South Tyneside Clinical Commissioning Group

Sunderland Clinical Commissioning Group

# Extraordinary Meeting in Common of South Tyneside CCG and Sunderland CCG Governing Bodies

## Minutes of the meeting held on Wednesday, 21 February 2018, 14.00-16.00pm, Hebburn Central, Glen Street, Hebburn, NE31 1AB



### South Tyneside CCG

Present:

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| Dr M Walmsley | CCG Chair and Chair of 'meeting in common' |
| Mr S Clark | Lay Member and Non-Clinical Vice Chair |
| Dr T Cross | Secondary Care Consultant |
| Mr J Gosling | Lay Member, Public and Patient Involvement |
| Dr D Hambleton | Chief Executive |
| Ms K Hudson | Chief Finance Officer |
| Mr P Morgan | Lay Member, Audit and Governance |
| Ms J Scott | Director of Nursing, Quality and Safety |
| Dr Vis-Nathan | GP Member |

In attendance:

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| Mr M Brown | Director of Operations |
| Mr A Sutton | Governance Officer |

### Sunderland CCG

Present:

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| Dr I Pattison | CCG Chair |
| Dr R Bethapudi | Executive GP |
| Mr D Chandler | Chief Finance Officer |
| Dr D Cruickshank | Secondary Care Clinician |
| Mrs A Fox | Director of Nursing, Quality and Safety |
| Mr D Gallagher | Chief Officer |
| Dr K Gellia | Executive GP |
| Dr J Gillespie | Executive GP |
| Dr F Khalil | Executive GP |
| Dr T Lucas | Executive GP |
| Mr C Macklin | Lay Member, Audit |
| Mrs A Sullivan | Lay Member, Patient and Public Involvement |

In attendance:

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| Mr Scott Watson | Director of Contracting and Informatics |
| Ms D Cornell | Head of Corporate Affairs |
| Mrs J Thwaites | Corporate Affairs Support Officer |

Expert advisors from South Tyneside NHS Foundation Trust and City Hospitals Sunderland NHS Foundation Trust and North East Ambulance Service (NEAS):

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| Mr K Bremner | Chief Executive |
| Dr S Wahid | Medical Director |
| Mr P Sutton | Director of Strategy and Transformation |
| Mr P Garner | Path to Excellence Programme Manager |
| Mr Paul Fell | Consultant Paramedic |
| Mr Graham Tebbutt | Head of Strategy and Transformation, Governance and Assurance |
| Ms Caroline Thurlbeck | Director of Strategy, Transformation and Workforce |

**MIC2018/01 Welcome and Introductions**

Dr Walmsley, as Chair of the meeting in common, welcomed members of the two governing bodies to the meeting and thanked members of the public for attending. The Chair noted that, to further emphasise the openness of the process, the meeting was being broadcast live on *YouTube*.

A welcome was given to senior leaders from South Tyneside NHS Foundation Trust and City Hospitals NHS Foundation Trust and other NHS officers who were in attendance and may be called upon if any further information was required.

The Chair also confirmed that in constitutional terms, the meeting was not a joint meeting of the two governing bodies, but a meeting *'in common'*, with both governing bodies meeting simultaneously but would make individual decisions for their respective CCGs in line with their respective decision-making powers. The Chair clarified he would chair the decision-making item for South Tyneside CCG and Dr Ian Pattison would chair this for Sunderland CCG.

The Chair reminded those present that the decisions to be made were the culmination of 20 months of work and emphasised the fundamental importance and value of local hospitals providing a range of services and the continued development of South Tyneside District Hospital (STDH) and Sunderland Royal Hospital (SRH) that would see both hospitals continue to develop and thrive over the coming years.

However the consequences of continued service duplication across STDH and SRH, not least in terms of workforce sustainability, presented challenges to the delivery of safe and high quality services. Stroke, obstetrics and gynaecology and paediatrics

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

The Chair emphasised that maintaining the status quo and not making any changes was not an option for these services. Health care leaders, who were also senior medical professionals, were responsible for the provision and delivery of local health services and, as a group, were certain that action must be taken to safeguard and improve patient safety. It was extremely likely that a failure to act would lead to service closures across South Tyneside and Sunderland under crisis circumstances, putting patient safety at risk.

The group of clinicians and health professionals in South Tyneside and Sunderland fully recognised the passion of local residents in retaining localised services and retaining the current secondary care services would be the easy choice, but would not represent the best that the NHS could provide.

**MIC2018/02 Apologies for absence**

No apologies for absence were received and as such the meeting was quorate.

**MIC2018/03 Declarations of interest**

A declaration was raised by Mr Chandler in relation to his sister who was a nurse in the ITU unit at South Tyneside NHS Foundation Trust. The Chair accepted the declaration and decided that as this was not material to the decisions being made today and Mr Chandler could remain as an active member for the remainder of the meeting.

**Items for Assurance**

**MIC2018/04 Path to Excellence: Phase 1 – Consultation Process**

The purpose of this item was to provide the two governing bodies with sufficient information to give consideration to and formally endorse the communications and engagement activities that had been undertaken as part of the consultation process for phase 1 of the Path to Excellence programme.

Mr Gallagher, Chief Officer for Sunderland CCG, introduced the paper and explained that consultation was a statutory requirement for CCGs when undertaking a review of services and included involving, engaging, consulting and listening to local people and

stakeholders for their views. The CCGs needed to be assured of the process and that they had fulfilled their statutory responsibilities in relation to this.

Mr Gallagher invited Mr Watson, Director of Contracting and Informatics and director lead for Path to Excellence for Sunderland CCG to present the report.

The purpose of the report was to provide assurance on the service reform process followed, in particular that commissioners had met their statutory duties for consultation and major service change. The CCGs had drawn upon NHS statutory duties, English law, NHS policy and case law to help form and shape the process and ensure the appropriate NHS England and NHS Improvement assurance tests and compliances were achieved. This included a requirement to act in accordance with the *Gunning Principles of Consultations*, which guard against the pre-determination of the outcome of a consultation exercise.

The Gunning Principles are:

- Consultations should occur when proposals are still at the formative stage
- Consultees should be given enough information to make an informed choice to permit 'intelligent consideration' of the options proposed
- There should be adequate time for consideration and response
- Decision-makers must conscientiously take into account responses from the consultation to inform their decision making.

The consultation process had been conducted with support of NHS North of England Commissioning Support (NECS), which had provided strategic advice and facilitated the delivery of the engagement and consultation on behalf of the four organisations that constituted the South Tyneside and Sunderland NHS Partnership, namely:

- City Hospitals Sunderland NHS Foundation Trust (CHS)
- South Tyneside NHS Foundation Trust (STFT)
- NHS South Tyneside Clinical Commissioning Group STCCG)
- NHS Sunderland Clinical Commissioning Group SCG)

Independent external expertise from the Consultation Institute was also commissioned as part of this process to oversee and evaluate the engagement and consultation process and to provide third party assurance and credibility to stakeholders regarding good practice.

An overview of the communications and engagement strategy was provided with an outline of the governance and partnership arrangements established to deliver the consultation programme. The overall process had been overseen by a governance group to ensure compliance with legal duties, local and national policy guidance and mandated requirements and to identify and mitigate any risks related to the consultation. The group had also overseen the communications and engagement strategy development and implementation and ensured equality and travel impact analysis and assurance was undertaken.

A communications and engagement group was also established to deliver the engagement and consultation work and representatives included members of Healthwatch, patient involvement staff and programme staff. The work of this group had been extremely positive and its input invaluable in ensuring the consultation had been wide ranging, high quality, open and taking different views and experiences into account. The group would continue to oversee the updated communications and engagement strategy for phase two, highlighting areas of improvement to be incorporated.

The process of engagement and consultation had been delivered in two phases: the pre-engagement listening phase and the formal public consultation phase.

The pre-engagement listening phase involved the publication of an issues document and engagement with partners, stakeholders and staff in relation to the vulnerability of these services. In addition, the CCGs had attended ward and locality meetings, undertaken media and publicity and carried out targeted work with people who had 'lived experiences' of services.

A detailed outline of the pre-engagement work was given as set out in the consultation assurance report, with the analytical detail underpinning the pre-engagement phase highlighted at appendix 4 of the report.

Attention was drawn to section 5 of the report which focussed on how the pre-engagement listening phase influenced the development of the options. The report was published online and also presented to the Joint Health Overview and Scrutiny Committee as part of the programme of ongoing engagement.
It was recognised during the pre-engagement listening phase that travel and transport was a significant issue and consequently additional dedicated events for this topic were arranged. These dedicated sessions ensured the transport issues were considered appropriately but allowed time in other events for the proposals on all clinical specialities to have due consideration.

It was noted that due to the general election in May 2017, the planned timescales for the consultation were affected by purdah. As a consequence, the consultation timetable was amended to take this into account. However to ensure this did not reduce opportunities for the public, patients and other stakeholders to participate in the consultation, it was agreed to extend the process to 14.5 weeks to ensure appropriate time was given to consider the options and respond.

Each service area had dedicated consultation events and supporting documentation and literature were made easily accessible to support intelligent consideration of the options. A comprehensive publication scheme was made available on the Path to

Excellence website, including technical business documents, impact assessment summaries and easy read versions of the consultation document.

The CCGs recognised this was a dynamic process and made changes to process as appropriate. Changes were made to the length of meetings, accommodating members of the public to sit separately from NHS staff during events if they wished to and also increasing the total number of events held.

To maximise the breadth and depth of responses to the consultation, a range of focus groups were commissioned which were run on behalf of the CCGs by local voluntary organisations. The opinions of groups, teams and other individuals were also sought and responses from key stakeholders such as Healthwatch, scrutiny committees, trade unions, affected staff groups and other elected representatives of both local communities such as MPs and local councillors were received. The CCGs also received a response from the Save South Tyneside Hospital Campaign, along with a petition with approximately 30, 000 signatures.

The consultation process had been carried out with third party oversight of the Consultation Institute (the Institute), which undertook an independent quality assurance review. At its mid-point, the Consultation Institute identified the consultation process as being on track for a 'best practice' certification.

The Path to Excellence consultation had achieved a response rate of 0.56% of the South Tyneside and Sunderland population. The national average for UK consultation is around 0.7% and the Institute advocates a 'good' consultation as achieving around 1% response rate for the targeted population. Whilst the CCGs recognised the consultation response rate for the consultation had fallen short of the average, the CCGs were assured through the depth and breadth of the qualitative methods used during the process that this had gathered a wide range of views and opinion from across our society.

Given the complexity of the consultation and the cross boundary nature of the path to excellence programme, a request was made to the respective local health overview and scrutiny committees to create a joint committee for consideration of the phase one process. This was agreed and a Joint Health Overview and Scrutiny Committee (JHOSC) was established for consideration of the phase 1 process.

No fewer than 11 meetings were held with the full formal JHOSC or JHOSC members and other gathered elected representatives, in total over 30 hours. The JHOSC's interim response to the consultation in October 2017 described the consultation as 'robust' and welcomed the involvement of the independent Consultation Institute in helping ensure that the Path to Excellence followed the best consultation practice. It also praised the cooperation and commitment of key staff from the NHS who had provided the committee with the information and evidence requested on numerous occasions and remarked this had helped the committee in its endeavours. It was noted

however that the JHOSC final response received in January 2018 contradicted its earlier response, citing serious concerns relating to the consultation process and identifying much of the information presented was complex, confusing and lacking clarity.

With regard to staff engagement, clinical leaders from both STDH and SRH were involved from the outset of programme. During the formal consultation period, both hospitals had openly encouraged the active participation of staff and made efforts to encourage input of their views as part the formal consultation process. It was recognised that this was an area of improvement for the next phase of engagement.

The CCGs were aware of the Save South Tyneside Hospital Campaign and the Chief Executive of the South Tyneside and Sunderland Hospitals Group had met with leaders from the campaign group during the consultation process.

As part of ensuring the CCGs met their statutory responsibilities for the Equality Act and Public Sector Equality Duty, a number of integrated impact assessments were undertaken to eliminate discrimination, promote equality of opportunity and ensure that, wherever possible, services were provided in ways which might reduce health inequalities.

In order to maintain independence and impartiality in the consultation process, the CCGs commissioned a third party company (Social Marketing Partners) to support the development and design of the consultation surveys and to review and produce the consultation feedback report, which was published in early December 2017 and published on the Path the Excellence website.

The publication of this report marked the start of a 'period of consideration' by South Tyneside and Sunderland CCGs which lasted until 8 January 2018. This period gave the public and stakeholders a further opportunity to comment on the findings of the consultation and the proposed next steps. It also included staff and public feedback sessions, clinical workshops with members of the clinical services review group and workshops with the two CCG governing bodies.

Governing Body members from both CCGs had attended a workshop in early December to hear draft feedback from the public and for members of the clinical design teams to make recommendations for adjustments to the clinical models as a result. As a consequence of the workshop, a number of additional assurances were sought and further information provided in relation to these.

To seek additional independent assurance on the consultation process, the CCGs' asked the independent Consultation Institute (the Institute) to undertake a quality assurance review of the process. At the pre-decision making position in February 2018, the Institute verbally confirmed a final 'best practice' certification would be pending,

subject to how the final decision making was conducted. A copy of the Institute's mid-term quality assurance feedback was included in the report.

The Chair thanked Mr Watson for his presentation and also expressed thanks to all who were involved in the significant communications and engagement activity.

The Chair invited questions from all governing body members and a number were raised by members from both CCGs.

An up to date position was requested about the travel and transport working group including any further mitigation of the issues identified. It was noted that this issue would be considered as part of the next item of business on the agenda, phase 1 – decision-making.

A query was raised about the differing responses from the JHOSC of October 2017 and February 2018 and what had happened between these dates to explain the difference. It was clarified that the reason for this change was unknown as engagement with the JHOSC had been consistent throughout the process.

Clarification and assurance was sought about any further staff feedback following the initial staff consultation process. In response it was noted that over 100 staff had participated in the engagement events from the beginning of the consultation process. Subsequently staff had submitted proposals on two specific issues: the Special Care Baby Unit (SBCU) and paediatrics. Both proposals were fed into the options assessment process and given full consideration.

As there were no further questions, the Chair moved to the recommendation in the report to formally endorse the communications and engagement activity for the consultation process for Phase 1 of the Path to Excellence programme.

Dr Walmsley, as Chair of South Tyneside CCG, invited South Tyneside Governing Body members to make their decision:

**Resolution**

**South Tyneside CCG Governing Body members formally ENDORSED the communications and engagement activity undertaken in the consultation process for Phase 1 of the Path to Excellence programme.**

Dr Pattison, as Chair of Sunderland CCG, invited Sunderland CCG Governing Body members make their decision:

**Resolution**

**Sunderland CCG Governing Body members formally ENDORSED the communications and engagement activity undertaken in the consultation process for Phase 1 of the Path to Excellence programme.**

**MIC2018/05 Path to Excellence: Phase 1 – Decision-Making**

Dr Hambleton, Chief Executive of South Tyneside CCG, introduced the decision-making report. He acknowledged that whilst the preferred option for many local residents was for no change to the services, the CCGs had been consistent throughout the consultation process that this was not possible and reasons for this had been outlined throughout.

At this stage in the proceedings, Dr Hambleton invited Mr Bremner, Chief Executive of both South Tyneside NHS Foundation Trust and City Hospitals Sunderland NHS Foundation Trust to give his considered view on the Path to Excellence proposals.

Mr Bremner noted that the meeting today was a culmination of a significant amount of work undertaken by partners and other key stakeholders and in particular expressed his thanks to the CCGs and all staff and hospital personnel in both Sunderland and South Tyneside. He reiterated that 'no change' was not a viable option and highlighted that throughout the clinical service reviews, the underlying key issues were clinical safety and quality and sustainability within the workforce. Within the past six months, there had been robust evidence to demonstrate the vulnerabilities of the services under review which clearly showed that 'no change' was not an option.

Dr Hambleton noted that the significance of the decisions to be taken was not to be underestimated and reiterated the importance that local residents place on these services. It was noted that this meeting was a culmination of a significant process, taking into consideration the views of local residents, the extensive and clinical expertise of staff and colleagues within South Tyneside, Sunderland, regionally and nationally, allowing the decision making process to be entered into with confidence.

Dr Hambleton invited Mr Brown, Director of Operations at South Tyneside CCG and director lead for the Path to Excellence programme for South Tyneside CCG to present the decision making report.

Mr Brown advised he would provide a small amount of context for each clinical service and then each service would be considered separately to allow governing body members to make their respective decisions.

Clinically-led design teams, informed by the pre-engagement, had produced a long list of options for consideration set out in the decision-making report. Each option had been assessed and required to satisfy a number of 'hurdle criteria' to demonstrate an ability to provide high quality safe care, sustainability of the clinical workforce, affordability and deliverability, resulting in a shortlist of options put forward for consultation.

It was important to note that opportunity was given for further options to be put forward throughout the consultation phase.

Through the process, and acting on feedback from public consultation, the two CCGs determined six decision-making criteria to help guide the qualitative assessment of options as follows:

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

Significant independent expertise and assurance had been sought from clinical networks and stakeholders, external regulatory processes and consultation experts. Specific travel and transport, and integrated equality, health and health inequalities impact assessments had also been commissioned. All of these were available through the public consultation and subject to much debate, and as a result, were tested, reviewed and strengthened in light of the feedback received.

A particular focus had been given to the integrated equality, health and health inequalities impact assessment (IIA) in terms of impact on vulnerable groups.
With regards to the travel and transport impact assessment, a substantial amount of work was now underway with the Travel and Transport Stakeholder Group. Membership of this group included representatives from the local NHS, local authorities, NEXUS, bus companies, patient user groups and elected members. In particular the CCGs had taken the personal impact of additional travel on families, patients and carers extremely seriously and strived to secure the best health and healthcare for the population of South Tyneside and Sunderland. The CCGs fully recognised the significance of this decision for the patients they served and sought to balance all factors as much as possible to make the best possible decision.

**Obstetrics and Gynaecology**

Mr Brown reminded all governing body members that the two options put forward for consideration for obstetrics and gynaecology were:

- Option 1 - the development of a free-standing midwifery-led unit (FMLU) at STDH and medically-led obstetric unit at SRH
- Option 2 - the development of single medically-led obstetric unit and an alongside midwifery-led unit at SRH serving both geographical areas.

It was noted that, given the services pressures, significantly different options were considered in the longlisting, which went as far as removing those services entirely from South Tyneside and Sunderland, although that option did not pass the hurdle criteria.

The recommendation was to approve option 1 for implementation and was based on consideration of all evidence available, with some key points including:

- 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. Option 1 was favoured by pregnant women and mothers of children under 2 years of age in particular
- Both options were supported by the Northern England Maternity Clinical Network but it was recognised that option 1 offered a greater choice of birth options to expectant mothers
- A high level of confidence that safety and quality would be improved, with increase of consultant cover on obstetric-led unit to 84 hours per week
- Better strategic alignment with the national *Better Births policy* in terms of the choices that expectant mothers would have and with NICE guidelines
- The potential for the free-standing midwifery-led unit to become a holistic, community-facing birthing centre for both South Tyneside and Sunderland, with the potential to be at the heart of the local community
- Whilst the independent integrated equality, health and health inequalities impact assessment (IIA) were positive for both options, the scoring was somewhat higher for option 1

The IIA had determined that both options would give children a better start in life and could therefore deliver enduring and significant benefits to child health, population health and improve inequalities across South Tyneside and Sunderland. The positive impact the IIA was judged to be across both populations. A number of considerations were noted around information for patients, establishing a women's services user group and considering breastfeeding initiation.

In terms of the public engagement and consultation, notwithstanding the previous points about the status quo, it was noted that option 1 had greater support than option 2 and particular consideration had been given to the feedback including:

- Clinical safety and the presence of a consultant - evidence was noted that FMLUs were at least as effective and safe as obstetric-led units. It was noted that the availability of senior doctors was a key driver behind the need for change
- Transfer requirements and the ability of NEAS to respond – it was noted that this was a key concern, but again the national evidence was clear that FMLUs were at least as safe and obstetric-led units and may also be associated with better outcomes. Also it was noted that clear assurance about the stratified risk transfer of patients had been provided by NEAS and the local clinical teams.

NEAS had confirmed that this site would not be considered a place of safety and hence would be prioritised accordingly

- Sustainability of free-standing midwife led units - it was noted that a large number of these units around the country were sustainable and were more than just a place to give birth including, antenatal care, smoking cessation, and breastfeeding support. It was proposed that a group of patients, staff, elected colleagues and other partners be established to develop a co-produced model seeking to ensure sustainability and to monitor post-implementation
- Travel and local services - it was noted that there was a travel impact for South Tyneside patients under both options, but that this was lessened under option 1. Increased consultant presence through co-location of obstetrics and inpatient gynaecology offered 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. The impact on mothers and visitors in particular was noted, albeit for a relatively short period, and the importance of the work undertaken by the Travel and Transport Stakeholder Group

Dr Walmsley thanked Mr Brown for the overview and invited questions from all governing body members.

A question was raised in relation to the FMLU as to how it would be ensured that the unit was used and how this would be communicated to the public to ensure its sustainability in the long term. In response it was noted that sustainability was about health outcomes as well as numbers. In addition, a marketing and engagement strategy had been developed to communicate with the public and this would be supported through the wide network of clinical teams throughout the localities.

The utilisation of the unit was also raised and how this would be monitored to determine its long term sustainability. It was noted that historically the number of eligible women who chose an FMLU had been less than predicted. In response it was clarified that estimations had been based on the best modelling techniques available but it was key to creating a positive unit at the heart of the community. It was also noted that there were many successful FMLUs around the country. It was considered that this option would give midwives an opportunity to take more leadership in contributing to the success of this unit and develop it as a centre of excellence.

A question was raised about potential complications occurring and, whether this would create pressures for the North East Ambulance Service (NEAS). It was noted that this had been a key area of concern for both the governing bodies and the general public. In response it was highlighted that NEAS, through the Medical Director on behalf of their Board, had confirmed its ability to deliver both options.

Assurance was sought as to whether there had been any feedback from the midwives on the proposed models and if they had been part of the development of the options. It

was confirmed that clinically-led design teams had developed the options and that, although trade unions had advised staff not to complete the survey around their appetite to work in a FMLU, sufficient responses had been received to show that the rota would be covered. The intention to continue to coproduce the model with midwives and patients was set out.

It was clarified that the FMLU would be available for use by residents of both South Tyneside and Sunderland. It was expected that a strong link between the two units would be established.

Assurance could also be taken from the evidence base and robust presentation given by Dr Sturgis to the Governing Bodies which had reiterated the aspiration that the unit could be a centre of excellence with the commitment of commissioners, partners and patients.

It was also important to reinforce the commitment from NEAS that emergency transfers from the FMLU to the obstetric unit would be treated as a blue light situation. It was clarified that the FMLU would not be designated as a 'place of safety' by NEAS and the 8 minute emergency response time would apply.

As there were no further questions, the Chair moved to the recommendations contained within the report.

Dr Walmsley, as Chair of South Tyneside CCG, invited South Tyneside Governing Body members to make their decision:

**Resolution**

**South Tyneside CCG Governing Body members APPROVED option 1 - the development of a free-standing midwifery-led unit at South Tyneside District Hospital and medically-led obstetric unit at Sunderland Royal Hospital, noting that the implementation would aim to be complete by April 2019.**

Dr Pattison, as Chair of Sunderland CCG, invited Sunderland Governing Body members to make their decision:

**Resolution**

**Sunderland CCG Governing Body members APPROVED option 1 – the development a free-standing midwifery-led unit at South Tyneside District Hospital and medically-led obstetric unit at Sunderland Royal Hospital, noting that the implementation would aim to be complete by April 2019.**

**Paediatrics**

Mr Brown reminded all governing body members that the two options put forward for consideration for paediatrics were:

- Option 1 - the development of a daytime paediatric emergency department (PED) at STDH and a 24/7 PED at SRH.
- Option 2 - the development of a nurse-led paediatric minor injury and illness facility at STDH and a 24/7 PED at SRH.

The recommendation was to approve option 2 for implementation as the most sustainable long-term model, but in recognition that it would take a period of time for the requisite work to be done for this to be deliverable, also to approve option 1 for implementation in the short-term. For clarity, it was recommended that option 1 be approved as a transitionary step towards implementing option 2.

An additional option had been put forward prior to public consultation by the paediatric consultant team at STDH however this option had not met the hurdle criteria. This option was reviewed by the Northern England Clinical Senate which supported the pre-consultation decision not to take the option forward.

It was noted that during the consultation period, a further transitional care SCBU model was proposed by staff but also did not pass the hurdle criteria. In particular the feedback from the Neonatal Network, NHS England specialised commissioners, the National Quality Surveillance Programme and external partners had been clear they did not expect this model of service to be considered as a viable? alternative option.

The recommendation to approve option 2 for implementation was made on the basis of all evidence considered, not least that:

- Whilst there were conflicting views about the options across local clinical teams and external clinical partners, including the Northern Child Health Network and Northern England Clinical Senate, both options were acknowledged to be credible and option 2 was identified to be more sustainable
- The Northern Child Health Network noted that both options were credible attempts to address the significant workforce challenges but option 2 was most likely to support staff retention and deliver long-term workforce sustainability. The Network's view was that both options were in line with the available clinical evidence base and were 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. Whilst it noted the risks associated with option 2 which needed to be addressed, it was felt these could be properly mitigated through taking a long-term approach to implementation, during which time option 1 would be implemented as a transitionary model
- A decision was needed on paediatrics urgently to address the service fragility in the short-term
- While option 1 was more deliverable in the short-term, it did not address the underlying issues relating to medical staffing that were the fundamental drivers for change. Although option 2 would take longer to become deliverable, it was

felt to be more sustainable in the long-term, not least because it addressed the medical staffing issues. Clearly, medical staffing concerns would mean paediatric services remain vulnerable throughout implementation.

- Assurance had been provided by NEAS in relation to patient transfers
- The IIA was positive for both options, with the scoring somewhat higher for option 1.

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

- Concerns expressed in relation to the opening hours, particularly the proposed 8pm finish time. As a result, this had been revised and a later opening time of 10pm was now being proposed for both options option
- Concerns in relation to the clinical model, particularly around the ability of the STDH adult emergency department to manage paediatric issues out of hours. It was acknowledged there was a need to ensure sufficient paediatric support skills under both options. It was noted that this was not an uncommon model and paediatrics was a core element of emergency medicine training
- The need for clear communication of any change in service to the people of South Tyneside and Sunderland
- The travel impact for South Tyneside patients under both options, although potentially significantly less under option 1, and the detailed work being undertaken to help mitigate this
- Key assurance from NEAS in terms of deliverability of the options, not least with respect to the transfer of patients and place of safety.

The Chair thanked Mr Brown for his overview and invited questions from all governing body members.

A question was asked as to what assurance could be given to parents presenting at STDH with a sick child requiring required urgent attention after hours.

At this point of the proceedings, the Chair invited Dr Wahid, Medical Director from STDH and SRH to provide expert advice in relation to the questions raised. Dr Wahid advised that a communication strategy was being developed to advise local residents of the new paediatric arrangements. He clarified that in the event that a child attended STDH out of hours, the child would be assessed and stabilised as all A&E consultants were trained in paediatric advanced life support. If necessary, the child would then be transferred to the PED at SRH or the Great North Children's Hospital if required. The last admittance would be at 10pm where the patient would either be discharged or transferred to SRH.

A question was raised as to the retention of paediatric nursing staff during the transformation period. It was noted that staff retention was good and that STDH already

had a number of advanced nursing practitioners which would support long term workforce sustainability.

In response to a question relation to the unification between staff of both STDH and SRH, it was noted that it was essential for staff to work as one integrated team.
A concern was raised as to whether SRH had sufficient staffing capacity to manage an increased number of paediatric cases. Assurance was given that this would be addressed by the workforce planning model. During option 1 transition, planning would be undertaken to ensure sufficient staffing for option 2. In addition efforts would be made to inform local residents that some child illnesses were able to be resolved within South Tyneside in other settings.

Clarification was sought as to whether both options would provide sub-specialist paediatric clinics within an outpatient setting, such as for children with long term conditions. It was noted that these developments offered the opportunity to attract more specialist skilled staff to modernise services closer to home and hence improve the local sub-specialist service for South Tyneside in particular.

The role of the external review group during the transition period was clarified as working with partners, such as the North of England Clinical Senate and the Child Health Network, to get expertise and ensure it was safe to move forward, including the involvement of staff to be able to assure them also. It was noted that the work with and views received from these expert groups had been important to develop safe models of care for the local population.

As there were no further questions, the Chair moved to the recommendations contained within the report.

He commented that paediatrics was the most complex of the three service areas under review, with workforce being the most challenging issue, therefore a staged approach would be more appropriate. The governing bodies were reminded that option 2 was being recommended for implementation as the most sustainable long-term model, but recognised that it would take a period of time for the requisite work to be done for this to be deliverable and, hence, option 1 was also being recommended for implementation in the short-term.

It was noted that implementation of option 1 would aim to be completed by April 2019, as a transitionary step and implementation of option 2 would include an external group to review the transition and proceed at an appropriate pace over the medium-term for likely completion by April 2021.

The governing body members were also asked to support the proposed amendment to opening hours under each option, from 8pm to 10pm as the closing time.

Dr Walmsley, as Chair of South Tyneside CCG, invited South Tyneside Governing Body members to make their decision:

**Resolution**

**South Tyneside CCG Governing Body members APPROVED option 2 for implementation as the most sustainable long term model but recognised it would take a period of time for the requisite work to be done for this to be deliverable and also APPROVED option 1 for implementation in the short term. For clarity it was recommended that option 1 be approved as a transitionary step towards option 2.**

**South Tyneside CCG Governing Body SUPPORTED the proposed amendment to opening hours under each option from 8am to 10pm as the closing time.**

**South Tyneside CCG Governing Body members NOTED that implementation of option 2 should include an independent external review group to review the transition and proceed at an appropriate pace over the medium-term for likely completion by 2021.**

Dr Pattison, as Chair of Sunderland CCG, invited Sunderland Governing Body members to make their decision:

**Resolution**

**Sunderland CCG Governing Body members APPROVED option 2 for implementation as the most sustainable long term model but recognised it would take a period of time for the requisite work to be done for this to be deliverable and also APPROVED option 1 for implementation in the short term. For clarity it was recommended that option 1 be approved as a transitionary step towards option 2.**

**Sunderland CCG Governing Body SUPPORTED the proposed amendment to opening hours under each option from 8am to 10pm as the closing time.**

**Sunderland CCG Governing Body members NOTED that implementation of option 2 should include an independent external review group to review the transition and proceed at an appropriate pace over the medium-term for likely completion by 2021.**

**Stroke**

Mr Brown reminded governing body members of the three options put forward for consideration:

- 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.

The recommendation was to approve option 1 for implementation. This recommendation was made on the basis of all evidence considered including the fact that:

- A clear preference for option 1 was expressed by the local clinical team as most likely to deliver best quality, specifically relating to fewer deaths and less life-limiting disability
- There was unequivocal support for option 1 from the Northern Cardiovascular Disease Network and the National Clinical Director for Stroke. The key issue was the likelihood of recruiting sufficient staff to enable appropriate competencies as compared with options 2 and 3
- There was a substantial difference in favour of option 1 in the IIA. It was noted that options 2 and 3 scored negatively under the IIA, being the only options to do under any of the three services
- Option 1 was most likely to deliver greatest improvement in quality and safety for both populations, building on the substantial increase in Sentinel Stroke National Audit Programme (SSNAP) scores for South Tyneside patients since December 2016. Particular improvements were noted in areas such as thrombolysis, although it was noted that the temporary relocation did not constitute full implementation of option 1, so there was more work to do such as in therapy and nurse practitioner support. It was noted that the SSNAP performance figures indicate no capacity issues at SRH since the temporary change
- Consolidation of the workforce in this way was 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 the following:

- Concerns about delays in treatment were highlighted. It was noted timely transport to the right hospital with the ability to deliver excellent, consistent hyper-acute stroke care was key. It was noted that the evidence was clear on that point.
- There had been no capacity issues at Sunderland Royal Hospital (SRH) since the temporary changes in 2016, nor were there 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
- Whilst option 1 would see an increase in travel for South Tyneside residents, both other options also required all South Tyneside patients to be directed to

SRH in the first instance. On balance, it was thought the clinical benefits of workforce consolidation should outweigh the increased travel time for visitors, but also that the work being undertaken on travel and transport would help to mitigate this

- There would be no change to the current transient ischaemic attack (TIA) service under any option
- The clinical team shared the concerns expressed by the public that repatriation, under options 2 and 3, would itself hamper recovery.

Dr Walmsley invited questions from all governing body members.

A query was raised in relation to whether the CCGs could influence the travel and transport authorities to provide an improved transport service from South Tyneside to SRH for visitors of longer stay stroke patients. Assurance was given that work had been undertaken with key partners, including NEXUS and other bus operators to ensure bus information and travel plans were developed, personalised journey planning ticketing and more streamlined information available between the two sites. The Travel and Transport Stakeholder Group would continue with this work.

Clarity was sought in relation to the TIAs and communication to general practitioners as to what was classified as high or low risk. Communication had already been issued to general practitioners in South Tyneside and patients with a high risk TIA were already being treated at SRH. Only low risk patients would remain at STDH.

It was expected that the next SSNAP results would be available in March 2018 and members were reminded that option 1 had not yet been implemented under the temporary relocation. It was noted that an additional nurse practitioner had been engaged in August 2017 to ensure the recent improvements following the temporary change in stroke care were continued.

The temporary model had been in operation since December 2016 with national data being very clear that there had been a positive outcome for South Tyneside residents. The crucial importance of ensuring patients get to the right hospital, with hyper acute stroke care over the first few days, was emphasised.

It was noted that Governing Body members expected the best care for the residents of both South Tyneside and Sunderland, hence that performance and standards would continue to improve with the implementation of option 1.

A question was raised about the ability to repatriate South Tyneside patients for rehabilitation to a bed closer to home. Patient safety and optimum recovery were the prime concern and it was clarified that early repatriation could have a detrimental impact for the patient so would need to ensure there was no clinical risk in doing so.

It was queried why it would take until April 2019 to implement option 1 as this had, if effect, been in operation since December 2016. It was noted that there was work to do around, for example, the recruitment of additional therapy staff. It was also noted that, following the conclusion of the meeting, there may be also further consultative, regulatory or legal processes that would need to be followed, so the timeline was intended to reflect that.

As there were no further questions, the Chair moved to the recommendations contained within the report.

Dr Walmsley, as Chair of South Tyneside CCG invited South Tyneside Governing Body members to make their decision:

**Resolution**

**South Tyneside CCG Governing Body members APPROVED option 1 for implementation - that all acute strokes are directed to SRH with the consolidation of all inpatient stroke care at SRH – and NOTED that implementation would aim to be completed by April 2019**.

Dr Pattison, as Chair of Sunderland CCG, invited Sunderland CCG Governing Body members to make their decision:

**Resolution**

**Sunderland CCG Governing Body members APPROVED option 1 for implementation - that all acute strokes are directed to SRH with the consolidation of all inpatient stroke care at SRH – and NOTED implementation will aim to be completed by April 2019.**

A general point was made that nurses, midwives and allied health professionals should be provided with the same support as those who were more central to the Path to Excellence programme and assurance was given that all staff would be given the required training and support.

**MIC2018/06 Next steps**

Dr Walmsley advised that the outcomes from this meeting would be communicated to all key partners and statutory stakeholders along with timescales for implementation. In addition it was essential that the implementation phase was addressed and carried in the same robust manner in which the implementation phase has been.

In closing the meeting, the Chair acknowledged the hard work and dedication of NHS staff, local authority officers and elected members, community and voluntary sector organisations, plus the positive role played by new partners such as NEXUS. New

working partnerships and relationships had been established which would help to break down organisational and institutional barriers.

The Chair also thanked the population of South Tyneside and Sunderland for considering the issues and providing their views as part of the public consultation. This information had informed the process and helped to strengthen the position of local services.

The Chair again noted the compelling rational for change to save many people's lives had been paramount throughout the process and whilst there would still be challenges ahead, he was confident the CCGs had made the best decision they could to improve local health care provision so the NHS could continue to grow and be secure for the future.

**MIC2018/07 Any other business**

As there were no items of any other business the meeting closed at 4pm.