of preference by area and consultation shown below -

Table 5-4. Resident street survey consultation feedback on proposed paediatric options.

	Closest to meeting needs		Farthest from meeting needs	
Option 1	80%	644	8%	61
Option 2	7.5%	60	80%	643

*All % figures shown as a percentage of all survey respondents (excludes no response/prefer not to say)

Table 5-5. Online/paper consultation feedback on proposed paediatric options.

	Closest to meeting needs		Farthest from meeting needs	
Option 1	36%	109	13%	39
Option 2	12%	36	31%	94

*All % figures shown as a percentage of all survey respondents (excludes no response/prefer not to say)

Table 5-6. Direct patient survey feedback on proposed paediatric options.

	Closest to meeting needs		Farthest from meeting needs	
Option 1	58%	59	7%	7
Option 2	7%	7	54%	55

*All % figures shown as a percentage of all survey respondents (excludes no response/prefer not to say)

The independent analysis of the qualitative consultation feedback highlighted how the public shared views on the following:

- Children get sick 24 hours a day, seven days a week and an appropriate inclusive service needs to reflect that an illness or condition that starts off not being an emergency with a child can quickly become a life-threatening.
- The issue of access to an 8am to 8pm service was also highlighted in relation to younger children, where parent/carers felt that symptoms are generally only noticed later in the day – such as at bath time.
- There were concerns raised over the general health and wellbeing of children and young people based on a delay in care if people can't get to Sunderland and they decide to 'wait and see' if the issue will resolve itself overnight.
- There should at least be Doctors at STDH for twelve hours a day.
- Children to be paramount; the options should focus on delivering safe care always and in the most efficient way.
- Transport and travel and the appropriate care of children and young people when they are unwell. This was most specifically articulated around the issue of 'out of hours' for Option One either accessing adult A&E or travelling to Sunderland.

5.3 Strategic alignment and external clinical view of the options

A number of national policy, clinical standards and strategies have been reviewed during the design process to assess the strategic alignment of the proposed paediatric changes. These include:

- Standards for Short Stay Paediatric Assessment Units, RCPH, 2017
- Facing the Future: standards for Acute General Paediatric Services, RCPCH, 2015
- Facing the Future: Together for Child Health, RCPH, 2015
- Defining Staffing Levels for Children and Young People's Services – RCN standards for clinical professionals and service managers, RCN, 2013
- Standards for the Care of Critically Ill Children, Paediatric Intensive Care Society, 2012.
- Standards for the Care of Critically Ill Children, Paediatric Intensive Care Society, 2015 (Reviewed post-consultation)

Both paediatric options have been assessed against their ability to deliver core strategic aims and clinical standards in these documents with the medical workforce consolidation benefits making the greatest contributions to achieving these.

The proposals are also supportive of local delivery of the National Urgent and Emergency Care Review which aims to ensure right places, response, high quality care for all, including the most critically ill and injured children.

Children's services are being reviewed as part of the Northumberland, Tyne and Wear and North Durham STP to address variation in quality and ensure appropriately balanced hospital based and out of hospital services that will lead to a reduction in secondary care service reliance. Paediatric services are identified within the optimal acute sector workstream priorities of the STP, together with neonatal and special care baby unit services. A view on the strategic alignment of the PtE paediatric proposals has been obtained from the STP clinical lead for paediatrics who has reaffirmed regional challenges around recruiting middle grade doctors and consultant paediatricians. He confirmed the PtE plans are in line with NTWND STP plans to focus on, among others area of paediatric care, acute paediatric service provision, particularly around the location of inpatient beds and sustainability of rotas across the region, together with the efficiency of paediatric support for vulnerable neonatal babies.

In relation to support from neighbouring Trusts and CCGs, formal consultation responses have been received from NHS Newcastle and Gateshead CCG, Newcastle upon Tyne Hospitals NHS Foundation Trust and Gateshead Health NHS Foundation Trust. All of the organisations have expressed broad support for the proposals contained within phase 1 of the programme.

As with the other services under review in phase 1 of the programme external clinical views were sought about the options and their ability to provide safe, high quality and sustainable services. Views were obtained from the Northern Child Health Network and also from the Northern Clinical Senate following a review visit in November 2017. A summary of both of their findings are summarised below.

5.3.1 Child Health Network

Representatives from the Northern Child Health Network reviewed the paediatric options that were consulted upon and gave its formal feedback to help inform the decision making process. The network's response is included at appendix 12.

In its response the network states that the both options are credible attempts to address the significant workforce challenges in paediatrics across both trusts, with the workforce challenges experienced locally and regionally echoing those that are being experienced nationally, particularly at middle grade level. It notes that the removal of medical rota allows immediate operational pressures to be addressed whilst moving towards RCPCH College standards of a 1:10 rota.

The response goes on to acknowledge that consultant workforce arrangements are dependent on attractiveness of service model with larger teams continuing to be more attractive in terms of recruitment and retention, as also outlined in the case for change section I this report.

The view of the network is that option 2 is most likely to deliver long-term workforce sustainability due to the concentration of paediatric acute emergency services onto a single site and is likely to support medical staff retention. Alternative workforce models in the form of nurse practitioners also reduce clinical risk and enhance service sustainability. The network added that greater staff retention and sustainability could potentially be achieved for option 1 if senior medical staff are rotated through both South Tyneside and Sunderland hospital sites.

Importantly, they identified no issues to question the safety and clinical efficacy of the proposals and their view was that both options are in line with the available clinical evidence base and are informed by appropriate clinical standards.

Overall they believe that the options put forward will provide a safer, more sustainable alternative to what is delivered at present, particularly given the current reliance on locum medical staff.

5.3.2 Northern England Clinical Senate

A full report from the Northern England Clinical Senate in relation to their review of the paediatric options is included as appendix 13. During their visit to evaluate the models that had been proposed and subsequent report, the clinical senate review

team acknowledged that the current services on both the Sunderland and South Tyneside sites were clearly staffed by medical and nursing teams passionate about providing high quality urgent and emergency paediatric services for their populations. However the challenges faced in maintaining sustainable services were evident and reflect similar challenges faced by paediatric services across the country.

The senate team also acknowledged that the two options that went forward to public consultation had tried to address the workforce challenges that the services face, although both would still require some further work to address risks to service delivery through the implementation process. However, given the fragile state of the current services, they concluded that change was necessary and a decision did need to be made to provide certainty for current and prospective staff to best support recruitment and retention.

In terms of the senate review team's findings for option 1, they agreed that it was reasonable to consider the overnight closure of the STDH PED and CSSAU due to low levels of activity during these hours and providing a service through the night for this small number of cases is not best use of staff when the service faces workforce challenges. The team commented that the medical model in option 1 was most closely aligned to the current clinical evidence base for the provision of urgent and emergency paediatric services and also replicates other models already working in other areas.

In terms of risks, the review team felt that attention should be paid in the implementation planning to ensure that unwell children do not inappropriately present to South Tyneside outside the hours of work of the paediatric service and that there are plans for safe transfer of any such children to Sunderland. However they acknowledged that it is likely that occasional sick children requiring immediate emergency management may present to South Tyneside. It would therefore be necessary that the adult emergency department clinicians maintain their emergency paediatric skills including advanced paediatric life support (APLS) to ensure safe management and stabilisation of children prior to transfer to Sunderland where appropriate. Despite this, the review team thought that option 1 was the closest to being a workable solution and could potentially be implemented incrementally to build confidence in it, should this become the preferred option following the decision-making stage of the process.

With respect to option 2 the review team found that there were unquantified risks associated with this model that would need to be addressed. From the discussion with the nursing staff from STDH, the team felt that staff lacked confidence in their ability to make this model work in practice, whilst maintaining their current risk threshold in the management of patients. This lower risk threshold would see an increase in transfers to SRH and therefore an increase call volume to NEAS. The review team also thought that greater clarity needs to be given on how the members

of staff working out of the STDH site would maintain their competence and how this model would attract future workforce and how new staff will be trained in this option. As in option 1, the transport and transfer arrangements needed further work to manage the risk of self-presenting patients (particularly out-of-hours) that require conveyance from STDH to SRH.

Other observations and recommendations made by the review team included:

- Whichever option the programme ultimately decide to implement, an effective communications strategy would need to be developed, with clear and consistent messaging given to the population of South Tyneside to make them aware of how to access the most appropriate service in the new configuration.

- The CCGs work with primary care and out of hours' providers to ensure that clinicians have the appropriate level of skills and capacity to manage paediatric demand on the hospital based services.

- That clear governance and safeguarding arrangements are made for the new configuration regardless of option selected.

In response to the senate's findings further work has been done looking at the medical rota for option 1. The revised model now has a consultant delivering care in the PED at STDH from 8am-10pm 7 days a week. This strengthens the model in terms of having more certainty of a senior medical decision maker being present in the department and brings associated benefits in terms dealing with sick children and safeguarding concerns. There is also an added benefit in that elective work will be protected as consultants wouldn't need to cancel activity on an ad-hoc basis to cover middle grade shifts when locums aren't available. Work has also been done in terms of developing an outline communications strategy to ensure there is consistent messaging given to the population of South Tyneside to make them aware of how to access the most appropriate service during the implementation of whichever option is chosen. This is included as appendix 9.

The main area of concern raised by the senate related to clinical transport as the full impact assessment from NEAS wasn't available to them at the time of their visit. The programme has had a continuous dialogue with NEAS since September 2016 on all of the phase 1 services and further in depth impact assessment work has been done since the senate visit. This has been reflected in the full NEAS impact assessment for phase 1 which is included as appendix 14.

5.4 Summary of TIA

The information below summarises the Travel Impact Assessment (TIA) for Paediatric services. More comprehensive information can be found appended as appendix 4.

South Tyneside parents who currently take their child to STDH Paediatric Emergency Department will be the main population group affected, particularly between the hours of 22:00 and 08:00 when no Paediatric ED or nurse-led minor injury or illness service will be available at STDH.

The analysis of the postcodes of previous paediatric patients living in South Tyneside and treated at STDH shows that the public transport journey time to SRH (instead of STDH) increases on average by 18-20 minutes depending on the time of day. Journeys by car to SRH, instead of STDH, will take around 8-11 minutes longer on average.

For option 1 (provision of a seven-day, 12 hour 8am to 10pm paediatric ED and CSSAU at STDH), the travel survey suggests that parents/guardians would use slightly different ways of getting to SRH as compared to STDH, with more using bus and metro, and less driving by car. There would be a small increase in parking demand at SRH, but this would be overnight, when there is plenty of spare capacity and would not add a significant level of traffic onto the local road network (based on the results collated from the travel survey).

For Option 2 (development of a nurse-led minor injury or illness service open 08:00 - 22:00), the impact would be broadly similar and small increases in parking demand at SRH would be expected.

5.5 Summary of IIA

The baseline IIAs for Stroke, Obstetrics and Gynaecology and Paediatric services were commissioned from an independent consultant in early 2017 to inform the evaluation of the options prior to them being agreed as appropriate options to be taken forward to public consultation. These IIAs have been tested during public consultation for relevancy and addendums produced in January, 2018 to reflect further evidence, assessment and findings. Below are the main findings for paediatric options.

5.5.1 Equality Impact

The baseline paediatric IIA identified positive impacts of the proposed changes for communities across both South Tyneside and Sunderland with protected characteristics. The post-consultation IIA review and update review did not identify additional impacts on equality groups or differences in scale or nature of the impacts previously identified. It also did not identify any other vulnerable group which would be vulnerable to the proposed changes in service provision.

The final IIA therefore concludes that both proposed solutions have the potential to transform the provision of high quality acute paediatric services with all equality groups benefiting equally across Sunderland and South Tyneside. The following groups are likely to be most vulnerable to the drawbacks associated with the proposed paediatrics options:

- Children, carers and families affected by socio-economic deprivation,
- Children, carers and families affected by substance or alcohol misuse
- Children, carers and families affected by physical or mental illness, disability or sensory impairment
- Infants and young people
- BME communities
- Children in need of safeguarding
- Pregnant and recently delivered mothers and their babies

It highlights that teenage children are a specific sub group to consider in terms of their specific needs around accessing timely and convenient care.

Final equality scores for the paediatric options are in table 5-7. Where scores are slightly lower for option 2, this is the result of the impact affecting more people, with equality groups in South Tyneside most likely to be affected because of the changes ranging to service availability.

Table 5-7. Final Equality Scores (Urgent and Emergency Paediatrics).

Equality group	Total Equality Impact Scores	
	Option 1	Option 2
Sex/ gender	6	6
Sexual orientation	9	9
Gender reassignment	9	9
Race	6	3
Marriage and civil partnership	9	9
Pregnancy / maternity	7	5
Religion or belief	9	9
Disability	6	3
Socioeconomic deprivation	6	3
Age	6	3

5.5.2 Health and health inequalities impact assessment (paediatric urgent and emergency care)

The HIIA indicated that both options have the potential to result in significant gains to population health and inequalities. These gains largely relate to use of, and access to, acute paediatric services rather than economic or environmental determinants. Moreover, the total positive HIIA impact scores were very similar for both options – 130 for option 1 compared with 133 for option 2. The slightly higher score for option 2 related to its potential to achieve greater cost efficiencies.

The review and update of the IIA highlighted no issues from the public consultation that had not already been comprehensively considered in the baseline IIA. Additional NEAS response times data was reviewed and considered in relation to the health and health inequalities aspects of the proposed paediatrics changes. This led to a slight change in the overall score for option 2 as a result of a slightly bigger negative impact on health inequalities being identified for vulnerable groups. It also recommended that the paediatrics IIA be considered alongside the obstetrics and gynaecology IIA, given the interdependencies of both services with the special care baby unit. The final equality impact scores are highlighted in table 5-8.

Table 5-8. Final health and health inequality scores (Urgent and Emergency Paediatrics).

	Option 1	Option 2
Baseline HIIA scores	**79**	**45**
Updated HIIA scores	**79**	**43**

5.5.3 IIA considerations for implementation

The baseline IIA highlighted a number of drawbacks to the proposals, although it emphasised that the identified drawbacks were rarely significant enough to offset the strongly positive health benefits identified. Some of potential mitigating considerations are listed below.

- Patient and public information campaigns could be developed and targeted to promote understanding and enable service users to adapt to the changes in the face of a child with an acute illness and ensure care can be given in the right place at the right time.
- A cross-area young people's user group could be supported to champion the views and needs of young people.
- Introducing oversight arrangements could ensure scrutiny of equity and user experience data and ensure that this information is translated into timely and appropriate service developments whenever necessary.

- Community engagement and development schemes could be implemented to build the capability and confidence of children and their parents and carers to self-care and use health services appropriately, for example, the provision of education interventions in schools and the community.
- Working groups to consider the needs of the protected characteristic groups identified in the IIA.
- New oversight arrangements could monitor user satisfaction and critical incidents relating to service continuity and coordination for all users, especially vulnerable groups and ensure that this information is translated into service developments as appropriate and necessary.
- New oversight arrangements could monitor equity of access audit data for each service and ensure that this information is translated into timely and appropriate service developments whenever necessary.
- Commissioners will inevitably monitor and evaluate the ongoing performance of these providers and ensure service improvements as necessary.

5.6 Evaluation against decision making categories

In relation to the safety and quality evaluation, a number of key clinical reference documents were used by the design team including Facing the Future: Together for Child Health', RCPCH 2015, 'Defining staffing levels for children and young people's services - RCN standards for clinical professionals and service managers', Royal College of Nursing, 2013 and 'Standards for the Care of Critically Ill Children', Paediatric Intensive Care Society, 2012. When assessing the options against this guidance and the 34 clinical standards that were drawn from these, 21/34 standards were met under option 1 and for option 2: 23/34 standards were met. Both options improved on the current baseline assessment for STDH. But option 2 improved on the baseline for SRH.

In relation to clinical transport, it is likely that there will be some onward conveyance from STDH to SRH both for those patients who need admitted for longer periods of assessment and also for those patient/families who attend STDH when the service is not available. This is more of a risk for option 2 and guarantees from NEAS that the unit would not be regarded as a 'place of safety' are welcomed.

Both options meet the requirement of improving clinical sustainability as there is less reliance on middle grade doctors. However option 1 only partly addresses the problem at STDH with currently only 2 doctors working on the middle grade rota. Further work has been carried out looking at the extra consultant resource required to staff the department up until 10pm and thus always being able to have senior medical staff on site 7 days a week regardless of whether a middle grade is available or not. Whilst there are no guarantees that the extra posts required to provide this cover could be recruited to, having one single team serving both populations will help with staff recruitment and retention of senior medical staff.

The view of the Child Health Network is that option 2 is the most likely to deliver long-term workforce sustainability due to the concentration of paediatric acute emergency services onto a single site. For option 2 however, additional Advanced Nurse Practitioners would be needed which introduces a staffing pressure with a long lead-in time to train extra staff.

There are still some concerns about the current staffing levels at SRH being able to deal with the increased demand in option 2. The original case mix analysis for option 2 (the development of the nurse practitioner model at STDH) showed that a high percentage of paediatric attendances appeared to be treated for relatively minor conditions, with the main disposition of patients being discharged back to their GP without any follow up. The - below shows this in more detail.

Table 5-9. PED presentations and outcomes, STDH.

Top 5 presentations and key outcomes	Number	Discharge to GP	Admit to PSSAU	Admitted to another hospital	Seen and treat by a GP	Referred to a F/U Clinic / other professional
'Unwell child'	5,161	2,977	695	26	1,141	209
Limb problems	3,717	2,629	55	3	58	449
Head injury	1,188	1,038	98	10	9	30
Rash	1,101	550	55	2	435	32
Shortness of Breath	992	577	215	4	104	11
Total	**12,159**	**7,771**	**1,118**	**45**	**1,747**	**731**
As a % of totals for disposal		**64%**	**9%**	**0.3%**	**14%**	**6%**

The analysis shows that 14% of PED presentations at STDH are already managed in the urgent care hub and 64% discharged to GP. However, despite this there were concerns raised that this may have overestimated the proportion of patients that could be seen by the nurse practitioners at STDH and the potential capacity problems this could cause at SRH. Therefore, additional analysis has taken place looking at the number and type of investigations and treatments that are undertaken on the current cohort of patients treated at STDH. The table below looks at the patients treated in 2017.

Table 5-10. Number of investigations carried out per patient in 2017, PED at STDH.

Investigations	Grand Total
0	10769
1	3982
2	325
3	243

4	155
5	89
6	28
8	2
9	1
(blank)	526
Grand Total	**16120**

The proportion of patients with no investigations is 67% and over 90% for one or fewer investigations. Using this as a surrogate for case mix would suggest (as the original disposition analysis did) that the majority of patients could be seen in a nurse practitioner led service and this providing reassurance around the original estimate activity shift in option 2.

In relation to the evaluation against the accessibility and choice decision making category there is an acceptance that patient choice will have to be reduced in part given the significant medical workforce pressures, particularly at STDH.

With that in mind there is more confidence in option 1 achieving the evaluation category, particularly with respect to choice by still having a PED at STDH for part of the day.

In either option outpatient services would be still delivered in both localities with the aim to deliver more specialist clinics from STDH.

In terms of deliverability, all options align strategically to both the national and local direction of travel.

A view on the strategic alignment of the PtE paediatric proposals has been obtained from the STP clinical lead. They confirmed the PtE plans are aligned with STP plans to focus on acute paediatric service provision, particularly the sustainability of rotas across the region.

The feedback from the clinical senate would suggest a greater degree of confidence of the deliverability in the short term of option 1, with more clinical pathway development and potential training for the nurse practitioners required for option 2. However concerns exist in relation to workforce availability for middle grades in option 1 and the need for a consultant delivered model, with concerns around the availability of nurse practitioners for option 2.

At the point of hurdle criteria assessment, it was judged that option 2 would be deliverable within the 1-2 year timeframe and hence this option was put forward for consultation. However, through that consultation with patients, public, staff and stakeholders, in addition to the external clinical scrutiny and assurance from the

Northern Child Health Network and Northern England Clinical Senate in particular, it has become clear that, while option 2 is likely to be the most sustainable in future, there is greater work to do in the short-term to ensure it is deliverable. This work will need to include development of the nurse practitioner workforce and consideration around medical input.

With respect to system wide capacity assurances the programme has had confirmation from other local providers (NuTH and GHFT) that they have sufficient capacity to absorb the modelled changes in patient flows.

For health inequalities the Integrated Impact Assessment (IIA) provides strong evidence that both options could achieve overwhelmingly positive impacts on health and inequalities. These benefits relate to the ability of the changes to result in more sustainable and consistent high quality care, regardless of the day of the week of the time of day; safer care due to improved levels of specialist staffing able to assess and treat children promptly; improved levels of specialist staff and resources able to deal with rising population needs in terms of scale and complexity; and finally cost savings.

Ultimately, because of the benefits for all service users as well as vulnerable and equality groups, the proposed service improvements could lead to significant benefits to child health and inequalities across South Tyneside and Sunderland.

Both options failed to meet a high degree of confidence for the value for money evaluation category. As the service would still make a loss when comparing the income and expenditure for the service, calling into question the longer term financial sustainability of the service in either of the options. However option 1 (incorporating the revisions around staffing models) would cost £94,000 less to provide the service than was spent in 2016/17. This would be £587,000 for option 2.

Both options would require £250k of capitals costs relating to the centralising of SCBU on the SRH site.

In summary both options, whilst significantly improving the vulnerability of the paediatric service at STDH, still have some risks around workforce sustainability and availability.

6.0 Stroke Services

This section of the decision making report summarises the options that were consulted on, the information considered as part of the decision making process, and an evaluation for each of the three options for stroke.

6.1 Options summary

The proposed stroke services reconfiguration options mean the rationalisation of all hyperacute stroke admissions to SRH from South Tyneside but with different configurations relating to how patients will receive their care following the hyper acute phase of their stroke. Residents who currently access stroke care at SRH would continue to do so.

Table 6-1. Outline of current and proposed reconfiguration models for stroke.

Current service configuration:		
Pre-December, 2016: acute stroke care and full stroke inpatient pathway at both STDH and SRH Post-December, 2016: all acute strokes being redirected to SRH with the consolidation of all inpatient stroke care at SRH as part of temporary arrangement		
Option 1: *All acute strokes being redirected to SRH with the consolidation of all inpatient stroke care.*	**Option 2:** *All acute strokes being redirected to SRH with the repatriation of South Tyneside patients back to STDH after 7 days.*	**Option 3:** *All acute strokes being redirected to SRH with the repatriation of South Tyneside patients back to STDH after 72 hours.*
- All suspected strokes within the South Tyneside area will automatically be re-routed to SRH via a NEAS bypass. - Acute stroke patients self-presenting to STDH to be redirected to SRH via ambulance once the appropriate treatment is given. - For inpatients at STDH who suffer a suspected stroke a telephone call will be made to the on call stroke physician at SRH to discuss transfer and review within 24 hours. - Stroke mimics with a predicted long length of stay will be repatriated to STDH. - ***Patients from both Sunderland and South***	- All suspected strokes within the South Tyneside area will automatically be re-routed to SRH via a NEAS bypass. - Acute stroke patients self-presenting to STDH to be redirected to SRH via ambulance once the appropriate treatment is given. - For inpatients at STDH who suffer a suspected stroke a telephone call will be made to the on call stroke physician at SRH to discuss transfer and review within 24 hours. - Stroke mimics with a predicted long length of stay will be repatriated to STDH. - ***Repatriation of South Tyneside patients to STDH***	- All suspected strokes within the South Tyneside area will automatically be re-routed to SRH via a NEAS bypass. - Acute stroke patients self-presenting to STDH to be redirected to SRH via ambulance once the appropriate treatment is given. - For inpatients at STDH who suffer a suspected stroke a telephone call will be made to the on call stroke physician at SRH to discuss transfer and review within 24 hours. - Stroke mimics with a predicted long length of stay will be repatriated to STDH. - ***Repatriation of South Tyneside patients to STDH***

Tyneside will have their acute and rehabilitation phases at CHSFT before being discharged to their respective community stroke teams.	***for rehabilitation would happen following 7 days for those patients requiring longer stays in hospital***	***for rehabilitation would happen following 72 hours for those patients requiring longer stays in hospital.***
- Daily high risk TIA clinics will be delivered at CHSFT with low risk clinics being delivered at STDH.	- Daily high risk TIA clinics will be delivered at CHSFT with low risk clinics being delivered at STDH.	- Daily high risk TIA clinics will be delivered at CHSFT with low risk clinics being delivered at STDH.

The preferred option agreed by CSRG at the pre-consultation stage for stroke was option 1, based on clinical data and feedback from clinical teams that demonstrated that the option would deliver the biggest quality benefit for patients across South Tyneside and Sunderland.

6.2 Summary of stroke services consultation feedback

The independent analysis of the quantitative consultation feedback showed that option 1 was the preferred stroke option with 59% of all respondents in the resident street survey, 25% in the online/paper survey and 38% of the direct patient survey stating that it was closest to meeting their needs. More South Tyneside people responding to the resident street survey favoured option 1 but slightly more South Tyneside people responding to the online/paper survey felt that option 3 was closest to meeting their needs. More people from South Tyneside completing the direct patient survey preferred option 3, however the independent analysis highlights that responses to this survey were low and therefore must be treated with caution.

The independent consultation feedback showed that option 1 is most likely to meet the needs of both sexes, however men rated this more likely than women. Option 1 was preferred by all age groups in the resident street survey and by over 25s completing the online survey with the exception of those in the 35-44 age bracket who preferred option 3. Option 1 was preferred by those aged over 65 and under 45 completing the direct patient survey with option 3 preferred by those in the 45-54 age bracket and options 1 and 3 preferred by those aged 55-64.

The breakdown of preferences by area and consultation methodology is at table 6-2, 6-3 and 6-4.

Table 6-2. Resident street survey consultation feedback on proposed stroke options by area.

	Closest to meeting needs				Farthest from meeting needs			
	South Tyneside		Sunderland		South Tyneside		Sunderland	
Option 1	61%	190	77%	288	37%	107	9%	32
Option 2	2%	6	3%	13	14%	41	44%	161
Option 3	37%	116	20%	74	49%	142	48%	177

** calculations are based on the percentage of respondents living in in each area (column totals), variances are explained by those who preferred not to say/other area and consequently are not counted.*

Table 6-3. Online/paper consultation feedback on proposed stroke options by area.

	Closest to meeting needs				Farthest from meeting needs			
	South Tyneside		Sunderland		South Tyneside		Sunderland	
Option 1	38%	25	69%	22	52%	37	17%	5
Option 2	17%	11	16%	5	13%	9	17%	5
Option 3	45%	30	16%	5	35%	25	66%	19

** calculations are based on the percentage of respondents in each area (column totals), variances are explained by those who preferred not to say/other area and consequently are not counted.*

Table 6-4. Direct patient survey feedback on proposed stroke options by area.

	Closest to meeting needs				Farthest from meeting needs			
	South Tyneside		Sunderland		South Tyneside		Sunderland	
Option 1	38%	6	94%	17	73%	8	10%	1
Option 2	6%	1	0%	0	9%	1	10%	1
Option 3	56%	9	6%	1	18%	2	80%	8

** calculations are based on the percentage of respondents living in in each area (column totals), variances are explained by those who preferred not to say/other areas and consequently are not counted.*

The independent analysis of the qualitative consultation feedback highlighted how the public shared views on the following:

- Concerns about the capacity at SRH to cope with extra stroke patients
- Concerns around the timeliness of stroke treatment amid a perceived applicable 'golden-hour' and the ability of the ambulance service to support this
- A recognition that access to specialist stoke care was important and therefore a positive element of the proposed changes
- Concerns about the potential negative impact for stroke patients in relation to the repatriation stroke options (options 2 and 3), in terms of the added step in the patient journey, leading to fragmentation, adverse outcomes and longer stay in hospital
- The need for clear service models in relation to care for patients experiencing a transient ischemic attack (TIAs) (often known as a mini-stroke)

6.3 Strategic alignment and external clinical view of the options

The PCBC demonstrated the strategic alignment of the stroke service proposals with national and regional stroke policy and strategy. This includes the NHS Five Year Forward View's recommendations around greater stroke care consolidation and the Northern England Cardiovascular Disease (CVD) Clinical Network's recommendation of a reduction to six hyper-acute stroke units across Cumbria and the North East in order to deliver optimal clinical outcomes.

This alignment has been reinforced through external clinical views that have been obtained as part of the consultation process. The Northern Cardiovascular Clinical Network's formal submission to the consultation (through the Clinical Lead for Stroke) stated that it supported the move to a single hyper-acute stroke unit, and furthermore it aligns to the strategic direction set by the network in their publication, *Resilience and Future-proofing Stroke services for the North East and North Cumbria* attached as appendix 7.

NHS England's National Clinical Director for Stroke (Professor Tony Rudd) has also reviewed the proposals and strongly supports the preferred option. In his formal response Professor Rudd concluded that the consolidation of the hyper-acute part of the stroke pathway would deliver `*much-needed improvements in local stroke care for your local population, contributing to both workforce stability and the achievement of a critical mass of patients*`. As with the local view, he also noted that the PtE proposals were in keeping with the local clinical network`s recommendations on the consolidation of hyper-acute stroke care across the wider Cumbria and North East area. The full response is contained in appendix 8.

6.4 Summary of the TIA

The information below summarises the TIA for stroke services. More comprehensive information can be found appended to this report as appendix 4.

The conclusion of the TIA for stroke is that it is visitors who will be most affected, as the majority of acute stroke cases arrive at hospital by emergency ambulance. Therefore, visitors will be required to travel to SRH, rather than STDH, to visit friends or family. The number of days that visitors will be required to travel to SRH, instead of STDH, will depend on the final service option taken forward for implementation.

Amongst the South Tyneside population aged 60+ (the category of population most at risk from a stroke), and depending on the time of day and direction of travel, the average public transport journey time to STDH is 24-26 minutes, whilst for SRH it is 42-47 minutes. This suggests an increase in the average journey time by public transport of 18-21 minutes for those affected South Tyneside residents. The analysis of the postcodes of previous stroke patients living in South Tyneside and treated at STDH shows that the average public transport journey time to SRH (instead of STDH) would increase by 20-25 minutes, reinforcing the findings from the census

data analysis. For journeys by car to SRH, instead of STDH, the average increase in travel time will be between 9 – 11 minutes longer.

The Visitor Travel Survey results suggest that following the temporary location of acute stroke services to SRH, around 40% travel by car on their own and a further 57% travel in the car with others. The remainder travel to SRH by bus.

The relocation of stroke services to SRH is estimated to have a very small impact on parking demands (and by extension on the local road network), with just 1-2 additional vehicles during afternoon visiting hours, and 2-6 vehicles during evening visiting time (based on the results collated from the travel survey).

6.5 Summary of the IIA

As described in section 3.4.1, baseline IIAs for Stroke, Obstetrics and Gynaecology and Paediatric services were commissioned from an independent consultant in early 2017 to inform the evaluation of the options prior to them being agreed for public consultation. These IIAs have been tested during public consultation for relevancy and addendums produced in January 2018 to reflect further evidence, assessment and findings. Below are the main findings for stroke services.

6.5.1 Equality Impact

The baseline IIA identified strongly positive impacts of the proposed stroke changes for communities across both South Tyneside and Sunderland with protected characteristics. The post-consultation IIA review and update did not identify additional impacts on equality groups or differences in the scale or nature of the impacts previously identified. It also did not identify any other group which would be vulnerable to the proposed changes in service provision.

The final IIA therefore highlights that the following groups are likely to be most vulnerable to the drawbacks associated with the proposed stroke options:

- Black Minority and Ethnic (BME) communities
- Disability groups
- Socioeconomically deprived communities
- Older people

While the drawback risks apply to all vulnerable groups across South Tyneside and Sunderland, they are more likely to apply to South Tyneside communities, given the nature of the proposals. However the IIA shows that the vulnerable communities are equally likely to realise the benefits of the proposed changes, as are all equality groups.

Final equality impact assessment scores are summarised in Table 4-5. Equality impacts are of a similar scale and nature for stroke options 1 and 2, but negative

impacts were slightly less for option 3 given the limited travel and cost impact for affected communities.

Table 6-5. Equality Impact Scores (stroke).

Equality group	Total Equality Impact score		
	Option 1	Option 2	Option 3
Sex/ gender	8	8	8
Sexual orientation	9	9	9
Gender reassignment	9	9	9
Race	5	5	7
Marriage and civil partnership	9	9	9
Pregnancy / maternity	7	7	7
Religion or belief	9	9	9
Disability	5	5	7
Socioeconomic deprivation	5	5	7
Age	3	3	6

6.5.2 Health and Health Inequalities Impact Assessment (HIIA)

The baseline IIA for stroke identified positive HIIA impact scores for option 1 but negative for options 2 and 3. The review and update of the IIA confirmed that the majority of the consultation concerns have been comprehensively reflected in the baseline IIA. One exception was concerns around North East Ambulance Service (NEAS) capacity and response times, but NEAS has provided formal written confirmation of ability to deliver the options proposed. Although the baseline IIA had assessed available NEAS data at the time, further, more up to date performance data was sought and used to review and revise the HIIA scores.

While this resulted in some changes to the HIIA scores, as per table 4-6, this did not alter the overall conclusions of the IIA. The IIA highlights how, while the repatriation elements of options 2 and 3 may be attractive to people who wish to see stroke care as close to home as possible, this would be at the expense of the highest possible specialist stroke care. This is because neither option 2 nor 3 could achieve the recommended levels of specialist stroke professionals which are essential to deliver a fully staffed stroke ward and improved outcomes after a stroke.

Table 6-6. Final Health and Health Inequalities scores (stroke).

	Option 1	Option 2	Option 3
Baseline HIIA scores	**185**	**-13**	**-11**
Revised, final HIIA scores	**173**	**-23**	**-23**

The IIA highlighted clear health and health inequalities benefits across both South Tyneside and Sunderland communities resulting from improved and sustainable levels of specialist medical and allied health professional staff, together with improved and sustainable 24/7 stroke care. These benefits would be felt by vulnerable groups in both CCG areas with anticipated benefits around:

- Reduced mortality
- Reduced morbidity
- Less disability and / or sensory impairment
- Improved quality of life and emotional wellbeing
- Less social dependency
- Improved stroke prevention.

6.5.3 IIA considerations for implementation

The baseline IIA highlighted a number of drawbacks to the proposals, although it emphasised that the identified drawbacks were rarely significant enough to offset the strongly positive health benefits identified. The review of the IIA highlighted a small number of further risk-mitigating action areas for consideration, in light of the consultation feedback, particularly around prioritising any support for helping patients to adapt to the changes for South Tyneside residents and in ensuring that the needs of South Tyneside vulnerable groups were appropriately considered throughout.

The IIA indicates that the suggested mitigating actions are not intended to be a recommendation or an instruction and should be considered with realistic reference to what can be achieved in the face of overstretched resources and the economic pressures on the NHS, hospitals and acute stroke services. Some of the suggested considerations for stroke are listed below.

- Patient and public information campaigns could promote understanding and enable service users can get the maximum benefits from the service reconfiguration.
- Stroke prevention programmes targeting at risk groups (could reduce their stroke risk and further reduce health inequalities).

- Working groups to consider the needs of the protected characteristic groups identified in the IIA.
- Best practice could be adopted in terms of provider handovers and integrated care planning with special reference to the needs of priority equality groups (older people, disabled groups, BME groups, socioeconomically deprived groups).
- Oversight arrangements could ensure scrutiny of user experience data and ensure that this information is translated into timely and appropriate service developments whenever necessary.
- Consider suggestions raised during consultation around parking charges and passes for staff, patients, regular visitors, duration of treatment and separate provision for staff parking.
- Patient safety incident data could be collected, monitored and evaluated.
- Formal modelling could shed light on the future health care needs and the level of capacity required to meet those needs.
- Considering prioritising existing plans to improve early supported discharge work will reduce lengths of stay and free up capacity.

The CCGs have given significant regard to these considerations and potential mitigations, to ensure they are addressed during implementation and to monitor the impact through the implementation process.

6.6 Evaluation against the decision making categories

The following section outlines considerations that have been given and additional work that has been undertaken since the pre-consultation stage of the process. This includes where consultation feedback has indicated a need to review previous information or to obtain new information.

Each of the options have been assessed against the evaluation categories in terms of having a high, sufficient, or low degree of confidence that the options will satisfy the sub-statements below the decision making categories.

Further assessment of the proposed clinical models has highlighted differences in the projected clinical and quality outcomes across the full stroke pathway. This work has focused on the SSNAP data which, as previously explained in the pre-consultation business case for Phase 1, reports on 44 key indicators representative of high quality stroke care. These key indicators are grouped into 10 domains covering key aspects of the process of stroke care. Both patient-centred (PC) domain scores (scores attributed to every team that treated the patient at any point in their care) and team-centred (TC) domain scores (scores attributed to the team considered to be most appropriate to assign the responsibility for the measure to) are calculated. The themes covered by the SSNAP domains are:

Domain 1: Scanning

Domain 2: Stroke unit

Domain 3: Thrombolysis

Domain 4: Specialist assessments

Domain 5: Occupational therapy

Domain 6: Physiotherapy

Domain 7: Speech and language therapy

Domain 8: Multidisciplinary team working

Domain 9: Standards by discharge

Domain 10: Discharge processes

Each domain is given a performance level A to E, and a total key indicator score is calculated based on the average of the 10 domain levels for both patient-centred and team-centred domains. A combined total key indicator score is calculated by averaging the patient-centred and team-centred total key indicator scores.

The investment in extra specialist nurses and net increase in therapy time at SRH as outlined in option 1 would have a significant improvement in the overall SSNAP score and particularly in the following domains:

Domain 4: Specialist Assessments
Domain 5: Occupational Therapy
Domain 6: Physiotherapy
Domain 7: SALT
Domain 8: MDT
Domain 9: Discharge Standards

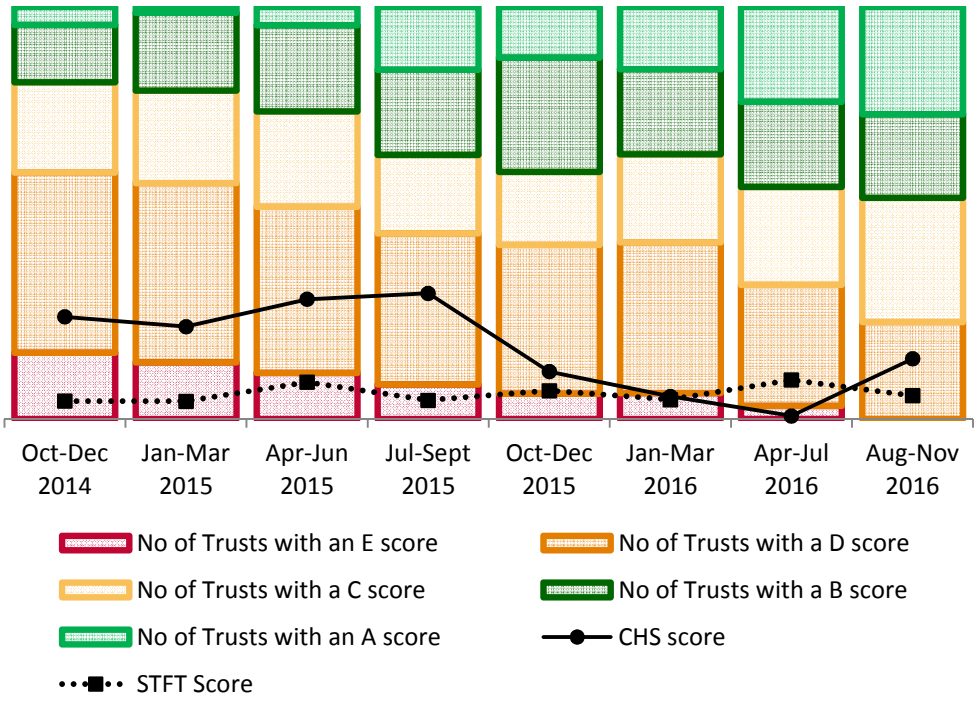
In total 24 out of the 44 separate indicators would be directly improved by the extra specialist nurse and therapist resource. The impact of these improvements has been estimated below. This impact could not be achieved in options 2 or 3 without investment in more senior medical and therapy staff however even if the funding was to be available there is little realistic prospect of recruiting those staff, particularly medical staff, given the recruitment challenges experienced to date.

Table 6-7. Projected SSNAP scores if option1 is fully adopted.

Trust/score	D1: Scanning	D2: stroke Unit	D3: Thrombolysis	D4: Specialist Assessments	D5: Occupational Therapy	D6: Physiotherapy	D7: SALT	D8: MDT	D9: Discharge standards	D10: Discharge Process
SRH	**C**	**B**	**B**	**A**	**A**	**A**	**A**	**A**	**B**	**A**

During 2015 (which was the time period for looking at the baseline data when the case for change for the stroke changes was started to be developed) SSNAP scores

generally improved across England over time with a greater proportion of Trusts gaining an 'A' or B score. However this was not the case for SRH, whilst they generally maintained a 'D' score, their relative position in that cohort of Trusts deteriorated. This was also the case for STDH. The graph below shows the relative performance over time and into 2016.



In 2016 given the vulnerability of the stroke service at STDH due to the ongoing senior medical staffing pressures the difficult decision was taken to centralise stroke at SRH on a temporary basis. This temporary change was implemented on the 5th December 2016. The table below shows the aggregate position at CCG level since the temporary change.

Table 6-8. SNNAP performance 2016-2017.

CCG	***Apr-Jul 2016***	***Aug-Nov 2016***	***Dec 2016-Mar 2017***	***Apr-Jul 2017***
South Tyneside	**E**	**D**	**C**	**D**
Sunderland	**D**	**D**	**C**	**D**

At an aggregate level, whilst some improvement can be seen in the period December 2016 - March 2017 it would be overly simplistic to draw conclusions from this. This is because the temporary model that was put in place was not a full implementation of option 1. However as demonstrated in table 2-1 we have already

seen dramatic improvements across a number of metrics in the front end of the stroke pathway for South Tyneside patients.

A number of key features of stroke option 1 were also not fully in place until after the last published data (April-July 2017). The remaining elements of the full model to be implemented include:

- **24/7 Stroke nurse practitioner cover.** Internal audit data shows that having a nurse practitioner facilitating the front end of the stroke pathway in the emergency department results in more timely assessment and treatment. For example the median time to initial assessment is 10 minutes and 55% of thrombolysis is carried out in 60 minutes with a nurse practitioner present compared to time to initial assessment of 24.5 minutes and only 10% of patients receiving thrombolysis within 60 minutes when they are not. A 24/7 stroke nurse practitioner was not achieved at SRH until November 2017.

- **Therapy levels.** As highlighted earlier in this section the SSNAP scores are heavily influenced by the amount of therapy time (and therefore resource needed) each patient receives, with 6 out of the 10 domains either directly or indirectly influenced by the therapy resource available. The therapy levels at SRH were not up to the levels included within the PCBC until the end of the summer 2017, and therefore it is expected that associated therapy related benefits will feature in the next set of data due to be published in summer, 2018.

It is clear from the analysis of the most recent SSNAP data that the full implementation of option 1, would give the best chance of achieving optimal quality and safety standards, with planned staffing levels in place to achieve an overall A or B standard for a single stroke unit at SRH. The benefits of access to specialist stroke care outweigh additional travel times for South Tyneside patients. The North East Ambulance Service has also confirmed that the additional 12-minute drive time for suspected stroke patients from South Tyneside is within the clinical time threshold of 4.5 hours for patients eligible for thrombolysis, confirming the safety of all three stroke options.

As has been highlighted in section 6.3, there is a lack of external clinical assurance for stroke options 2 and 3, with regional and national stroke experts advocating the centralising of stroke care at the SRH site.

Further clinical consideration has been given to the benefits and risks of repatriating South Tyneside stroke patients to South Tyneside after their hyperacute or acute period of care, as per options 2 and 3. This follows some public and staff concerns raised during consultation of the negative impacts of transferring potentially frail elderly patients between hospital sites, leading to a poorer experience and potential

outcome for the patients and risks of a longer hospital stay. Clinical teams have confirmed that some stroke patients can still be medically unwell after a 7 day period whilst some patients are frail with existing co-morbidities. Transferring such patients could hamper their recovery, certainly in the short term. Additionally, the transfer process itself adds to a longer length of stay, which again, can hamper recovery. The transfer of patients would also require additional non-urgent ambulance journeys.

The proposed model for transient-ischemic attacks (TIAs) has been revisited in light of consultation feedback. Clinicians have confirmed the deliverability of a daily high risk clinic from SRH for both populations with a weekly low risk clinic at STDH, under all options.

Further analysis of the workforce required to deliver the proposed models has been undertaken to inform an assessment of their clinical sustainability. Health Education England North East is supportive of the models. Options 2 and 3 would continue to require an additional stroke consultant to be in post to support the capacity requirements under a split-site stroke model. It is difficult to see successful recruitment to such a post, given the failed recruitment efforts between 2014 to the end of 2016 which threatens the services sustainability, even in the short term. Options 2 and 3 are also likely to have difficulty in recruiting and retaining senior therapy and specialist nurse posts. Option 1 is likely to be more clinically sustainable, given the consolidation of medical, nursing and therapy staff on to a single site.

For the deliverability category, all options align strategically to both the national and local direction of travel in reducing the number of hyper-acute stroke units in the region in order to help improve specialist care for people who suffer a stroke. All relevant service interdependencies have been assessed.

The implementation of the temporary stroke model has allowed the service to test if the capacity concerns raised during consultation have been a real issue. The stroke clinical and operational teams at SRH have confirmed there have been no capacity constraints since the temporary model's introduction in December 2016. The number of stroke beds has been sufficient, evidenced through the amount of time patients have spent on the stroke ward. This is measured through domain 2 of the SSNAP audit: *2.3 Percentage of patients who spent at least 90% of their stay on stroke unit.* The tables below shows this metric over the last 4-5 years and confirms an improvement since the temporary stroke service consolidation, particularly for South Tyneside residents.

Table 6-9. Performance over time at SRH for the percentage of patients who spent at least 90% of their stay on stroke unit.

Apr 2013-Mar 2014	Apr 2014-Mar 2015	Apr 2015-Mar 2016	Apr 2016-Mar 2017
86.4%	90.2%	91.9%	91.7%

Table 6-10. Performance over time for the percentage of patients who spent at least 90% of their stay on stroke unit for South Tyneside residents.

Apr-Jul 2016	Aug-Nov 2016	Dec 2016-Mar 2017	Apr-Jul 2017
52.5%	71.3%	88.0%	95.4%

As clearly demonstrated, patients across both South Tyneside and Sunderland are spending more time on a specialist stroke unit which supports the view of the clinical team that there are no capacity constraints for stroke patients at SRH.

In relation to non-stroke patients who previously occupied beds on the stroke ward, an extra 12 medical beds have been provided on a separate ward on the SRH site to accommodate these patients and senior managers and clinicians from SRH have confirmed these to be sufficient during the temporary stroke change.

There is however a high degree of confidence about the deliverability of option 1 given that it has already been partially implemented through the temporary change in December 2016. The deliverability of options 2 and 3 is dependent on additional workforce to support their implementation, as outlined above and there is no available investment or likely workforce supply to enable this to happen in a timely fashion.

Options 2 and 3 scored substantially lower than option 1 in the health inequalities category given their lower scores in the Integrated Impact Assessment (IIA). The IIA provided quantitative and qualitative evidence that the proposed changes relating to option 1 could have major benefits for the resident populations including all vulnerable groups.

The key benefit here relates to the ability of this option to improve the quality of stroke care 24/7 by improving and sustaining levels of specialist staff.

The IIA also noted that these improvements can deliver multiple benefits for stroke sufferers and their carers, family and friends including:

- reduced mortality,
- reduced morbidity,
- less disability and / or sensory impairment,

- improved quality of life and emotional wellbeing,
- less social dependency and,
- improved stroke prevention.

All of the options failed to meet a high degree of confidence for the Value for Money evaluation category. This is because the service would still make a loss when comparing the income and expenditure for the service calling into question the longer term financial sustainability of the service in any of the options. When looking at value for money in the wider health economy context it is reasonable to suggest that option 1 would give better outcomes and therefore stroke survivors would have a better quality of life following their care, this is extremely difficult to quantify however. Option 1 would however cost £510,000 less to provide the services when compared to what was spent in 2015/16. Options 2 and 3 evaluated even more poorly as they also require extra substantial investment in therapy staff to ensure that both wards across the two sites were staffed to the recommended levels. This level of investment would be £431,000.

In summary, option 1 has evaluated better than option 2 or 3 against the decision making evaluation criteria.

7.0 Satisfaction of the Four Tests for Service Change

Throughout the service change process, CCGs are required to mind the “Four Tests” for service change set out by (then) Secretary of State for Health Andrew Lansley. The Four Tests are:

- a robust clinical case,
- strong patient and public engagement,
- consistency with choice and competition, and
- GP commissioner support.

An additional test around bed reductions was added in 2017.The information below outlines to the Governing Bodies how the clinical commissioning groups have ensured that the five tests for service change have been met throughout this process

7.1 Clear clinical evidence base

The design process for the options that went to public consultation was clinically led with the relevant clinical directors and senior nurses for each service across the Trusts leading the process. The clinical design teams used a range of reference documents and/or clinical performance data to first benchmark the current services, and then to inform the potential solutions to ensure the proposals had a clear evidence base in relation to improving or maintaining quality. The key reference documents and standards have been highlighted in previous sections of this report. The clinical design teams also looked at other reconfigurations and service models to learn from other organisations where possible.

7.2 Strong patient and public engagement

North of England Commissioning Support have delivered the engagement and consultation work of behalf of the four organisations involved in the programme. The main elements of this work have included:

- Pre-engagement work was used in the design work.
- A comprehensive communications strategy was put in place for public consultation with numerous ways to feed back on the proposals put in place.
- An independent company (SMP) was commissioned to carry out the public consultation analysis. A draft has been shared with the public with a final report expected w/c 15/01/18.
- Oversight from the Consultation Institute has added an extra quality assurance process – on track for best practice.

As described in section 3, details of the engagement, communications and engagement activity undertaken through the service change process are outlined in the Consultation Assurance report which is being considered by Governing Bodies as part of the final decision-making meeting.

7.3 Consistency with choice and competition

Given the significant workforce challenges across all the services in Phase 1, a degree of consolidation of services has been required to deliver more sustainable services. That said, the clinical design teams have tried to protect patient choice where possible. This has included:

- Maintaining low risk TIA activity at STDH.
- Maintaining choice in the Obstetrics and Gynaecology review in terms of the development of a Free-standing Midwifery Led.
- Developing a local nurse practitioner led service in South Tyneside for minor illness and injury as part of the paediatric proposals.

7.4 Support from Commissioners

The options that went to public consultation were fully supported by the CCGs prior to consultation through sign off of the Pre-consultation Business Case with options being approved for consultation by both Executive Committees and Governing Bodies prior to the consultation launch. In addition to this the CCGs took the lead on the public consultation activities with support of the programme team, NECS and Director colleagues from both provider trusts.

7.5 Potential bed reductions

Table 7-1. Bed reduction test summary

Service	Bed closure implications	Evidence to satisfy conditions
Stroke	20 beds would close at STDH under option 1. Beds will be retained under repatriation models within options 2 and 3.	Sufficient alternative inpatient stroke provision (39 beds) is available at SRH to accommodate STDH and SRH stroke activity. Section 6.6 expands on this.
Obstetrics	Full closure of delivery unit beds under option 1 with a partial reduction under option 2.	Increased activity from STDH would be accommodated in an increased number of beds at SRH. Improved discharge pathway to be implemented to support capacity increase. Obstetric beds could not be used for any alternative service.

Gynae	The female surgical beds that are currently used for gynaecology patients at STDH will be retained as surgical beds.	Inpatient bed capacity currently at SRH has the flexibility to increase with staffing establishment already able to deliver this capacity. Modelling confirms capacity to be sufficient to absorb increased inpatient elective and non-elective gynaecology activity.
Paediatrics	No paediatric inpatient beds at STDH. CSSAU beds would be retained at STDH as part of the day-time paediatric service proposed in option 1. The CSSAU beds would close in option 2. Children's Day Unit beds would be retained for paediatric dental surgery.	Children's Short Stay Assessment Unit (CSSAU) will remain at SRH and can absorb additional activity from STDH with average occupancy currently at 46%. 20 beds (plus 6 escalation beds) on SRH paediatric surgical ward is currently at 50% occupancy with sufficient capacity to absorb small number of additional Children's Day Unit surgical, diagnostic, orthopaedic activity from South Tyneside.
SCBU	6 SCBU cots would close at STDH under both proposed options.	The 16 SCBU cots at SRH will absorb displaced STDH activity with some capital work needed to expend the physical capacity.

8.0 Recommendations

In reaching these recommendations, evidence has been taken into consideration from many sources, including:

- Clinical Services Review Group, including views of local staff and clinicians
- Patients, public and staff through the pre-consultation and consultation processes
- Impact assessments from key partners, including North East Ambulance Service
- Independent Travel and Transport Impact Assessment
- Independent Integrated Equality, Health and Health Inequalities Impact Assessment (IIA)
- External clinical assurances, not least:
    - Northern Cardiovascular Disease Network
    - Northern Child Health Network
    - Northern England Clinical Senate
    - Northern England Maternity Clinical Network
    - Northern Neonatal Network
- External assurance mechanisms with NHS England and NHS Improvement

It should also be noted at this point there was much public feedback, through the consultation process, in favour of simply retaining services as they are now (or were prior to the temporary relocation of stroke services). This feedback was given serious consideration by CCG Governing Body members during the decision-making workshops (and with reference to the Pre-Consultation Business Case), however, the weight of evidence received about the need for change was compelling and unavoidable for each of the services.

To reiterate, retaining the status quo is simply not a viable option for these services, for all the reasons set out in this paper and the Pre-Consultation Business Case. Hence, the status quo was not put forward for consideration in the public consultation. The CCG Governing Bodies are required to make decisions seeking to ensure safe, sustainable services for the future.

8.1 Obstetrics and Gynaecology services

It is recommended that Governing Body members of South Tyneside and Sunderland CCGs approve option 1 for implementation. Option 1 is the development of a free-standing midwifery-led unit (FMLU) at South Tyneside District Hospital (STDH) and medically-led obstetric unit at Sunderland Royal Hospital (SRH).

The Governing Body members of South Tyneside and Sunderland CCGs are asked to note implementation will aim to be complete by April 2019.

This recommendation is made on the basis of all evidence considered, not least that:

- A strong preference for choice and to retain births in STDH was expressed by patients and the public, through both the pre-consultation and consultation processes.
- Both options were supported by the Northern England Maternity Clinical Network, but it was recognised that option 1 offered greater choice of birth options to expectant mothers.
- Strategic alignment with *Better Births* is greater with option 1, in terms of the choices that expectant mothers would have, with the introduction of a free-standing midwife led unit.
- Option 1 presents the opportunity to develop a free-standing midwife led unit that could become a holistic, community-facing birthing centre, with the potential to be right at the heart of the local community.
- Whilst the Independent Integrated Equality, Health and Health Inequalities Impact Assessment (IIA) are positive for both options, the scoring is somewhat higher for option 1.
- Both options provide more sustainable models of care for the future, particularly in terms of workforce availability, recruitment and retention.

In terms of the public engagement and consultation, it was noted that option 1 had greater support than option 2 and particular consideration was given to the feedback about:

- Consultant presence only at SRH – it was noted that a key driver for change is the ability to recruit the medical workforce, hence the need for consolidation, but also that the evidence on FMLUs is that they are at least as effective and safe as obstetric-led units.
- Low to high risk births – it was noted that this was a key concern, but also that the national evidence is clear, that free-standing midwife led units are at least as safe as obstetric units and may also be associated with better outcomes. Clear assurance about the stratified risk transfer of patients has been provided by NEAS and the local clinical teams.
- Sustainability of free-standing midwife led units – concerns about the sustainability of these units were noted. However, it is clear that there are a large number of these units around the country that are sustainable. Furthermore, it is proposed that a group of patients, staff, elected colleagues and other partners be established to develop a co-produced model seeking to ensure sustainability. This group should also continue to monitor and assess the success and viability of the FMLU post-implementation. It is also recognised that new clinical protocols will need to be implemented and that midwives would need to be supported to working within a new clinical environment.
- Travel and local services – it was noted that there would be a travel impact for South Tyneside patients under both options, but that this was lessened under option 1. It was felt that the increased consultant presence through colocation

of obstetrics and inpatient gynaecology offers a substantial opportunity to improve quality, but also that a significant amount of work is being undertaken to help mitigate the travel and transport impact.

8.2 Paediatric services

It is recommended that Governing Body members of South Tyneside and Sunderland CCGs approve option 2 for implementation as the most sustainable long-term model, but recognise that it will take a period of time for the requisite work to be done for this to be deliverable and, hence, also approve option 1 for implementation in the short-term. For clarity, it is recommended that option 1 be approved as a transitionary step towards option 2.

Option 1 is for a daytime paediatric emergency department (PED) at South Tyneside District Hospital (STDH) and 24/7 PED at Sunderland Royal Hospital (SRH). Option 2 is the development of a nurse-led paediatric minor injury and illness facility at STDH and 24/7 PED at SRH.

It is recommended that Governing Body members of South Tyneside and Sunderland CCGs support the proposed amendment to opening hours under each option, from 8pm to 10pm as the closing time.

The Governing Body members of South Tyneside and Sunderland CCGs are asked to note implementation of option 1 will aim to be complete by April 2019, as a transitionary step. Implementation of option 2 should include an independent, external group to review the transition and proceed at an appropriate pace over the medium-term, for likely completion by April 2021.

This recommendation is made on the basis of all evidence considered, not least that:

- There are conflicting views about the preferred options across local clinical teams and external clinical partners, including the Northern Child Health Network and Northern England Clinical Senate.
- The Northern Child Health Network noted that both options are credible attempts to address the significant workforce challenges, but that option 2 is most likely to support medical staff retention and deliver long-term workforce sustainability due to the concentration of paediatric acute emergency services. It identified no issues to question the safety and clinical efficacy of the proposals and its view was that both options are in line with the available clinical evidence base and are informed by appropriate clinical standards.
- The Northern England Clinical Senate noted that option 1 was the closest to being a workable solution and could potentially be implemented incrementally to build confidence in it. It noted that option 2 had unquantified risks that needed to be addressed, however it is felt that these risks can be properly mitigated through taking a long-term approach to implementation, with option 1 as a transitionary model.

- While option 1 is more deliverable in the short-term, it does not address the underlying issues relating to medical staffing that are the fundamental driver for change. Although option 2 will take longer to become deliverable, it is felt to be more sustainable in the long-term, not least because it addresses the medical staffing issues. Clearly, medical staffing concerns will mean paediatric services remain vulnerable throughout implementation.
- Suitable assurance has been provided by NEAS around patient transfers.
- Whilst the Independent Integrated Equality, Health and Health Inequalities Impact Assessment (IIA) are positive for both options, the scoring is somewhat higher for option 1.
- There will be a need to properly assess the implementation of the model, in terms of staffing competencies and confidence, patient behaviour and capacity at the SRH site in particular.

In terms of the public engagement and consultation, it was noted that option 1 had greater support than option 2 and particular consideration was given to the feedback about:

- Concerns around the opening hours as outlined in the public consultation – it was noted that concerns were raised about the proposed 8pm finish time. This has therefore been revised and it is now proposed that the unit stay open until 10pm.
- Clinical model – particular concerns were noted about the ability of the adult emergency department team at STDH to deal with paediatric issues out of hours. It is clear that there will be a need to ensure sufficient paediatric life support skills to manage this under both options.
- Communication – feedback was noted about the need to clearly communicate any change in service to the people of South Tyneside and Sunderland. The need for a clear communication and engagement strategy around this is self-evident.
- Travel – it was noted that there would be a travel impact for South Tyneside patients under both options, although potentially significantly less under option 1 and that a significant amount of work is being undertaken to help mitigate this. It was also noted that key assurance had been received from NEAS in terms of deliverability of the options, not least with respect to transfer of patients.

8.3 Stroke services

It is recommended that Governing Body members of South Tyneside and Sunderland CCGs approve option 1 for implementation. Option 1 is that all acute strokes are directed to Sunderland Royal Hospital (SRH), with the consolidation of all inpatient stroke care at SRH.

The Governing Body members of South Tyneside and Sunderland CCGs are asked to note implementation will aim to be complete by April 2019.

This recommendation is made on the basis of all evidence considered, not least that:

- A clear preference for option 1 was expressed by the local clinical team.
- Unequivocal support for option 1, over options 2 and 3, were given by the Northern Cardiovascular Disease Network and the National Clinical Director for Stroke.
- There is a substantial difference in favour of option 1 in the Independent Integrated Equality, Health and Health Inequalities Impact Assessment (IIA). Indeed, both options 2 and 3 scored negatively.
- Option 1 is most likely to deliver greatest improvement in quality and safety for both populations, building on the substantial increase in SSNAP scores for South Tyneside patients since December 2016.
- Consolidation of the workforce in this way is considered most deliverable, sustainable and most likely to enable future recruitment and retention of clinicians

In terms of the public engagement and consultation, it was noted that option 1 had broad support and particular consideration was given to the feedback about:

- Delay in treatment – it was noted that the key consideration is timely transport to the right hospital, able to deliver excellent hyper-acute stroke care, rather than any hospital
- Capacity at Sunderland Royal Hospital (SRH) – it was noted that this has not been an issue since the temporary changes, nor is it expected to be, with at least 90% of patients spending at least 90% of their stay on a stroke unit for residents of both South Tyneside and Sunderland, since December 2016
- Increase in travel for South Tyneside residents – it was noted that all options required all South Tyneside patients to be directed to SRH in the first instance, but that patients would stay longer at SRH under option 1. The clinical benefits were felt to outweigh the increased time for visitors to the c250 patients per annum, but also that the significant amount of work being undertaken on travel and transport would help to mitigate this.
- TIA clinics – it was noted that there would be no change to the current service under any option.
- Repatriation – the clinical team shared the concerns expressed by the public that repatriation, under options 2 and 3, would itself hamper recovery.

9.0 Implementation considerations

Through the public consultation and decision making processes a number of important considerations have been raised in relation to the details required for a successful implementation of options chosen. Whilst these considerations aren`t required to make the final decision they will need to be explicit in the detailed post decision implementation plan. Table 7-8 highlights some of these important considerations by each speciality.

Table 9-1. Implementation consideration for Phase 1 of the PtE programme.

Speciality	Implementation consideration
Stroke	Review of community stroke team interface to demonstrate prompt, equitable input (follow-up appointments, support for intermediate care patients).
	Review of discharge processes and length of stay for ST CCG patients.
	Discharge processes and capacity from SRH to South Tyneside (& Durham).
	Review of post-implementation incidents, complaints and patient experience.
Obstetrics and Gynaecology	Gynaecology day case escalation protocols and pathways to be agreed.
	Clarification of the emergency gynaecology / early pregnancy pathways.
	Impact on maternity and gynaecology screening programmes (if any) to be determined.
	Early discharge plans to be developed for maternity pathways.
	Community hub arrangements for FMLU option to be developed.
	Communications to challenge perceptions around the safety of the FMLU option to be developed.
	Further work with staff and key partners to develop and sustain a FMLU.
	Indicative implementation timelines and risk assessment of sustaining services during implementation to be completed.
Paediatrics	Safeguarding pathways to be refined.
	CAMHS pathways to be clarified.
	Plan to communicate change at implementation stage to support right-place presentation required.
All specialities	As confirmation of deliverability has been received from NEAS, clarification on the effect of the specific impact mitigations will be needed around increased transfer activity between STDH and SRH.
	Self-presenting patients pathways and protocols to be developed.

	EPRR impact assessment to be completed.
	High-level implementation timelines across options to be finalised.

The implementation of the chosen options will be led by the operational and clinical teams across STDH and CHS with evaluation and benefits realisation information being fed into the Clinical Service Review Group and relevant South Tyneside CCG and Sunderland CCG meetings.

10.0 Glossary

FYFV	Five Year Forward View
A&E	Accident & Emergency
AMLU	Alongside Midwifery Led Unit
ANNP	Advanced Neonatal Nurse Practitioner
ANP	Advanced Nurse Practitioner
APLS	Advanced Paediatric Life Support
AQI	Ambulance Quality Indicator
BAPM	British Association of Perinatal Medicine
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CCN	Children's Community Nursing
CHSFT	City Hospitals Sunderland NHS Foundation Trust
CIP	Cost Improvement Programme
CPAP	Continuous Positive Airway Pressure
CQC	Care Quality Commission
CSRG	Clinical Service Review Group
CSSAU	Children's Short Stay Assessment Unit
ED	Emergency Department
EIA	Equality Impact Assessment
EPRF	Electronic Patient Record Form
EPRR	Emergency Preparedness, Resilience and Response
F&F	Friends & Family
F1 / F2	Foundation Year 1 / Year 2 doctor
FMLU	Freestanding Midwifery Led Unit
FTF	Facing the Future (RCPCH Standards)
GP	General Practitioner
GPVTS	General Practice Vocational Training Scheme
HEENE	Health Education England North East
HIA	Health Impact Assessment
IIA	Integrated Impact Assessment
ISLA	Internal Service Level Agreement
LAC	Looked After Children
LDRP	Labour, Delivery, Recover and Postnatal (rooms)
LMS	Local Maternity System
NQSP	National Quality Surveillance Visit Programme
NMPA	National Maternity and Perinatal Audit
NCAT	National Clinical Advisory Team
NCT	National Childbirth Trust
NEAS	North East Ambulance Service
NECS	North of England Commissioning Support
NHSE	NHS England Specialised Commissioners

NICE	National Institute of Clinical Excellence
NICU	Neonatal Intensive Care Unit
NLS	New-born Life Support
NN	Neonatal Network
NTWND	Northumberland, Tyne & Wear and North Durham
PCBC	Pre- Consultation Business Case
PBR	Payment by Results
PDSN	Paediatric Diabetes Specialist Nurse
PED	Paediatric Emergency Department
PLICS	Patient Level Information & Costing System
PLN	Paediatric Liaison Nurse
PNP	Paediatric Nurse Practitioner
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics & Child Health
RVI	Royal Victoria Infirmary
RSCN	Registered Sick Children's Nurse
RTT	Referral To Treatment
PtEP	Path to Excellence Programme
SCBU	Special Care Baby Unit
SRH	Sunderland Royal Hospital
SSNAP	Sentinel Stroke National Audit
STDH	South Tyneside NHS Foundation Trust
STP	Sustainability Transformation Plan
TTIA	Travel and Transport Impact Assessment
WTD	Working Time Directive
WTE	Whole Time Equivalent

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