NHS
South Tyneside and Sunderland
NHS partnership

28 February 2018

Dear Cllr Dix and Cllr Wright,

Information for the Joint Health Overview and Scrutiny Committee (JHOSC) to consider prior to a potential recommendation for referral to the Secretary of State (SOS) for Health and Social Care concerning the Path to Excellence programme phase 1 consultation decisions

Thank you for the contributions and continued diligence by elected members in exercising the functions delegated to JHOSC by South Tyneside Borough Council and Sunderland City Council.

We fully recognise and respect each local authority's right to exercise their option to refer decisions to reconfigure local health services to the Secretary of State and we are aware that the JHOSC intends to consider whether it wishes to recommend a referral under the regulations the Secretary of State issues at its meeting on Thursday 1st March 2018.

As you will know the regulations allow for referral by Local Authorities on three grounds. We have outlined these below with our views on them.

1. The JHOSC is not satisfied with the adequacy of content or time allowed for consultation with itself (in previous responses to referrals made on this basis, IRP has been at pains to point out that the regulation refers to content and time allowed for consultaiton with the scrutiny body. The reguation does not refer to wider public consultation.)

Since September 2016, we have attended 11 formal JHOSC meetings, we have provided access to The Consultation Institute for training around the NHS legal and policy context for service change and consultation. We have facilitated attendance at JHOSC by national and regional independent clinical experts, provided additional sessions on maternity and offered field visits.

At the time of writing we anticipate the final written confirmation from The Consultation Institute of their independent quality assurance review giving the Path to Excellence a Best Practice certification.

As part of the consultation scrutiny process, we have received two formal submissions from the JHOSC, the content of which the CCGs have conscientiously taken into account in their final decision making. For completeness, a copy of the final decisions and the key considerations, and where appropriate conditions, are included at the bottom of this letter.

We would wish the JHOSC to note these key considerations as they provide assurance to elected members to the issues of consultation content the JHOSC have raised in their formal responses to the consultation.

Taking the above factors into account, we hope that the JHOSC chairs will agree that there is no case to basis for JHOSC referral on grounds one.

2. The JHOSC has *not* been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

Given the activity pointed out above, it's highly unlikely a case could be made for a referral on this basis.

As noted during the extraordinary meeting in common of the governing bodies on 21st February, we are puzzled at the change in view of the JHOSC between the interim response in October 2017 and the final response in January 2018.

The queries and concerns about the individual service areas remain broadly consistent through both responses, reflective of feedback from the consultation process and have been considered and taken into account in our decision making.

However, the comments about the process itself changed significantly from the interim response and the final response.

In section 7.2 of the interim response (October 2017), we felt that fair comments were made by JHOSC, that "the consultation process has been robust in fulfilling the legal requirements and the committee is satisfied to acknowledge the monitoring that has been independently undertaken by the Consultation Institute. Although the Committee would also acknowledge that the consultation has raised a number of concerns for staff, patients and the public and this cannot be ignored."

We would agree that many questions, concerns and positive comments were raised throughout and we have sought to take these conscientiously into consideration. However, this is quite different to the comments made in sections 7.2 and 7.3 of the final response (January 2018), "However there remain issues and general concerns that the Joint Committee has with the process and the consultation as a whole.

Throughout the process the Committee has struggled to understand the balance between service improvements and cost saving measures. The Joint Committee remains concerned that there is a risk to the reliability of the consultation through the continued emphasis on service improvements against savings implications. The Joint Health Scrutiny Committee also remains unconvinced of the potential to influence the decisions of the Path to Excellence consultation."

These final comments are directly at odds with the interim response and previous discussions with JHOSC, on the basis of which we have dynamically altered our process throughout.

In section 7.1 of the interim response (October 2017), the JHOSC noted, "The Committee would like to acknowledge the cooperation and commitment of key staff from the NHS who have provided the Joint Health Scrutiny Committee with the information and evidence requested on numerous occasions.

This has certainly helped the Committee in its endeavours to date" whereas in section 7.4 of the final response in January 2018 the JHSOC noted, "The limited knowledge displayed by the South Tyneside and Sunderland Healthcare Group, Clinical Commissioning Groups and North East Commissioning Support of the context of public scrutiny and the formal role of scrutiny in local government within a partnership scenario has proved problematic. In particular, the presentation of evidence to the Joint Committee was often inappropriate and inaccessible; it was also complex, confusing and lacking clarity. Furthermore, the presentation of evidence was quite often compounded by the extensive use of abbreviations and jargon."

We are at a loss to understand this, particularly given that these concerns were not raised with us at any point prior to the final response. Clearly, we would have sought to address these immediately.

3. The JHOSC considers that the proposal would not be in the interests of the health service in its area.

As joint NHS partners in the Path to Excellence programme, we thought it helpful to set out our concerns about the risks of delaying implementation will have on these very vulnerable services. We do this so that elected members are advised about the consequences delays will have on the delivery of safe and high quality services to enable a fully informed recommendation on a referral.

So there is no element of doubt, safe and high quality services means care that treats your medical condition by the correct professional, with access to the best diagnostics and treatment to give people the best possible chance of recovery and if they are not able to recover, does not make them worse or do harm.

You will recall that the reasons why these services were prioritised were the clear safety, quality, sustainability risks they have – and these are agreed with the foundation trusts two clinical operational teams.

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.

If there is a formal referral from the individual councils to the SoS, then the two hospital foundation trusts would need to halt the mobilisation and implementation on these changes until such time we are advised by the SoS or the Independent Reconfiguration Panel (IRP) of the outcome.

We are aware that current timescales for response by the IRP could be as long as six to nine months (based upon the current experience of NHS organisations in other parts of the country).

We feel strongly that in the interests of patient safety we are not able to delay changes to these fragile services any longer, and these changes must be done in a considered and planned manner with staff, patients and partners.

External and independent organisations such as the NHS Clinical Senate recognised that given the fragile state of the current paediatric services there is a need to provide certainty for current and prospective staff to best support recruitment and retention.

They also added that there is a need to accelerate the further development of the two options (maternity and paediatric) with staff from all disciplines from both sites, noting the critical interdependencies between maternity care and the special care baby unit.

The Child Health Network also remarked that the (consultation) scenarios described represent a credible attempt to address the workforce challenges that have left the paediatric service at South Tyneside District Hospital particularly vulnerable.

We feel a delay will be a significant risk in the foundation trusts having to make changes in a crisis situation (like we saw in December for the special care baby unit and subsequent impact that had on South Tyneside maternity services)in order to protect patient safety.

Again, to be clear what we mean by risks to patient safety, is increasing the potential risk of death, serious harm or a life-long health condition or disability.

For example:

- Not implementing the full stroke option as soon as possible means the foundation trusts cannot improve the acute rehab and community rehab elements of care, which increases the risk of disability for our patients. Although we have dramatically improved the rate of thrombolysis taking place within an hour, from 0 to 63%, since the temporary change, we are still 37% short for South Tyneside residents
- In South Tyneside, the foundation trust continues to struggle to fill the paediatric middle grade rota on a weekly basis and often relies on consultants acting down. This places the service at risk some days when there will be no senior cover onsite meaning that the Trust will not be able to take patient admissions overnight with the consequent knock on effect on SCBU and maternity services given the close interlinks between paediatrics and these services. There are also some acute staffing pressures with the obstetric middle-grade rota which again will have a knock on effect with consultant cover.

The foundation trusts will of course strive to retain full levels of service provision during any referral period and will continue to keep the JHOSC informed if vulnerabilities are exacerbated and in any way threaten service continuity, and we draw elected member's attention to the NHS England Joint Working Protocol: When a hospital, services or facility closes at short notice' which is attached to this letter.

Since the CCG's decision on the afternoon of Wednesday 21st February, the hospital foundation trusts senior staff have met with affected staff teams that same evening and in the following days.

The strong message from staff attending those sessions was a sense of relief that a decision had been made, bringing to an end the uncertainty which the consultation process has inevitably brought for staff working in the affected areas.

Staff at the sessions also expressed how important it was to now have further rapid clarity about what the services changes will mean for their own individual circumstances as the new service models are now mobilised.

They also expressed concern that any delay to the April 2019 implementation date or further uncertainty would negatively contribute to staff potentially leaving and looking for jobs elsewhere, thereby exacerbating the service vulnerabilities and workforce issues even further.

Taking all this further information into account, as a group of NHS partners we are united in the opinion that a delay to implementation would not be in the best interests of the local health services as per the third grounds cited in the SOS regulations and would urge the JHOSC to consider carefully the serious implications for both patients and staff.

Given the information contained here, if JHOSC and then individual councils are still minded to refer the consultation process to the SOS, we would ask for clarity on the next steps and a time frame.

Having reviewed the regulations, our understanding is that the local authority is required to make a formal recommendation to the respective clinical commissioning groups on the matters of concern – setting out the issues.

Our understanding is that after due consideration, if the clinical commissioning group disagrees with that recommendation, both parties must take 'such steps as are reasonably practicable' to reach agreement.

If agreement is not reached, the local authority is required to present evidence to support its referral.

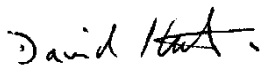
The Secretary of State for Health receives the referral and passes it to IRP (Independent Reconfiguration Panel), which is appointed to review each case and advise the Secretary of State.
We would be grateful if you could ensure that JHOSC members have the opportunity to review the content of this letter in advance of their meeting on Thursday 1st March 2018.

We feel that elected members should be fully appraised of the risks to the quality and safety of services and the impact on patients and staff should there be any un-necessary delays to the planning, mobilisation and implementation the new models of care.

We understand from the JHOSC terms of reference that if a referral is recommended by the JHOSC then this would then be progressed by the individual local authorities through the relevant council governance structures.

As such we would very much welcome a clear view after the JHOSC has met on the next steps so we are able to inform staff, other key partners and to plan accordingly, in order to ensure the NHS can meet our joint statutory and mandatory requirements to commission and provide safe, high quality health services for local people.

Yours sincerely



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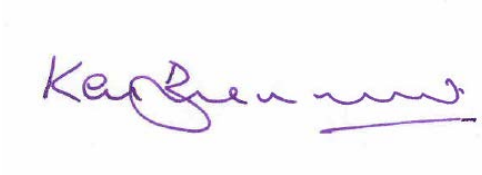

Ken Bremner
Chief Executive
South Tyneside NHS Foundation Trust and
City Hospitals Sunderland NHS Foundation Trust

Copies to:

NHS England
NHS Improvement
Care Quality Commission
South Tyneside Health Watch
Sunderland Health Watch
North East Ambulance Service

Attached: NHS England Joint Working Protocol – When a hospital, services or facility closes at short notice

Enclosure below:

Information about the decisions made by the two CCGs on 21st February 2018

Stroke care services

Option 1 will be implemented which is all acute strokes are directed to Sunderland Royal Hospital (SRH), with the consolidation of all inpatient stroke care at Sunderland. This was based upon the clear clinical preference for option 1 by the local clinical team, unequivocal support from Northern Cardiovascular Disease Network and the National Clinical Director for Stroke. In terms of reducing health inequalities, option 1 was most likely to deliver greatest improvement in quality and safety for both populations, building on the substantial increase in the key stroke quality indicators known as SSNAP scores for South Tyneside patients since December 2016.

In terms of the public engagement and consultation feedback, 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 that is able to deliver excellent hyper-acute stroke care, rather than getting to any hospital.
- Capacity at Sunderland Royal Hospital (SRH) – while people in the consultation have raised concerns about this it 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 the temporary change in December 2016 carried out on safety grounds.
- Increase in travel for South Tyneside residents – all the stroke options had South Tyneside patients to be directed to Sunderland in the first instance, but that patients would stay longer at Sunderland under option 1. The clinical benefits were felt to outweigh the increased time for the approximately 500 visitors for those patients per year. (Stroke patients would be likely taken to hospital by ambulance). Also, recognised was the significant amount of work being undertaken on travel and transport would help to mitigate the travel impact.
- Patient repatriation – the clinical team shared the concerns expressed by the public that repatriation, under options 2 and 3, would itself hamper recovery.

Maternity (obstetrics) and women's healthcare (inpatient gynaecology) services

Option 1 will be implemented which is the development of a free-standing midwifery-led unit (FMLU), known as a birthing centre, at South Tyneside District Hospital (STDH) and medically-led obstetric unit at Sunderland Royal Hospital (SRH).

This decision is made on the basis of all evidence considered, including that a strong preference for choice and to retain births in South Tyneside 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.

It presents the opportunity to develop a new 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 South Tyneside community and provide more choice to both South Tyneside and Sunderland women on where and how to have their baby.

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:

- Low to high risk births, it was noted that this was a key concern, but also that the national clinical 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 transfer of patients has been provided by North East Ambulance Service 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 members 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.

Children and young peoples (urgent and emergency paediatrics) services

Option 2 the development of a nurse-led paediatric minor injury and illness facility at South Tyneside District Hospital – open 8am to 10pm - and 24/7 paediatric emergency department at Sunderland Royal Hospital is recommended as the most sustainable long-term model.

However, the clinical commissioning groups recognise that it will take a period of time for the development work for this be deliverable therefore approve option 1 for implementation in the short-term which is the development of a daytime paediatric emergency department at South Tyneside District Hospital and 24/7 paediatric emergency department at Sunderland Royal Hospital.

For clarity, option 1 has been approved as a transitionary step towards option 2. The South Tyneside daytime paediatric emergency department service and future nurse-led paediatric minor injury and illness facility will be open from 8am to 10pm – extended from 8pm as a result of public consultation feedback.

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.

Travel and transport

Two meetings of the working group to tackle travel and transport issues identified from the Path to Excellence first phase public consultation have taken place, with terms of reference being agreed and a work programme underway.

Membership includes the NHS organisations, Health Watch Sunderland, Health Watch South Tyneside, Sunderland City Council, South Tyneside Borough Council, Nexus, Go North East, Stagecoach and Tyne and Wear public transport service users group. The work programme to date includes:

- Travel planning resources
- Mapping and leaflets
- Personalised journey planning
- Discounted staff travel tickets
- New patient/visitor travel tickets
- Bus stop information
- Co-ordinated communications and marketing strategy with NHS and travel organisation
- Bus information displays in hospitals

The terms of reference are available on: www.pathtoexcellence.org.uk/travel-and-transport

Links to a recording of the live broadcast is available via the programme website www.pathtoexcellence.org.uk