Partners in improving local health

North of England Commissioning Support

Path to Excellence Phase two – Seeking staff views

Event summary report FINAL

March 2018

Contents

1 Executive Summary

As part of the clinical review process, staff in both Trusts have highlighted the many challenges they encounter in their daily roles. Feedback obtained via a survey of over 700 employees across both Trusts between December 2017 and February 2018 highlighted many recurring themes around workload, capacity and staffing, as well as equipment and facilities. These themes were echoed by almost 200 staff who took part in engagement workshops held in March 2018. A high-level summary of the key issues and concerns highlighted by staff are summarised below:

Workload and staffing

Staffing was identified as a daily issue and staff from both hospitals highlighted how nursing vacancies posed some challenges in being able to continue providing the best possible quality of safe patient care. Recruitment and retention challenges were a major theme with staff highlighting a reliance on both temporary staff and 'goodwill' to cover staff shortages in various specialties. Staff reported how this had a negative impact on personal resilience and wellbeing, with an inability to achieve a good work / life balance and risk of 'burnout' described. The ability to cover unexpected staff sickness within services which are already carrying high vacancy levels, was also highlighted as a concern, with examples given of clinical managers stepping in to undertake unfilled shifts.

Staff described how this had a knock-on effect in other areas of care with the risk of essential quality improvement tasks, such as clinical audit, being forgone.

Capacity and demand

There was widespread acknowledgement of the growing and relentless demand on services all year round. This was felt to impact on the quality of service provided and staff described the challenges of caring for more older people with incredibly complex conditions and with rising levels of dementia. Some staff described how running at 100% bed occupancy presented a challenge, particularly during winter when they felt greater capacity was needed to accommodate the seasonal surge of patients. Staff also talked about the need for more efforts across the NHS to avoid hospital attendances and admissions. Suggestions included GPs working in nursing homes, virtual clinics for patients with long-term conditions, more ambulatory care, enhanced specialised nursing outreach and improved frailty services. Staff also shared experiences of how barriers in accessing appropriate social care support for patients could often delay discharges, impacting on overall capacity.

Staff training and development

Staff also described how pressures on the workforce presented a significant challenge in getting the time to undertake appropriate training or one-to-one supervisory discussions. Ensuring appropriate time to train and support newly qualified nursing staff was also voiced by some staff as a challenge, while the lack of substantive consultants in some services also meant junior doctor training

supervision fell to a smaller number of permanent medical staff. Staff also highlighted how the high use of temporary staff could result in different skill mixes being available, with a risk to quality and real challenges in ensuring that new staff were familiar with systems and ways of working. They also commented how they needed a ‘consistent consultant’ instead of locums to help support the team and ease pressure.

Differences between the two Trusts

Many staff highlighted how the current inequity of service provision between the two hospital sites needed to be addressed, with the limited amount of specialty cover at South Tyneside District Hospital at weekends given as an example. Staff described how medical staffing shortages particularly impacted on the ability to provide the optimal level of senior doctor cover at both sites.

This also extended to cultural differences in ways of working, with differing policies, procedures and protocols, as well as different working patterns, roles and skill mixes of staff within teams. It was recognised services need to be aligned and standardisation is required. A key recurring theme was also around the IT infrastructure and need for unity across both Trusts, which was recognised as a both a major challenge, but also a key enabler, to improve integration of services and crosssite working.

Communications and engagement

Staff repeatedly emphasised the importance of engaging and empowering people at all levels, in both trusts so they feel part of the Path to Excellence programme and ensuring all communication is timely, open and honest. The importance of staff engagement and regular communication, even when there are no updates to give, was a recurring theme so staff constantly felt kept informed, able to provide reassurance to colleagues and to dispel rumours. It was strongly felt that the success of change depends on the involvement of staff at all levels, with the importance of ensuring that clinical leaders speak positively about the future opportunities. The importance of clear communication also extended to the public, who were recognised to be very skeptical about the future of South Tyneside District Hospital.

As well as sharing their thoughts on the challenges faced, our staff in both hospitals also articulated a number of shared ambitions for the future. There were several recurring themes from staff in attendance at the March engagement events who expressed a universally desire to:

- have a clear, shared vision for each clinical service across both Trusts
- have stable, integrated teams which are sustainable deliver
- standardised care and treatment across both Trusts which offers the safest, most effective care for patients – ‘clinical excellence’

- provide a smooth journey for patients and ensure they are seen by the right specialist, at the right time, in the right place seven days a week become an employer of choice offering greater flexibility for staff, a better work / life balance and attractive working conditions
- Have fully integrated IT systems deliver improved outcomes for patients through continuous learning, innovation and improvement

2 Event analysis

2.1 Clinical support services; Monday 19 March 2018

2.1.1 Introduction and reflection

To initiate table discussions, staff were asked to discuss their hopes and fears of The Path to Excellence programme.

Opportunities

In terms of the opportunities that the programme presents, the following were identified;

- A thorough review of current service provision across both trusts
- Improved service delivery – seamless pathways and integrated services
- Sharing and implementation of best practice
- Generation of new ideas through working in larger teams
- Improved skill mix, staff development and progression
- Professional leadership
- More appealing working practices for new staff
- Improved capacity and ability to implement 7-day working due to increased staffing pool
- Improved efficiency and cost savings
- Maximise opportunities regarding trust initiatives i.e. research.

Worries and fears

There were however, a number of strong themes that emerged in relation to the worries and fears that staff have.

There was a perception among some that many of the larger decisions concerning the programme have already been made, and further that these will favour Sunderland. Comments were made that the systems and processes at South Tyneside have not and will not be considered, that the influence / voice from both sites will not be equal and that it will be South Tyneside who will have to make the compromises. Those who worked in South Tyneside highlighted some of the work that they do, that Sunderland aren't able / don't currently deliver. It was reinforced that there must be scope for change at both sites.

"We feel swallowed up by a bigger trust"

"Just because we are a smaller organisation, we are ignored"

“Not one thing has happened in South Tyneside’s favour – need re-assurance that it is collaborative working”

“South Tyneside has a lot of community services, and Sunderland doesn’t. Sunderland can learn from stuff that South Tyneside does”

“Developing pharmacy technicians to work as patient focussed, whereas Sunderland doesn’t do this”

Staff emphasised the importance of engaging and empowering staff at all levels to feel part of the programme, and ensuring that all communication is timely, open and honest. It was emphasised that advanced notice of engagement events must be given to ensure that all those who want to attend can, and that consideration is made to those who are unable to attend but want to be part of the process. Conversely, there was also an acknowledgement that some staff are reluctant to get involved and that this can act as a barrier.

“Staff on ground need to influence clinical decisions”

There was a feeling among some that decisions need to start to be made, and communicated, to help teams plan and ensure that the process is not ‘dragged out’ longer than necessary.

“Can’t plan until you know what is happening”

“Changes and improvements need to happen faster”

“There must be basic decisions made by now? Be honest and open so we can start making changes”

One of the major concerns regarding the future integration of services was the different systems and processes that are currently in place, with many referring to the IT infrastructure. Furthermore, there was widespread recognition of the difficulties that will be encountered in terms of standardising policies, protocols and procedures between the trusts.

“We can’t work well together at the moment because the process is so different”

To a lesser extent, transport and parking was also considered an issue for some. Furthermore, it was noted that from a patient perspective that residents living in Jarrow and Hebburn already experience issues travelling within South Tyneside which will be further exacerbated if they have to travel to Sunderland for their care. Members of pharmacy discussed not having an onsite pharmacy, and the potential issues that this will create.

“The hospital pharmacy is the point of call for the public”

Additional concerns related to;

- Downgrading and loss of jobs, de-skilling of staff

- Managing capacity and demand issues across both sites.

2.1.2 **Challenges faced**

Staff were asked to identify the current operational challenges that they face, and need to be considered. However, staff tended to talk more broadly about the issues that they would be faced in terms of the integration of services. The issues are discussed under the sub-headings;

- Capacity and demand
- Differing systems and processes
- Differing staff role and responsibilities
- Poor staff morale and wellbeing
- Financial constraints

Capacity and demand

Capacity was repeatedly discussed throughout the event, with staffing gaps identified within teams. It was noted that the uncertainty of the future of the alliance makes it difficult to recruit to posts, this was particularly the case for some individuals who worked in South Tyneside who felt that new recruits are more inclined to apply for positions in Sunderland. This situation is further exacerbated by staff moving to other NHS providers and the private sector due to the uncertainty of the future. This is inevitably leads to increased costs of using locums to fill positions quickly.

These staffing gaps were felt to make it difficult for teams to plan for the future and move forward.

"Work gets missed i.e. governance / paperwork because the team is restricted in capacity. There is no backup option"

There was further concern about capacity issues, as well as the financial implications, in relation to the introduction of 7-day working, within those services where this has yet to be introduced.

"There is the issue of not enough staff – will dilute what is already being provided"

Differing systems and processes

Concerns were repeatedly raised about the IT systems in both sites being so different and the impact this will have on data collection and sharing of clinical records. It was felt imperative that alignment of these systems must be considered first.

Some staff from South Tyneside highlighted that adopting Sunderland's current system would be impossible for them due to current staffing and resources, with concerns that this would compromise patient safety. It was noted that the system in place in Sunderland is different from the whole of the region, and that South Tyneside has already merged systems with other organisations e.g. Gateshead.

Furthermore, it was repeatedly reinforced that standardisation of all policies, protocols and procedures will be required.

Although it was recognised that services needs to be aligned and standardisation is required, adopting new working practices of work was undoubtedly a concern for staff.

Differing staff roles and responsibilities

There was a recognition that job roles and the skill mix within teams vary significantly between the trusts and that this will present a challenge in terms of integration. This was particularly the case for pharmacy staff.

Furthermore, it was noted that the flow through grades is not well-established and that development and training opportunities are not currently clear.

Pharmacy staff from South Tyneside indicated that staff are adapting to be flexible in different roles, in preparation for change;

"We have papered over crack to stay and try to be resilient. We always work as a team to help each other to get the job done"

Poor staff morale and wellbeing

Poor staff morale and wellbeing was felt to be common within the workforce, a result of constant change over the years. It was acknowledged that this has a significant impact on the care delivered to patients. Some staff discussed their fear that the changes will not have a positive impact on staff.

Staff reluctance to engage was also identified as a barrier.

Financial constraints

Comments were made about the lack of investment that has been made in staff (i.e. training and CPD) as well as resources and equipment.

It was recognised that financial constraints prevent collaborative working between the trusts, in addition to raising difficulties in the trusts being able to follow / achieve national standards.

It was highlighted that investment is needed to be able to re-align services, and further that joined up budgets requires a long-term commitment from the trusts.

Other less frequently discussed challenges related to;

- Patient flow – supporting efficient patient flow/safe service provision
- Transport links and parking (cross-working)
- NHS professional service not currently being well perceived
- Lack of leadership, ownership and direction
- Loss of confidence of patients during the public consultation process
- Integration of CCGs

- Services provided by private providers (outsourcing of CT/MRI reporting is costly)

- Facilities and technology – patient safety issues if all centralised (i.e. centralising pharmacy services can lead to storage issues)
- Outcomes and impact from phase one and phase two and impact on CSS.

2.1.3 **Our future aspirations**

- A shared vision of focus and way of working within stable, integrated teams
- A levelled and future proof service
- A provider of services which can meet / exceed national standards, is well respected by members of the public and delivers the safest, most effective care (that you would expect and want to receive yourself)
- Services that are being continually improved through constant feedback processes
- An employee of choice; attractive working conditions for staff and new recruits (increased capacity, 7-day working)
- Fully integrated IT systems i.e. HR, regional networking and patient systems
- Improved staff morale and wellbeing with;
    - Opportunities for staff to improve their existing skillset
    - Staff being able to fulfil what they want to achieve
    - Staff being able to work pro-actively within a larger team
    - Opportunities for ideas and creativity
- Improved efficiency and cost savings through reductions in maintenance costs and waste, maximising administrative capacity, reduction in waiting times for patients, resources and equipment
- A management structure fit to support a sustainable operational merger with the knowledge of clinical aspects of the service
- Patients being able to plan their own journey and make informed choices about their care (including appointment times and locations)

Specifically, for pharmacy, their aspiration was to have one integrated functional pharmacy team with uniform high standards across the board providing one standard core service.

And for the radiology department;

- One team across both trusts using multiple sites and a standardised practice
- High quality, accessible diagnostic imaging reporting's in a timely manner (same day inpatient service)
- Fully functioning shared RIS
- Full complement of radiologists covering full skill mix – required to absorb majority of work (in house)
- Fully staffed department to allow capacity to match demand
- Raised profile of the service.

Markers for success

- Increased patient satisfaction – with active feedback systems back to teams to boost morale
- Standards within NHS benchmarking / national guidance
- Locally agreed quality standards
- Patient safety
- For pharmacy; minimal dispensing errors, discharge process time, patient flow, minimal medicine incidents
- For radiology; 2WW (urgent, STAT, routine), radiation/MRI safety.

2.1.4 **Achieving our aspirations**

Staff had a preference towards a stepped change approach, as opposed to a radical reform, with an acknowledgement that some of the smaller steps could start to be implemented straight away.

"*Stepped – don't want to change too many things at a time – basing on assumption that one clinical team will work better"*

"Excellent opportunity to make a big shake up – start from scratch"

Furthermore, it was recognised that problems can occur when staff start to integrate. Therefore, it was felt that this needs to start to happen as soon as possible to minimise issues and alleviate fears before official integration. By doing so, this would give staff the opportunity to communicate at lower levels whilst providing feedback to 'the top'. Attendees questioned whether staff could be 'freed up' to visit sites and meet teams.

"*More action, less talk"*

Actions required:

In terms of going forward, staff recognised some of the steps that need to be undertaken;

- Regular meetings between trust leads to ensure strong leadership
- Infiltration of staff on both sites – giving staff the time, space and empowerment to have conversations
- Map current service provision and patient flow across both trusts; identify which services are being provided in which, and which areas are ahead of others
- SWOT analysis – identify current strengths and weaknesses of services, identify problems and what is done well and move forward together
- Map a good clinical pathway
- Alignment of IT infrastructure with IT support (standardisation of data collection and sets
- Modality lead reviews
- Standardisation of patient pathways, protocols and procedures (e.g. review appointment templates, radiologists to agree standardised protocols with support from modality leads, supported by regional discussions and linked in with clinical referrers)
- Clear roles and responsibilities; specialised roles within teams, no more efficiencies, one team for each task, no variation in banding levels between trusts.

'Must-dos'

- Establish a clear vision
- Involve the correct people in decision making
- Give staff time to respond to engagement and feed into the programme and keep them up-to-date as and when decisions are made.
- Encourage open communication and collaboration between teams – so they can learn from each other to create the best service
- Take on board regional best practice and don't duplicate mistakes (e.g. regional pharmacy network, regional guidance model)
- Don't work in isolation – keep other trusts informed about innovations and link in with local authorities
- Engage with patients as much as possible and use their feedback to improve service delivery
- Manage patient expectations early
- Give resources to help investment in teams - investment must be equal to services across the board
- Reduce reliance on neighbouring trusts / less outsourcing
- Give staff time to do their job, progress and provide the best service they can
- Pharmacy considered it essential to transfer to electronic prescribing – as not changing this will deter people from applying for positions.

2.1.5 **Staff engagement**

A re-occurring theme throughout the event was the importance of staff engagement and providing open, honest and regular communication, even if there are no updates that can be provided.

The following were identified as the best methods to involve staff and wider clinical teams;

- Engagement and feedback events / road shows
- Visual displays e.g. white board

- IT systems / Intranet
- Videos / webinars – film events and upload (sometimes more helpful than minutes)
- Monthly newsletters (including myth busters)

It was noted that consideration should be made to engaging and empowering those at lower levels, as well as capturing feedback from those who want to participate in the discussions but are unable to do so.

Furthermore, it was suggested that subgroups are formed which are comprised of health professionals from different disciplines (including therapists and representation from therapy groups).

2.2 Surgery, theatre and critical care (including elective and specialist services); Tuesday 20 March 2018

2.2.1 Introduction and reflection

To initiate table discussions, staff were asked to discuss their hopes and fears of the programme.

Opportunities

In terms of the opportunities that the programme presents, the following were identified;

- To share good practice and learning
- To explore different ways of working
- Increased knowledge and specialities
- Career development and progression
- Improved capacity / ability to cover staff shortages
- Integrated IT system
- Standardised care and treatment
- Demand management
- Efficiencies and cost savings

Worries and fears

There were however, a number of strong themes that emerged in relation to the worries and fears that staff have.

As with any process of change, although there was a recognition among some that change is required, staff were uncertain about what the future holds and when changes will take effect.

“Can’t sustain unsustainable services”

Furthermore, concerns were raised about decisions being made in favour of Sunderland at the expense of South Tyneside - downgrading services, deskilling staff and negatively impacting on staff morale. It was noted that previous agreements of expansion of ITU and HDU have been put on hold.

“Concern that South Tyneside will be downgraded to day surgery only”

“Can communities cope with the deployment of services”

This apprehension was additionally noted to exist among the public – arising from decisions made from phase one of the programme.

Staff strongly re-enforced the need for open and transparent communication, as and when decisions are made, to dispel rumours and provide re-assurance. A comment was made on one table that it must be acknowledged that communication has not been great in the past but that improvements will be made.

“Open and transparent discussion rather than just hearing things through other people”

“Share what is happening as decisions are made - quash the rumours”

Staff acknowledged the differences in working practices that exist between the sites, specifically in terms of IT infrastructure, paper vs electronic records, facilities and equipment. This was felt to pose major challenges in terms of the integration of services and cross-site working (i.e. staff training).

Increased travel for staff was also identified as a concern as this was felt to have both financial and life quality effects. It was suggested that if staff are expected to work between sites that a structure is in place to make it fair for all.

“Further travel costs, less time to spend with family, increased stress because of extra travel and lack of confidence working with other people”

Concerns about travel also extended to patients, in terms of moving them between sites and the impact this would have on waiting times and patient safety.

Other less frequently raised concerns included;

- Ability to maintain quality standards with new teams, processes, equipment and facilities
- The potential impact on community services which are already overstretched and don’t have capacity.

Challenges faced

Staff were asked to identify the current operational challenges that they face, and need to be considered. However, staff tended to talk more broadly about the issues

that they would be faced in terms of the integration of services. The issues are discussed under the following sub-headings;

- Capacity and demand
- Staff training and development
- Financial constraints
- Differing systems, policies and procedures
- Discharge and rehabilitation
- Cultural change and resilience

Capacity

Staffing was identified as a daily issue for both trusts, especially during holiday periods. It was recognised that capacity issues makes services difficult to run with safe staffing levels and ultimately impacts on performance and quality.

For example, ICU staff described how they are pulled from their unit to cover other wards which has a knock on effect on maintaining ICU services, as well as impacting on training, education and morale. Concerns were also raised by about the acute pain service which has no prospective cover if staff are absent.

"Staffing pressures compromise quality standards"

"Stretched at South Tyneside, high workload but doable through the good will of a small team. But still causes stress among staff"

Staff retention and recruitment were recognised as issues, the latter especially the case for South Tyneside. This was felt to be down to the uncertainty of the future of the alliance as well as the more attractive working conditions within the community (e.g. working hours). There was concern that the segregation of services between sites might cause future challenges in terms of recruitment.

"Nobody knows what's going to happen"

Retention of staff was felt to be particularly an issue for younger staff with concerns being raised about the future with an ageing workforce.

Particular areas / positions struggling to recruit were identified as nursing / nursing students, junior doctors (less uptake via flat rate), trauma vacancies (Sunderland) and Band 6 positions (South Tyneside).

"No ward based doctors at South Tyneside"

Staffing gaps result in greater use of agency staff which poses problems in terms of skill mix and experience. It was noted that typically agency staff are employed to cover nightshifts which can result in a reduction in skill mix and experience, this is exacerbated further by on call cover when 'a body is used to fill a gap'. Rates of pay for NHSP staff were also identified as a future challenge;

"Pay for bank staff is insulting"

A number of issues were discussed in relation to community care, specifically;

- Long working hours ‘puts staff on their knees’
- Reliance on bank staff who don’t have the same skills
- Inability to stop discharge surge even when resources aren’t enough – perception that they can’t say no
- No escalation plan in place

In terms of the future integration of services, managing staffing and skill mix was identified as a challenge.

Demand

There was a widespread acknowledgement of the demand that is placed on this clinical area and that this is not just limited to peak times, but all year round. This was felt to impact on the quality of service that is provided.

“It’s not just winter surge anymore, it’s all year round”

Staff described how they do not have the capacity to do their ‘normal’ work never mind anything additional.

“Meetings are cancelled where risks can be addressed because staff are needed back in work”

“Daily ‘firefighting’ to ensure care and cases achieved, last minute changes are frequent”

Over-running of theatre lists was frequently discussed by staff, with staff reporting that they feel pressure to stay to avoid procedures being cancelled.

“Lists aren’t closed soon enough”

Staff training and development

Capacity issues, as well as financial constraints, were identified to have a significant impact on staff training and development with an acknowledgement that there is a lack of specific trained staff.

“Need to invest in staff training education to allow development in roles”

“*Lack of funding for training i.e. Degrees, leads to less experiences staff getting higher posts and very experienced staff unable to progress”*

“Unable to release staff for training due to staff shortages”

Differing systems, policies and procedures

There was a widespread acknowledgment of the differing IT infrastructure in place at the sites, which was felt to be a major barrier for the integration of services. Further concerns related to the slow computers on wards and the high demand for these.

“Barriers are IT systems – Sunderland moving to paperless, South Tyneside don’t have Meditech”

The differing policies, procedures, equipment, procurement and supplies were also identified as challenges, as well as a general lack of knowledge of how each trust works currently.

"Pre-assessing at CHS difficult as information not available across trusts – off site investigation results not available"

Financial constraints

It was recognised that lack of investment is an issue as staff are required to 'do more for less'. It was suggested that more funding is required or alternatively that activity needs to be limited.

"The NHS needs to say no to things or say they don't do things"

"No room for improvement or progression as no one will invest"

Discharge and rehabilitation

Staff discussed how patients are often discharged too early due to bed capacity without proper planning, equipment being in place and/or sufficient medication. Furthermore, district nurses are not always informed when patients are discharged. The importance of taking patients straight from hospital to rehabilitation was highlighted in terms of reducing the chance of re-admission.

"Getting patients out to have the capacity to get them in"

"Early discharges needed at South Tyneside, however people still need care with nowhere to go"

Staff highlighted the challenge that will be faced in terms of communication if care is provided in Sunderland but community care is delivered in South Tyneside, and further the difficulty of joining up hospital and community services.

Cultural change and resilience

Differences in culture and ways of working were identified as a major challenge for the programme. It was recognised that for some their reluctance to adopt new working practices might result in staff looking for jobs elsewhere.

A number of comments were made about the loyalty and resilience of staff, especially in departments such as ITU, HDU and theatre, as well as within the community. However, it was felt that with the amount of change that have occurred, staff are beginning to reach 'breaking point'.

"The restructuring at South Tyneside has really impacted on the service"

"In South Tyneside staff resilience is based on good will"

Additional, but less frequently discussed challenges included;

- Referral systems / plans

- Emergency services don’t have the pathways to deliver

- Patient safety;
- Due to the interdependency of specialities for example medical / surgical patients
- Concentrating emergency services on one side

- Impact on interdependencies e.g. laundry and porters

- Patients’ needs not being met elsewhere – hence A&E visits.

Our future aspirations

- To develop a clear vision for surgery, theatre and critical care

- Open and honest communication – clarity and consistency

- To deliver the safest, most effective care for patients – ‘excellence’

- To provide a smooth journey for patients – to ensure that patients are cared for in the right place / speciality by the right staff

- Better equity and access to care across both trusts with streamlined care and standards

- Improved waiting times and reduced delays for patients

- A single integrated IT system

- To provide a stable environment for staff which allows / encourages training and education to ensure staff are able to reach their full potential

- To provide a good work / life balance and flexibility to boost staff morale and positively impact on patient care

- Improved capacity through cross-site cover

- To be an employee of choice.

Markers for success

- Financial; increased income and reduced costs
- Patient care; reduced length of stay, fewer complications and re-admissions
- Patient satisfaction / positive feedback; friends and family survey
- Staff satisfaction; staff surveys, reduced turnover, decreased job vacancies
- Better utilisation of lists; less on-the-day cancellations
- Indicators; WHO checklist, theatre count, SOPS, 18 weeks, 31/62 day targets, diagnostic tests, pharmacy metrics
- External reviews, CQC and CEEPOD feedback

It was emphasised that patient and staff safety, re-admission and infection rates, should not be compromised on.

Achieving our aspirations

The majority favoured a stepped change approach, as opposed to a radical reform, however there were some that favoured a 'big bang' or felt that a combination of both approaches should be used;

"One big bang change"

"*Radical reform of IT and equipment across both trusts – may be an issue due to current contracts - stepped changes of policies and guidelines"*

"Big bang after full involvement and communications with staff"

A stepped change approach was felt to give more time for staff and patients to adapt, allow standardisation of working practices and involve less risk;

"Emergencies could be compromised due to lack of knowledge/equipment for each (surgeon/speciality)"

"New ways of working. Need transition time"

Actions required;

Strong leadership was felt imperative to implement change and challenge barriers. It was noted that the right decisions need to be made to generate business and match this with capacity.

Staff agreed that decisions need to start to be made, specifically with regards to what services will be where, to help teams start to plan for the future.

"Hard but right decisions – putting off inevitable"

"Stop deliberating – do it and keep staff informed and let it happen"

"Make a final decision, quickly, and stick to it"

“It’s easier when there is more detail”

A service review was considered necessary to understand what both trusts do, what works and what doesn’t, to allow replication of good features across both sites. It was felt imperative that this included provision within the community. Staff at South Tyneside discussed how they are keen to learn from Sunderland in terms of having a better scheduling process for theatres.

“Truly explore what is currently delivered at both”

Communication and cross-working between the sites was considered to be the first step in the process of integration. However, there were concerns as to how this would be feasible with current capacity issues.

“Peoples best interest to discuss now“

“Not going to be harmful to talk and share”

“Get clinicians to talk – stop sub-grouping”

Learning from other trusts such as London, where a single team operates over multiple sites, was identified as a must to understand the issues that other trusts have faced and how these have been addressed.

What does an integrated service look like?

Staff were asked to think about what a single team serving two populations might look like in terms of surgery, theatre and critical care. Some of the ideas that were discussed are presented here;

- Specific specialities located at each site with matching skill mix
- Surgical ambulatory care service at South Tyneside
- Joint surgical ambulatory unit with emergency admission unit
- Direct referral from NEAS / clinics / GP / nurse practitioner to surgical ambulatory care (already in place for NEAS at Sunderland for medical)
- Nurse practitioners across both sites for surgery
- Increased flow through the front door and discharge home without admissions to hospital for next day follow up /surgery / in-clinic investigations
- Capacity for ambulance transfers between sites
- Standardisation;
  - IT systems
  - Hours of operating sessions
  - Shift patterns

- Working practices – equipment, processes, supplies, documentation (clerking and electronic)
- Information – service / ward names and numbers

- Centralised administrative team - to provide better planning of theatre lists and resources, with separate emergency and urgent lists

- Patients given date for surgery immediately following assessment (patients feel better going home with a date)

- Earlier pre-assessment to prevent last minute cancellations (time to deal with problems)

- An improved discharge process – including access to community physiotherapist teams, a specific place for patients to go for problems after surgery rather than by-passing A&E

- Matched demand & capacity;
- More efficient use of staff
- Increased capacity

- Staff training and education;
- Joint educational training for both sites
- Induction of staff on both sites
- In-house training
- Greater collaboration with Sunderland University
- Increased numbers of student nurses and support for healthcare support workers into training (provide a clause to stay)

- Better bed management - more rehabilitation beds

- Standards for occupational therapy and dieticians being met
- Acute pain service delivered over both sites
- Transport system between sites for patients and staff.

Staff engagement

A re-occurring theme throughout the event was the importance of communication and engagement to allow staff to be kept informed, to provide reassurance and to dispel rumours. It was strongly felt that the success of change depends on the involvement of staff at all levels, with the importance of ensuring that leaders speak positively about opportunities also being highlighted.

"Board managers have responsibility to provide information to other staff"

It was noted that by providing options to staff gives them something more tangible to work with.

The following were identified as the best methods to involve staff and wider clinical teams;

- Team / ‘huddle’ meetings (board members to visit each team for discussion and boost morale)
- Face to face engagement / Q&A events on neutral ground (with subsequent feedback given after the event)
- Central website with integrated forums – to discuss issues
- Newsletters – distributed and available on the intranet
- Ice breaker party / meet and greet.

A number of key points were made with regards to communications sent be email;

- Reduce the amount – only communicate accurate details
- Condense to specific points
- Be less corporate and specific to the audience
- Stop sending emails ‘on behalf of’.

Other staff groups connected with surgery, theatre and critical care were identified as; physiotherapy, pharmacy, community care, mental health, pain, porters and dietetic.

2.3 Medicine and emergency care; Wednesday 21 March 2018

3 Appendix

3.1 Clinical support services

Monday 19 March: The Path to Excellence - Staff Engagement Workshop - Clinical support services

Pharmacy

Discussion 1

- We feel swallowed up by bigger trust
- Feels though all the big plans have already been agreed.
- Decisions have already been made by Sunderland.
- They haven't looked at ST's systems; they just keep looking at what is best for Sunderland.
- Some things are better here at ST rather than Sunderland.
- Dealing with change now.
- Everyone will have individual ways of doing things
- The benefit is that this will mean we have exposure to a larger trust, there will be progression opportunities.
- Staff just want to be involved in the process
- Just because we are a smaller organisation, we are ignored.
- We are worried of the unknown.
- Previously in mergers, it was 50/50 with the influence / voice we had.
- This is the right thing to do, but it's the way that it's happening, which is the problem.
- The process being different at the moment is the barrier.
- We can't work well together at the moment because the process is different.
- Sunderland requires a lot more staff input, whereas ST don't have this.
- If there was investment in staff and resources then this would make things work.
- Acknowledgement of the good work in ST, we don't want people to lose sight of the good work that ST does.
- ST has a lot of community services, and Sunderland doesn't. Sunderland can learn from stuff that ST does.
- Where is there only 1 public consultation in phase 2?
- Why doesn't pharmacy itself go to public consultation?
- Problems can arrive when staff integrates. This needs to happen sooner to avoid issues. Before official integration, alleviate the fear
- Both ST and Sunderland need to know the same information at the same time.
- Not having an onsite pharmacy is worrying
- Learning from other organisations for good practice, and taking on board what works
- Transport is an issue- people need to have access to an onsite pharmacy, without travelling out

Discussion 2

- Staffing
- Resources
- Not much investment in pharmacy
- Lack of direction
- Giving the best service we can, even though we are not meeting certain timelines
- Extension of staffing levels – (7 day week) Makes a difference, we would see significant changes
- 2 separate systems causing issues – if we adopt Sunderland systems, we don't have staff and resources to work well. It would actually be impossible, and it would like to patient safety being at risk.
- ST systems are a different way of working, and it would lead to safety issues.
- Changing systems to Sunderland - would benefit the staffing and investment to make safe workflows.
- There is a perception that Sunderland don't want to downgrade, but don't want to share their processes, and make their resources slip.
- Culture shift – results would change if systems changed.
- Sunderland over recruit – ST was never allowed to recruit when the timing was right
- Moving forward – using agency staff
- The perception is that what is the point in applying for here, as Sunderland is larger and these changes are happening anyhow
- We want investment to be equal service across the board. Making it better for all departments.
- We want to work collaboratively for patients, but financial constraints stop this.
- Concern that investment is not there.
- Risk of patient flow, A&E blockages due to overstay. Depends on what it will look like. Unknown leading the unknown.
- Retained a lot of staff at ST. We are an integrated little team. Staff have left and returned. People have worked here for years. Encouraged to develop and learn more.
- We have papered over crack to stay and try to be resilient. We always work as a team to help each other to get the job done.
- You do feel impact, if people go of on sick / annual leave.
- Staff are adapting to be flexible in different roles.
- At the moment people work in different roles. If we were in Sunderland, people may not be skilled in all areas.
- Work gets missed i.e. governance / paperwork because the team is restricted in capacity. There is no backup option.
- Our goodwill is driving us forward but things can start to slip – we have no capacity.
- Not being able to train / pull staff in because of uncertainty of how the service is going to look.
- We have had outsources services – and it hasn't been great. The financial impact has created capacity but it hasn't been great.
- Public should be aware of the risk of the impact on patients. People don't realise the impact.
- The hospital pharmacy is the point of call for the public.

- Electronic prescribing – not changing this will deter people from wanting to work here.
- ST to step up
- Been left in limbo for years that even if we now get updated technology, we will still be left behind in comparison to other trusts.
- Ensuring the right systems are given to us, not just to copy others, but to look at the bigger picture and give us what we need.
- Sunderland running services in their way, doesn't mean that this the best way.
- SR processes and skill mix is much better.
- Different ways of working would depend on how the service is delivered.
- Processes need to work for both.
- Developing technicians to work as patient focussed, whereas Sunderland doesn't do this.
- Worried that staff will be de skilled.
- Training differences and responsibility in roles
- Sunderland don't downgrade their systems to help ST. There needs to be 2 way conversations.
- Quality of data / systems will be impacted if we use their systems. Quality risk on patient safety.
- Uncertainty is having an impact on the demand for people wanting to work.
- Recruitment needs to be held at certain time to actually recruit.
- People are worried then recruitment is taking place – questions are asked at interviews.
- At the moment this is not an issue but it could turn out to be.
- It would've been nice to see Sunderland's thoughts on what is working for them.
- Impact on patient safety because different working means Sunderland has bigger teams to look at things.
- Perception that Sunderland don't need to engage, because it's going their way.
- This could be wrong as this is only our ST perspective.

Themes:

- Technology and facilities
- Staffing - mixture in skills and staffing
- Culture / ways of working
- Decision already been made without engaging
- Patient safety

Discussion 3

- Best effective pharmacy we can be for patients
- Give staff time to progress
- Give time to do their job – best service they can provide
- Across the board levelled service
- Everyone needs to be involved in decision making – bottom up – instilling staff confidence in patients
- Staff informing change. Valued when included in decision. Empowered in change
- Change is scary for patients and staff

- Develop and make service future proof
- Provide a good service for them – reflects on patient experience
- Positive feedback from patients. More valuation from patients to impact pharmacy morale
- Service change becoming less attractive to keep and recruit staff. Future proof attractions
- Efficiency in staff number trails. Getting us to fulfil what we want to achieve
- Give resources to help investment in team
- Very good at day to day but reactive. Very little change to do other tasks like governance work. Things start to slip
- Ideas and creativity within the team – little investment – reward would be a massive
- Safest, most effective care in service
- What you would expect for yourself
- Strive to be the best that you can so people you know would be happy to be treated by you
- Standards within NHS bench marking
- Minimal dispensing errors. Discharge process time, patient flow
- Model hospital
- Patient safety
- Medicine incidents
- Staff appropriate roles/staff skill mix
- Influencing purchasing right medication
- Specialised roles within the team
- Understanding 2 sites will be different
- One system – one process
- Staff integration
- Clear communication and responsibilities
- Centralised staffing – implications of environment being centralised
- Site and facilities being centralised could be dangerous for storage
- Patient experience in hospital – pharmacy last port of call
- Benchmarking against national guidance
- Standardisation of interpretations of work
- Standard core service – done wherever you go
- Patient facing
- Don’t want to compromise on anything
- Not losing sight of where pharmacy fits into other services
- We Influence many different areas – not just pharmacy
- One integrated functional team – uniform high standards across the board
- No variation between two sites
- Best pharmaceutical care throughout service
- Shared vision of focus

Discussion 4

- Stepped change – looking at one thing at a time. Don’t wait to change too many things at a time

- Perfect time now to integrate staff. Communication in lower level and feedback to the top
- Identify what problems there are and what is done well then move forward to work together
- If not aware of problems, don't know how to solve. Unaware of what the processes and systems are, so that we can compare
- Are we in a position to send staff over and see how they work and what way they do things
- Communication ongoing and see what both sites are bringing
- Infiltrate both sites and staff
- Budget around staffing and safe radical reform, however can impact straining staff etc.
- Needs investment to safely re-align services
- Is there anything Sunderland is doing that can free up their staff to come to ST?
- No investment – what can Sunderland bring then?
- Has to be some scope for change on both sides
- Some sort of warning – new system has to be safe
- Standard operating procedures right across site – centralised. Some services delivered across the board
- Smaller issues will turn into big issues because of change between two sites
- ST is having to sacrifice/change everything
- ST and Sunderland so different – look at aligning systems and processes first to make most efficient process
- Shouldn't we be adopting systems aligned with STPS
- Trying to align with Sunderland, but all region works in one way and Sunderland do it differently
- ST have already merged systems with other organisations e.g. Gateshead (similar systems)
- ST and Sunderland need to look at wider regions systems throughout region
- Learn from what other Trusts have already done
- Aligning with Sunderland – will mean moving further away from everyone else
- Open discussion – learn from region
- Uniformed practice within region
- Communication/open dialogue – best practice with region, not duplicating mistakes
- Use regional model for guidance
- Equal change in services moving forward
- More action – less talk
- Start the process of change – eliminating rumours
- Is it ever going to happen? Maintain engagement but start getting results
- Deflating no involvement from staff
- Getting appropriate staff to do the right job
  * Responsibilities
  * No more efficiency
  * One team for each task
- Don't just look at each other but take a regional systematic approach
- Communication – keep us informed and in place

- Accepting this is how we are going to do it – quick wins to get staff on board – actions - maintain

Discussion 5

- Trying to keep staff engaged without knowing vision for the future is hard
  * No vision from higher level
  * Communicating honestly with people
- If you weren't involved you would be angry, even though you are now involved – cases
- Facilities in ST are bad – hopes are not being fulfilled– demoralising
- Too long – it's a dying process
- More engagement events – to keep involved and then feedback at work
- There must be basic decisions made by now? Be honest and open so we can start making changes
- Bring on opportunities – implementing up to date systems but no support
- Fear that changes will not have positive impact on staff
- Feel like decisions already made
- Inform us of vision – be clear, instead of just ideas
- Open conversation on what is actually happening
- Long process, why has decision not been made
- Not hearing what's going on, and then there is a sudden change
- Not one thing has happened in ST's favour – need re-assurance that it is collaborative working
- Pharmacy impacts on all departments
- Cant plan until you know what is happening
- Need to look at pharmacy as a whole impact
- Involving at the right time, not when it's gone
- Not working as a clinical team
- Have time to go over to Sunderland and see
- Skill mix very different in both sites
- Different job roles in both sites
- Identify correct skill mix for each job
- Senior level needs to have some vision

Monday 19 March: The Path to Excellence - Staff Engagement Workshop - Clinical support services

Opening bit of reflection:

- CONCERNS : Working across two sites – new departments, how others work (training), may affect the patients – impact on both populations
- Adopting different practices of work – both want to work to same standards
- Managing capacity and demand issues across both trusts
- Ability to standardise i.e. protocols
- Losing jobs and downgrading

- Financial investment into IT service
- OPPORTUNITIES : to improve the service delivery across both sites and implement best practice
- Right equipment - right location (for the right job)
- Land availability at ST
- Maintenance cost reduction and consumable cost reduction
- Staff development – career progression
- Centralising some services
- Bigger staffing pool
- RIS
- Opportunity to work across the two sites – improving skill mix
- 7 day cover
- Maximise opportunities regarding trust initiatives i.e. research

What are the challenges we face?

- Capacity demand issues
- Patient flow – supporting efficient patient flow/safe service provision
- Vacant posts
- Financial gap to support funding of modalities when required
- Ability to follow national guidance due to staffing gaps and budgetary
- Inability to be provider of choice
- Loss of confidence of patients during public consultation process
- Transport links
- IT structure – impact on data collection
- Difference in policies and procedures
- Parking – cross working, trying to consolidate meetings and costs increase
- Standardisation – protocols, appointment times
- DNA's
- Issues with consultant vacant post, band 5 & 6, apprenticeships – expectations of newly qualified staff
- 7 day cover – cost
- Workforce planning future
- Workforce resilience i.e. future proofing
- Equipment
- Long term sickness
- Staff morale
- Communications with staff
- Outcomes from phase one and phase two and impact on CSS
- Standardisation

What are our aspirations for the future?

- High quality, accessible diagnostic imaging reporting's in a timely manner (same day inpatient service)
- Locally agreed quality standards
- Improve morale – staff pro-actively working as a team
- Fully functioning shared RIS
- Increase patient satisfaction
- Full complement of radiologists covering full skill mix – required to absorb majority of work (in house)

- Fully staffed department to allow capacity to match demand
- Right service in the right place
- 7 day working
- Standards – 2WW (urgent, STAT, routine) radiation/MRI safety
- Fully functioning IT systems i.e. HR, regional networking and patient systems (outpatient style – booking in/portal)
- Reduce maintenance costs
- Reduce waste in all areas – supplies
- Shared policies and procedures – to reduce rework
- Maximise admin capacity
- Raising profile of service
- Team building

How can we fulfil our ambitions?

- Modality lead review
- Review patient pathways and standardise as much as possible
- Standardise protocols
- Away days – two trusts modality leads
- Review appointment templates
- Ability to follow national guidance i.e. Barium Enema & IVU
- Reduce reliance on neighbouring trusts – skill mis
- IT

How do we take this work forward?

- Shared staff details
- Radiologists to agree standardised protocols (with support from modality leads, supported by regional discussions and linked in with clinical referrers
- Patient flow review and review of appointments
- BARRIERS : lack of engagement
- IT systems
- Staff availability – conference call
- Visual display – whit board
- Road shows ?

Monday 19 March: The Path to Excellence - Staff Engagement Workshop - Clinical support services

Opening bit of reflection:

- Staffing –capacity & sharing best practice
- Get smarter with budgets – share resources
- Sharing clinical records
- Get better at forecasting
- Staff on ground need to influence clinical decisions
- Patient records
- IT systems
- Recruitment – need to give candidates in i.e. merger – better retention

What are the challenges we face?

- Capacity and demand issues – standardisation of protocols and appointments
- IT issues (Inc. reporting)
- Impact of phase one on services
- Parking
- Recruitment and retention (communications)
- Workforce planning
- IT
- Outsourcing but can do it internally
- IT- 2 systems between 2 trusts and community
- Staff community between trusts
- Staffing/capacity
- Some services 7 day working, some not
- Staff unable to invest in CPD training
- Join up dots across systems
- Sometimes not enough time to care for patients
- Referral pathways
- Pharmacy (ST)
- Systems and processes (2 trusts different)
- Facilities and technology – patient safety issue if all centralised

What are our aspirations for the future?

- One integrated team
- No variation of staffing levels
- Provide best pharmacy care for patient throughout journey
- Safe, timely and sustainable outcomes
- Be employee of choice
- Do 2 CCGs need to come together more
- More transparency
- Do the things that we can get on with now
- It's got to be about staff engagement
- Shortest journey time
- Best possible service
- Try to do everything in house
- High quality service
- Fully staffed department
- Fully functioning IT service (HR and patient)
- Management structure that's fit to support service
- Maintaining and improving existing skill set
- Make sure therapists voice is heard
- Triage of patients – one stop shop, centralised point of access
- Outcomes for patients getting that right
- Improving attendance
- Better choice for appointment time
- Best data available (not just locally but nationally)
- Communications (upto date website)
- Giving confidence to ST residents
- Keeping services local (staff will want to stay local)

How can we fulfil our ambitions?

- Services not currently talking/working together – should start doing so now
- Don't work in isolation – keep other trust informed about innovations
- Need to look at discharges
- IT systems need to be better and support
- Need to talk to patients more and involve them – we could have a patient reference group
- Need to link into local authorities
- Different name for hospital
- Cant split acute and community therapy
- Staff need to be given time and space to get involved
- Standardise data collection
- Benchmarking for capacity and demand
- Give 2 trust leads time and space to meet regularly
- Standardise patient pathways
- Use standard appointment templates
- Use national guidelines – allowing us to do this by supporting each other
- Excellent opportunity to make a big shake up- start from scratch
- Focussing resources to deliver on call on site
- Not making use of radiology reporting
- Need strong leadership
- Assumption that one clinical team will be better- this does need to be a step change. ST already had to make service change
- Need for equity across both trusts
- Need to understand the current set up across both trusts
- Staff to be given time & space and time allowed to respond to engagement
- Need correct people involved in making decisions
- Look at regional positives - there is a good regional pharmacy network – need to look at bigger picture – look at STP area
- Efficiencies – less talk more action – changes already made but more to be done

How do we take this work forward?

- More integration between teams and then look at how region works together
- Need information to flow both ways – opportunities for staff to feed into the processes
- Recognition that 'therapies' covers a diverse group – need to make sure we get the right representation
- Important that information is fed to and from sub groups
- Monthly newsletter
- If nothing to report – say that
- Barriers – IT – can we start work already?
- Share staff details between 2 trusts
- Advise colleagues about changes – look at patient flow protocol
- Barriers –people who don't want to be engaged
- IT
- Staff availability
- Whiteboard update
- Roadshows
- Communication – having time to come to meetings
- Single intranet
- Webinars

- Myth busters
- We should ask staff how they want be communicated with – don't assume
- Getting to know you sessions
- Barriers – delayed decision making
- Therapies – diverse group – not just a 'bucket of therapies'
- Minutes not that helpful – could meetings be filmed?
- Merger – what does this mean? Need to be clearer

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Opening bit of reflection:

- Finance is in the way of patient safety
- Want to be able to have seamless pathways/clarity between the two trusts
- There is a growing population so when are the trusts going to get closer together to support what the NHS is trying to do
- There needs to be a solid surface amongst nursing homes, the demographic and the travel involved
- There are opportunities for seamless care – care closer to home, staff are used to providing services in certain settings
- There are opportunities to review services on both sides but there's the fear that if services overlap, they won't do as well in one trust as the other original
- There's scope to review services across both trusts
- Working together across trusts provides larger groups of people with more ideas to be shared
- The RVI and freeman work together and have a better skills mix, and recruitment will be better if people know there's chance to work in both areas –appeals during recruitment
- Services available need to be shared across both trusts
- There is uncertainty about the merger, people need clarification and honesty
- Therapies can complement each other and have community opportunities, which is what patients want

What are the challenges we face?

- There is a difference in the computer systems – both trusts need to be able to see if patients have been admitted with ease
- Changes and improvements need to happen faster
- Computer systems need to be matched up as currently they are not in the best interests of the patients
- Details need to be view/able to be accessed without having to ask, as this is not good use of time. There needs to be one overall system that joins both the trusts together
- NHS services need to be integrated
- It's not about whether staff like the systems, but what meets the needs of the patients
- Each trust needs to know what the other would do in certain circumstances

- Travel is an issue – patients want home visits
- People already face travel issues within ST just to get to Jarrow/Hebburn, never mind SLand – it's not free for patients to even be able to see GPs
- Better IT systems will benefit staff as time won't need to be accounted for to travel to physical meetings/finding car parking etc – it will speed up the process
- Trusts need to learn more about each other's services
- For SLand, there is not enough funding to be able to focus more on community aspects, whereas ST get funding from the CCG, although is just a small area/not well known/very well heard of?
- Some services offer 7 day care/service whereas others only offer 5 - there is the issue with not enough staff/will dilute what is already being provided
- Some areas need 7 day services because if someone is nil by mouth on the Friday afternoon & don't offer 7 days, they will have to wait until possibly Tuesday to get any information/test due to under staffing/small teams
- Need to upskill where necessary in smaller teams in order to provide 7 days rather than just 5
- Services are limited if not 7 days, benefits will come from it, such as a positive staff morale
- 7 days could prove difficult within smaller teams but it could be do-able if things are prioritised and get appropriate staff
- Patients to be seen in one hospital throughout treatment, not treated in one then have check-ups in another – services differ and care needs to be consistent
- Students coming in through universities need to be part of the services, not just coming in for six weeks and then leaving again
- Communication within trusts is key

What are our aspirations for the future?

- Make sure guidelines are being met – if they're met then the needs of the patients are being met also
- Make patients aware of any progress/improve patient & staff communication
- Patient expectations are getting higher all of the time, the more that is offered to them, the more they will be expecting in future – need to manage expectations
- Get more staff to fill in & return staff questionnaires
- keep things local – there is the cost implication of shuffling staff from one place to another
- share improvement plans with patients – give them a better image & update websites so that the latest information is always available to patients
- present feedback to patients so they can see if and when things are being done and they can be kept in the loop
- staff use social media to their advantage – dedicated so many hours a week to replying to social media comments and giving a good staff image
- provide services that are exciting and engaging for staff, communicate positively and present lots of opportunities
- staff get scared of change and uncertainty then start to leave – spread positive messages

How can we fulfil our ambitions?

- Trusts need to talk to each other to see which services are provided in each
- Banding differs amongst services – which staffing levels are needed to provide services
- Different areas are ahead of others – need to increase communication so all services are at the same level
- Develop a pathway to come up from and look at what services have and do to work together
- Improve communication and joint working – it's good to see what innovations trusts have
- There is confusion between trusts/products and patients – medication shouldn't differ when out of hospital to when patients are in
- It's like staff are 'trained' to give appointments – provide patients with tools to manage/look after their illness and come back only if necessary rather than saying to anyway just for a check up
- Use tele health more
- Make use of the amount of apps available
- Put more focus on patients to self-manage more – teach them how to look for trends/re-dose, etc. provide them with the tools to change themselves
- When implementing innovations, make sure trusts are linked in from beginning and aren't working in isolation

How do we take this work forward?

- Staff to be involved in discussion
- Subgroups need different disciplines together
- Work collaboratively
- Involve staff by having them in their staff groups
- Have videos where staff can watch rather than physical meetings – better use of resources
- Be honest and open with staff
- Speaking to other services need to branch out to different hospitals and little steps to be taken by each team

Monday 19 March: The Path to Excellence - Staff Engagement Workshop - Clinical support services

Opening bit of reflection:

- Not enough communication
- Lots of subgroups – not enough notice of meetings
- How can staff feed in to meetings if they can't attend
- Restructuring as working closer
- Ai to share best practice across the trusts -- stat better communication and share work plans
- Networking and building bridges required

What are the challenges we face?

- Recruiting the correct people for the long term

- Day to day morale
- Constant change over lots of years
- Decisions made without staff impact or input
- Out of hour on an evening?
- Getting staff voices heard
- Credibility
- Lack of knowledge of services – where money comes from
- Smaller teams means longer waits
- Staffing gaps – sick leave, high female number, consider local university links
- Training – is everyone qualified
- Clinical records are different
- Will CCGs work more integrated
- Joined up budgets – longer commitment
- Data forecasting
- Data sharing

What are our aspirations for the future?

- Stability – how service will work, who will deliver
- Constantly reviewing of work , feed in what's good and feed into plan
- Waiting time and better efficiency
- Triage – educational piece
- Complex patients
- Work better between two trusts so we can get to where we need to
- What do patients need – capacity improvements
- Triage across areas to save time
- Educating referral
- Improving patient journey –one stop shop
- No postcode lottery - evidence based
- Setting patient expectations early
- Patient education – RE travel
- Timely for patients – especially children
- Choice of appointment – living far away early parking
- Talk to patients – patients helping plan their own journey
- Can we have patient groups?
- Competency and capacity
- Continually improve train others
- Share best practice – easy to get involved, what works well elsewhere - trusts don't do enough of what other trusts are doing message, cost saving – web based appointments
- Central point of access
- Efficient cost saving – technology
- Better choice – appointment times
- Inform people of decisions
- Look nationally – what's working – best practice

How can we fulfil our ambitions?

- IT infrastructure – clinical systems, better IT support, better outcomes as people are more informed
- Talk to people – clear pathways – regular visits

- Review efficiently
- Knowing who professionals are in each trust
- How do people spend their time
- Prioritising complex conditions
- Look at appointment times
- Closer working of the two trusts – sharing info and plans
- Have a flexible workforce
- Come out of comfort zone
- Integrate two trusts
- Look at what services across the trusts have in common

How do we take this work forward?

- Regular communication
- Face to face contact
- Ask staff how they want to become passionate
- Work as one team
- Listen to worries/concerns of staff
- Interact with all services
- Succession planning
- More empowerment at lower levels

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Opening bit of reflection:

- An alliance is necessary
- If service moves, then there will be more transport issues for both staff and patients
- Opportunity for professional leadership
- Difference in senior structure from CHS to STFT
- Need involvement from all services – learn from each other – create the best service
- Unsure what the organisation and directorates are going to look like - difficult to describe structure of clinical support
- Difficult to describe a service in a location if the location moves
- 7 day current working resources
- Services provided by private providers
- IT infrastructure
- Referral process
- Clinical systems – digital examples
- Training
- Policies and procedures
- Patient pathways – standardise response times/processes
- Standardise triage processes

What are the challenges we face?

- Recruitment – communication challenge, not clear on what the future holds for the alliance
- Risk of losing staff due to uncertainty

- Working as one team would be an opportunity, however – challenges on knowledge of systems, differences in operational processes
- Different timings, unclear processes
- 7 day service limited – current staffing capacity, cannot handle the 7 day service
- Staff being lost to private providers or other NHS providers
- Timing and loss of staff ad their replacement – leads to increased costs – using locums to fill positions quickly
- NHS professional service not currently being perceived well and efficiently
- De-scaling of staff
- Not encouraging staff
- Need to cover within team
- Pressure to staff
- Long term health and well-being of staff compromised – leading to an impact on patient care
- Movement of patients in and out of community – where does this fit?
- Communication not great – many systems and resources but not efficiently used
- Facilities - restriction on services to have access to – can't go outside of listed contracts
- Changes to funding – funding reduces further
- Development and training opportunity not currently clear
- Flow through grades not established
- Service leadership, ownership and direction not there
- Restructure of the trusts

What are our aspirations for the future?

- Management structure – fit to support a sustainable operational merger with the knowledge of clinical aspects of the service
- Maintaining and improving the existing skillset
- Equity of care pathway prioritise across STST & CHS
- Representation of therapists in the appropriate forums

How can we fulfil our ambitions?

- Mapping a good clinical pathway then understanding
- Giving staff the time, space and empowerment to have the conversations
- Due to small number of staff, staff are more generic in skillsets (but a good skills mix)
- Need to standardise data collection
- Disparity in outpatient and inpatient data
- Capacity and demand management – scheduling and utilisation
- Benchmarking
- Electronic system essential – data sharing , data collection , contingency planning
- Clinical standard, guidance , best practice and benchmarking

How do we take this work forward?

- Map current service progression across both trusts
- SWOT analysis - gap analysis of strengths and weaknesses of services
- What will services looks like if 7 day becomes available
- All electives in one place – what does that look like – staff to rotate across both sites
- Representation of therapists and therapy services - implication/impact out of 1 day job

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Discussion 1

- Need to have more AHPS in community end of life care
- Already submitted
- Time to work with colleagues across both sites / need to know strengths of both sites.
- Knowing where high cost, low impact clients are and look at hub and spoke arrangements.
  - Looking at the bigger picture on sub-regional commissioning of services
  - Data sharing across agency / IT solutions
- In some specialties there are huge discrepancies between the two sites / services
  - Levelling up services / not down
  - Sharing resources
- Understanding what currently happens and giving clinicians enough time to input and develop the service
  - Will help identify waste
  - Allow staff to thrash it out together
- Podiatry
  - Not much contact between services
  - Need to understand how things work across both
- Contracting
  - Need to look at contract conversations
- Services Already decommissioned that keep people out of hospital: left hand needs to know what the right hand is doing
- Working with CCGS to understand
- Workforce
  - Leaving in droves to go to other Trusts (EOLC) – South Tyneside
  - Uncertainty / people not clear
- AHP Day
  - Myths about jobs security
  - People thought they were going to hear about jobs
- Radiographers / Restructures
- Culture – people not feeling able to contribute ideas
- Pressure on workload / budget being cut
- Health and wellbeing of staff.

Discussion 2

- Demand outstripping capacity / staffing
- Patient demand growing
- Resilience to cope with sickness, leave
- Locum staff / bank staff – struggling to fill posts
- Staffing working over and above / burnout
- Issues with CPD / service development / no time to invest

- Appraisals saying the same over past 2 years because of lack of time
- Podiatry (not struggling as much re recruitment)
- No reserve pot of budget to cover leave / maternity / long term sick
- Prioritising certain clinical areas – juggling act between acute / community (stopping people coming in / discharges)
- Competing agendas / decommissioning / not knowing what is coming up / still awaiting contract outcomes
- A lot of staff have already voted with their feet

SHIFTS

- 12-18 months is a long time to cope with uncertainty
- Maternity leave and long term sick
- Specialist areas – sub specialisms
- Cross working / already starting to talk across sites
- Specialist nurses EOLC / prescribers too
- Can't recruit into medical vacancies
- Consultant vacancies not able to fill / back fill
- Celebrating the positive things / attracting workforce

Safety and Quality

- Not enough staff and time to see patients
- Patients wait longer / some people die before EOLC get to see them
- RTT
  - New referrals seen on time but ongoing / open episodes of care not as well managed
  - High referral rates during peak demand / fire fighting
- Lose of education / training / motivation / retention on various circle
- Voice patients – may not be seen as high risk but consequences may mean surgery – pressure elsewhere
- Paediatrics – hard to invest where we need to in terms prevent / mental health
- Aging population – pressures – we know they are coming
- Podiatry – high risk patients in nursing homes – emergency admissions
- Profile / Trust with patients
  - Often have to push back what we said we would do
  - Simple reviews can then turn into complex cases
- Understanding links with hospice / whole system working
  - Clarity about what you are referring to
- People referring into SLT
  - wasted time telephoning round to get the right details
  - education around referral guidelines
  - new types of referral coming into palliative care
  - recognition due to aging population that overall workload increase
  - AHPs are the afterthought in terms of budget setting
  - Distribution of budgets need to change
  - Support staff / admin cover – clinical time
  - Inviting teams to be part of discussion / Comms / employee voice
  - We know where clinical pressures will be

        - Children with ASD / neurodisability
        - Aging population
        - Support to do more research and development / sharing innovation
    - Income / how the money works

Discussion 3 - Ambition

- Safe, timely, sustainable, properly funded, cost effective
- To effectively forecast when we are going to see patients and deliver on that
- For staff – that they are fully trained, competent – right therapist seeing right patients at the right time
- Career pathways for our staff and opportunities to develop
- Nationally exclaimed / recognised
- Employer of choice
- Supporting patients to get the best outcomes
- Focus on
    - Health improvement / prevention rather just the care
    - Scope within the service to develop something new to do it / share best practice
    - Ring fenced time to look at improvements / feeling comfortable about taking time out to plan long-term
- Improved co-ordination and comms between services to improve patient journey
- Improve awareness of what is available
- Promoting the service / increase the voice of the service / internally
- How can we do better
    - Sharing best practice / creating the opportunity to do it
    - Ability to sit down between processional groups – develop trust / honesty
    - When do we do that? At which point do we start?
    - Understanding the benchmarking
- The two CCGs to improve flow of money – should CCGs merge?
- Meeting response times across all areas (not just high risk)
- Staff and patient feedback – positive
- Reputation / national benchmarking
- Reduced complaints / incidents (Level 3)
- Reduced hospital deaths – preferred place of care for death
- Outcomes
- Reduced readmissions and avoidable deaths
- Improved retention of staff
- Not having to prioritise care based on achieving targets / equity of service for everyone.
- 48 hour response for high risk patients
- Clinical standards are not contracted standards
    - Being involved in setting targets
    - Clinically appropriate CQUIN Targets
- NICE guidelines must adhere to
    - RTT is the main measure at the moment
    - Transparency about targets and standards
        - What we will do and what we won't do
        - EOLC guidelines – need to be developed

Efforts

- Staff engagement and support
- More streamlined pathways within and across specialties and sites

Discussion 4

- Assumption that one team / service is better
- Anxiety for staff across both Trusts / all sites already
- Job/work factors as well as rumour mill / staff are also members of the local community

Stepped Change

- Support for staff must be paramount
- What works well and what doesn't work well?
- CHS SLT pockets elsewhere / fragmented care / no integration
- STFT – 4 different management in 2 years / lots of changes
- If change has to happen – what is it and when? – what about merger?
- Equity across both Trusts – looking at what is good at STFT not just CHS
- Perception about 'take over'
- Managers who know the specialty / less changes in structure
- Process is unsettling in itself
- Sharing the current set up / details
- Must be flexible / responsive / joined up
- Less of / stop
    - Moaning
    - Stop reinventing wheel on policies / process
        - Best bits from both
    - Less inequality between services for patients
        - Standards?
- Not making changes that are not proven / necessary / change for change sake

Discussion 5

- We need to make sure information flows both ways
- Who's who in workstreams and subgroups
- Therapies is such a diverse group – how do we make sure all informed
- So there is already discussions happening – need to make sure same times at same time
    - What do you need from the teams
- Every two subgroups – face to face with key staff to cascade information
- Responsibility of CSRG leaders to cascade information
- Videos / roadshows on site / in community venues
- More notice (min 6 weeks) for clinical time

Additional information via post-it notes:-

- Involvement of Local Authorities / education / social services
- CSR will impact on therapy services work with LA

- Patient Engagement – needs “non ED” P – eg OP, Community, paeds and adults
- If we can support patient care at “other” site – can we do this (financial flows, referral voices etc)
- CSR “button” on front page of intranet
- Staff survey – very surprised at low response rate – were you??
- Need time to respond to queries for work as part of this process with clear expectations / guidelines
- Where do private providers fit into CSR?
- Where does the MCP fit with all of this? Staffing structure very different across both organisations – who’s going to influence that?
- Is it already decided that each service will merge into 1? Is there evidence that this will result in improvements?
- How do we recognise Comm teams in pathways / processes e.g. early d/c – ongoing rehab in community (d/c to assess) and reduced length of surgical stays impact on com nursing, VTE, complex wounds, pre op prep.

Clinical Support Services Staff Engagement Workshop – 19/03/18

Radiology

Discussion 1 – Reflections so far

- MRI pressures, more demand than capacity. Need help with capacity issues to ensure good delivery of service.
- Pressures on planned and acute; if the pressure continues to grow there will not be enough capacity.
- A lot of job loss worries and fears.
- Outsourcing for CT/MRI reporting is costly.
- IT infrastructure (Meditech) needs updating or the service will bottleneck. It does not support a lot of the needs of Radiology.
- Staffing issues. Will we be moved to shift work?
- What will be the way of working going forward? Will it be 1 team across 2 trusts or 2 teams in each trust?
- Not all of the outpatient radiology work needs to be at CHS
- If we invested in the staff now in 2 years we would have enough to cover
- There is instability in the staff; need to know what is happening?
- How do we actually work as one team? Is it possible?
- Trusts are not making best use of the resources; why are we sending work back to CHS to be reported when STFT can do that work?
- We would like 1 team across both trusts using multiple sites and a standardised practice.
- There are culture issues around reporting.
- Risks of moving work back into the community.
- Major external factors – GP patients/ cancer patients who need continual radiology services.
- There are a lot of unused rooms at CHS due to aged equipment.

Discussion 2 – Challenges

- IT systems – STFT seems to work a lot better than STFT. Meditech will not be able to handle the future work.
- Having standardised vetting - 1 way to image – both to have a lean process/less time.
- Will both trusts be working from 1 IT system.
- STFT only use paper for the patient checking before scanning while awaiting infection control laptop.
- What CHS want to do cannot be done with Meditech.
- Protocol developments – have standardised protocols. All in agreement; no re-calls at STFT.
- CHS have no lead for MRI protocols – have no out of hours support; there is a protocol but it is not robust. Difficult issues with Paeds.
- 4 ways are being paid while CHS have sufficient radiologists on site to do the work.
- There is a gap in service for an out of hours MRI service.
- Inpatient work is being continually put back due to capacity issues. Need to start looking at 1 site having a specific 24/7 MRI service.
- Larger capacity issues regarding reporting – sufficient capacity to scan patients but no-one to report them.
- 4 ways ED scanning varies – it is not 100% but is working well at present.
- ED pressures for head CT's (nightshift)
- Recruitment issues
- Off site on call won't deliver with a shift system.
- Need to review the use of external providers
- Off-site providers do not use the same protocol as CHS and want extra things to be done and looked at.
- Culture change is hard – some do not want to change at all and some are willing to change.
- Departments work different patterns and hours and both sites work differently.
- Specialised staff and teams don't/cannot co-work and cover different departments.
- STFT are short of Radiographers and higher 5/6 band staff.
- Trusts are working on 2 different IT systems which will cause problems switching from 1 to the other. This makes a potential for errors and has high safety risks associated with it.
- Need to invest in our staff / role development / more training
- More staff benefits / make trusts equal
- Invest more in equipment
- A lot of staff worried about their job security?
- Both trusts need better communication and re-assurance to the staff
- Public statements are poorly worded and are giving the wrong impressions
- Use of full staffing rotas will increase retention
- Invest in updating department look; CHS X-ray department looks very old and shabby

Discussion 3 – Aspirations

- Why do OPD MRI scans only sit on the system for 48 hours to be reported before being picked up when the referral waiting time is 9W? (CHS). What should be the allowed waiting time for these scans to sit before being picked up by 4 ways?
- CHS reporting prioritisation and allocations a problem
- Re-insourcing Radiologists for overnight on call
- Need to make sure the emergency side is staffed first
- We would like a 24hr CT service not just a on call service

- What is the shortest time for patient pathways while having high quality care? Radiology should support this and have some timescale in place
- Breach dates for pathways have become a priority over clinical care
- New MRI booking system is not working very well and is causing issues at present (more complex cases and take longer so they are harder to protocol)
- Knock on effect on capacity issues from other OPD department's not just A&E; for example both fracture clinic and chest clinic have appointments with x-ray on arrival and no pre-warning for us.
- Obsolete testing – (IUV, Barium Enema) why are CHS still doing these tests. They should be done by CT or colonoscopy
- Standards – stroke/ trauma, acute on-set headache, cancer 2WW
- We aspire for a short wait time with appropriate testing – high quality care
- Radiology to be supported

Discussion 4 – Fulfilling our Ambitions

- Having a standard protocol
- Radiographer reporting services - need staff and IT backup
- Better use of our own resources (skilled staff are underutilised) MRI staff can also report but do not have the time
- Service needs a radiologist to lead and push forward
- Radiologist support is a hot topic with ongoing issues that need addressing
- Need a foundation core of radiologist and reporters
- Culture issues are stopping the service in moving forward
- There are larger issues where there is no money to fix them (equipment)
- Patient choice of sites (patients are sent to CHS when they live metres away from STFT)
- We have unused machines and rooms at STFT but CHS are at full capacity?? Makes no sense
- There should be 1 pool for appointments and all be in 1 system working as one across 2 sites
- This is an excellent opportunity to shake up the services and make big changes to have a service that we all want and how it should be
- **The service should be built up from scratch and built to be robust. A standardised protocol, 1 IT system, strong leadership, commitment from all, investment in good quality equipment, staff investment, strong communications, build a framework with staff engagement from all levels, innovation, collaborative working between the teams, Radiologist support, patient priority (clinical needs are not always 1st)**

Discussion 5 – Moving forward

- Need to get the staff on board with credible information
- Regular staff meetings are crucial to involve the staff
- The sub group members should lead the staff meetings
- Use of email/posters/intranet to update staff
- Monthly newsletters to all staff would be helpful
- Admin staff and all services need to be connected
- Both trusts need to work as 1 team; staff exchange, fact finding, shared practice, shadowing at other trusts
- Barriers – cant cross over as separate trusts at present
- IT systems/culture differences

3.2 Surgery, theatre and critical care

Tuesday 20 March: The Path to Excellence - Staff Engagement Workshop – Surgery, Theatres & Critical Care

Opening bit of reflection:

- Good practice from both sides – opportunities to share
- Can learn from each trust
- Focus on patient – concern/apprehensions from phase 1 (core of discussion)
- Move into community – don't have resources – community colleagues involved. Delayed discharge – involve appropriate teams
- Two services – combined / separate?
- Indirect impact on services
- Concern and suspicion with trusts working together – a lot more in common on a clinical level – similarities
- Reviews to have impact – achieving targets, etc
- Current standards don't work
- Staff issues/ worries on what's going to happen
- Suffering due to delays
- Poor staffing levels – job applications lacking –problems retaining and recruiting staff because of uncertainty from phase one – nobody knows what's going to happen
- Open/transparent discussion rather than just hearing things through other people
- Anxiety of patient safety
- National take?

What are the challenges we face?

- Workload – deliver more on same/less than they need
- Workforce- capacity is a daily issue
- Lack of beds all year round
- Staff retention
- Staff going elsewhere
- Budgets
- Discharging to community – concentrating emergency services on one side
- Patient groups and social care more complex
- Lack of proper care for patients – struggling already, will do more with merger
- Services centralised on one site – impacts on patients
- Becomes a point where can't do as well – capacity
- Getting staff back – international – staff go to community –manageable workload – standard 9-5
- 24 hr care – work and life balance, jobs not as attractive
- Staffing – high demands on wards quality is reduced
- Safety and quality – expense of staff
- Pressure on wards – capacity
- Shared pressures across both trusts
- Emergency services don't have pathways to deliver
- Staff are stretched – quality improvement – no time
- Meetings cancelled – where risks can be addressed – because staff needed back in work (risk)
- Staff training – cant complete/not supported / no time
- Priorities – no capacity to do 'normal' work never mind other things
- Shared concerns across both trusts
- Cant improve/progress as no one will invest
- Trusts aren't progressing together
- Getting patients out to have the capacity to get them in
- No one can give answers
- Prioritising work – work stopping due to merger
- Contradicting work decisions
- Services already stretched
- Organisation – has to be agreements in future to be better
- Need more funding or NHS say no to things/say they don't do things
- Can't give everything to everyone
- NHS wasn't designed for how it is now
- Need to influence more up the line
- Charge A&E patients when could've gone to pharmacists
- Patients have needs that aren't being met elsewhere – hence A&E visits
- Join the dots across systems – one trust, one CCG joining up doing things as one

What are our aspirations for the future?

- Right place, right people, right time
- Safe effective care
- Community based services
- Need staff to deliver needs
- More capacity in hospitals for follow up and community
- Taking up inpatient capacity
- Problems after surgery – specific place for them to go rather than by-passing A&E

- Look at different pathways – be able to look at other issues in other areas , cancer, chest etc
- Inefficient use of staff – make better
- Make clearer pathways
- Don't be as target driven? – taking away patient care/priority
- Have more specialisation access
- Matching times and need
- Matching ambulatory services- extend times – find staff
- Identify needs day surgery – fit for purpose
- Improve feedback from patients
- Performance measures, generic cancellations methods – reduce number of cancellations
- Match the business to the capacity
- Make right decisions to generate business
- Keep staff and patients on one patch
- Eradicate breaching capacity
- Get a better retention rate – career progression
- More progress likely to keep people
- Concentrating efforts onto staff, it follows onto patients
- Services to be prioritised across Sunderland and ST & back rather than just one way
- Zero tolerance for on the day cancellations

How can we fulfil our ambitions?

- Sharing experiences, learning on the job
- Things needs to happen quickly so people know what's going on- thought through but to get rid of uncertainty
- How to make models work
- Hard to do a workforce plan, when no one knows the plan
- Be clear about the future – don't rush things but be planned
- Missed opportunities for cross site colleagues
- Peoples best interest to discuss now
- Collaborate so both trusts have a voice
- Not going to be harmful to talk and share
- Look at policies and procedures – follow same guidelines- don't renew separately – join up
- Can't sustain unsustainable services
- Hard but right decisions – putting off inevitable
- Clarify about what needs to be done and do it
- Lots to keep busy – both sites won't be doing everything

How do we take this work forward?

- Team briefings
- Board managers have responsibility to provide information to other staff
- Clinicians to sit down and work out what issues are
- Stop sub grouping and get clinicians to talk
- All people should be on the same team – soon as clinicians talk, things will get moving
- Common issues are the same across both trusts
- Sub groups generating conversation more

- Negative vibe /cultural differences together because the trusts are geographically closer, but positive once plans are followed through
- Stop deliberating – do it and keep staff informed and let it happen
- Not think about hours and pay but healthcare and why staff are working for the NHS
- Not be so patient- centered, aren't customers and don't pay to be seen by NHS staff

Tuesday 20 March: The Path to Excellence - Staff Engagement Workshop – Surgery, Theatres & Critical Care

Opening bit of reflection:

- Public concerns and petitions (-)
- Working together (+)
- Public perceptions – services so far going to CHS (-)
- Staff concerns – services going to CHS – what is coming to STFT (-)
- Travel implications – patient /client groups
- Opportunities for skills / competencies working across specialities
- Staff retention
- IT systems

What are the challenges we face?

- Staff travel across sites
- Different policies and procedures (-)
- Systems and processes- risks associated (-)
- Paper v electronic records (-)
- Medical devices different (-)
- Procurement / supplies alignment
- Nurse staffing and recruitment (-)
- Retention issues – skilled staff, work & life balance – lack of certainty (=)
- Waiting lists patients (dental services) (-)
- Demand /complex patients/staff capacity (-)
- Skill mix- bank/agency/NHSP fill rates (-)
- Resilient experienced staff (+)
- Succession planning /ageing workforce (=)
- Lack of knowledge now each trust works currently (-)
- Communication from senior management to clinical teams (-)
- Lack of community service involvement – how do we join up hospital and community services (-)
- Referral systems /plans
- Ambulatory surgical care – pathways between CHS and STFT
- Changes in specialities – vascular, acute and day care
- High levels activity and demand – long waits
- Need more streamlining between dental and theatres
- What service specs are needed/service – what do CCG want for community services
- Understanding current community services available/accessible

What are our aspirations for the future?

- Delivering best care – truly explore what is currently delivered at both CHS and STFT – come up with the best (+)

- Engage with peers within specialties (+)
- Look at resources, reduce waste and align supplies etc
- Learning from other trusts – positive and negative
- Will be ‘one’ trust – what will this mean, what will it be called
- To have a clear goal/vision
- Patients to be cared for in the right place/speciality by the right staff
- Nurse practitioners across both CHS and STFT for surgery
- Streamline information (service names, ward names & numbers)
- Developing existing staff – upskill, opportunities, retention, practitioner role – recognised, autonomy, training
- GP admissions, nurse practitioner referrals
- Direct attendance from NEAS to surgical ambulatory care (medical already has this at CHS)
- Functional unit – capacity to admit, set most appropriate patients
- Clinic referrals to surgical ambulatory care
- Surgical ambulatory care service at STFT
- Capacity for ambulance transfers between trusts
- Transport system between sites for patients and staff
- Single IT system
- Align nursing documents /clerking and electronic
- Bigger, better – surgical practitioners – turnaround patient care
- Demand and capacity dental (support patient travel requirements , manage expectations)
- Limit unrealistic choice for patients

How can we fulfil our ambitions?

- Suggestion of joint surgical ambulatory unit with emergency admission unit
- Professional development for current staff at CHS & STFT
- Sharing best practice between both sites
- Sharing areas of development / learning between both
- Joint IT systems (barrier)
- Streamlining resources
- Increase capacity
- Increase flow through the front door and discharge home without admissions to hospital for next day follow up /surgery/R/V in clinic investigations
- Joint forum – website – trust access to discuss any issues
- Clinician to start cross-covering and feeding back – learning from best practice
- Barriers are IT systems – CHS moving to paperless, STFT don’t have meditech

Tuesday 20 March: The Path to Excellence - Staff Engagement Workshop – Surgery, Theatres & Critical Care

Opening bit of reflection:

- Staff shortages, constantly plugging gaps, difficult to run sessions and keep safe staffing levels (-)
- Problems for CHS & STFT similar as neither trust has an abundance of staff (=)
- Potential to move staff between trusts to cover staff shortages (+)

- Pre-assessing at CHS difficult as information not available across trusts – off site investigation results not available (-)
- Different IT systems and equipment in each trust (-)
- If IT combined would make things easier and safer – better
- Training issues If working across areas r.e. equipment (-)
- Things don't run as smoothly if different/unfamiliar staff involved (teamwork) (-)
- Transport time for staff if required to work at a trust they have not chosen – family friendly, etc – will they be expected to work between trusts or will it be an option (-)

What are the challenges we face?

- Staffing – shifts people don't want to cover i.e. on calls
- No night shift in theatres at ST – skill mix can be poor on call due to sickness – find a body to fill the gap, may not be as skilled as the original person
- Pre-assessment more difficult to cover staff sickness due to limited staff
- Lack of funding for training i.e. Degrees, leads to less experiences staff getting higher posts and very experienced staff unable to progress.
- More collaboration with Sunderland Uni
- Unable to release staff for training due to staff shortages
- Quality of care usually kept very god by adjusting skill mix within the theatres
- Infrastructure needs to be in place to support changes in x-ray equipment, radiographers
- Daily 'firefighting' to ensure care and cases achieved, last minute changes frequent
- ST – recent difficult time, resilient but restructure really impacted on service
- NHS staff in general are very resilient but staff are beginning to reach breaking point
- Some changes can bring improvements in morale and bring the department together
- Needs to be planned better in advance – i.e. put on a theatre link sooner allowing better planning of equipment, pre-assessment, skill mix, staff rotas (sessions currently planned but links not populated until much later)
- Future proofing – better admin support reduced
- Communication is always a challenge – how best to do it – reduce the number of unnecessary emails, only accurate details to be communicated
- Need to ensure that if staff are expected to work between sites, structure is in place to make it fair to all staff
- This gives an opportunity for better cross-trust training and sharing of best practice

What are our aspirations for the future?

- Need right amount of staffing otherwise it inputs on service provision, skill mix. Aiming for staff to have a good morale & want to work at all trusts
- We will not compromise in safety for patients or staff, however less staff means that staff often work extra unpaid hours to allow the high quality care to continue, this should not be necessary
- Need more time for training and reworking between departments to allow a greater appreciation of others roles
- More time to spend as team leaders, community openly with staff and therefore this would help to improve morale as they would feel more involved
- Knowing your staff/ team is vital to be able to support your staff and help to know if there is a problem with a particular staff member
- Over running lists frequently assess issues where staff feel pressured to stay to avoid patients being cancelled
- Better planning / earlier populating of theatre lists would reduce a lot of the issues

- Priorities should be patient safety and experience staffing levels and planning
- If cross site working happens next to ensure that induction is given on both sites. Also if it is improved on staff it will have both financial and life quality effects – further travel costs, less time to spend with family, increased stress cause by extra travel and lack of confidence working with other people.

How can we fulfil our ambitions?

- Radical reform of IT and equipment across both trusts – may be an issue due to current contracts stepped changes of policies and guidelines
- To work as a single team – need to get the same equipment and processes to allow staff to work at both
- Teams need to stay separate on each site, too many losses and not enough gains. But when decisions are made as to if specialities are moving either to STFT or CHS we would then need to look at ensuring the skills are moved to match the work
- ST keen to have a better scheduling process for theatres, would be useful to learn from them
- Early pre-assessment can help prevent last minute cancellations - time to deal with problems
- Patients could be schedules immediately following pre-assessment – they feel better going home with a date for their surgery
- Need to share best practice between trusts
- Need to share what is happening with staff as decsions are made – quash the rumour

How do we take this work forward?

- Face to face Q&A session with staff led by someone who knows what is happening
- Condense emails into specific points
- Give staff options that gives them something specific to work with i.e. option A is… option B is…
- Emails sent on behalf of someone gives the impression that the person is not really interested
- Emails more specific to the audience less corporate
- We are now able to tell staff that ST is not going to close but we don't have a lot else that we can tell them
- Success of change depends on staff involvement
- Admin, wards, pre-assessment, radiology, booked admissions

Tuesday 20 March: The Path to Excellence - Staff Engagement Workshop – Surgery, Theatres & Critical Care

Opening bit of reflection:

- No contact to data with STFT – difficult to form opinion/lack of knowledge
- Need information sharing across two services
- Made some progress around shared learning and flexible working across sites
- Opportunity to see different ways of working
- Need to alleviate fears
- Difficult to comment when don't know outcome
- Working together provides opportunity to share

- Patient collaboration started, not on staff/ways of working
- It will standardise processes

What are the challenges we face?

- Only one dietician – no meeting national standards
- Pressure during sickness/holiday - no service development
- ICU staff are having to cover other wards – operational pressure – impacts on training, education and morale
- How long 34 STFT staff have to cover other wards – covering other wards has a knock on effect to maintaining ICU services
- Recruitment isn't issue but retention is – high turn over
- We don't use agency, we cover our own
- Constant training - challenge to maintain standard of unit because people are training
- Need to future proof and look four future leaders
- Funding of very expensive service

What are our aspirations for the future?

- Low morality, high mobility, high rehab
- Need to know what is going to happen in future
- Want a good quality service
- Want the time to allow to provide good quality service
- High quality & safe service
- Want to allow staff to develop and rewarded - how do we reward staff?
- Need to get right patients in right bed – utilise beds appropriately across hospitals
- Offer staff development and promotion
- Safe high quality – right place, right time
- Staff – service with recognition and development
- Success makers – national outcome indicators
- Lots of measures/indicators
- Increase staff satisfaction /morale
- Increase friends and family
- Lower turnover rate
- Excellence – collaborating – theatres and surgery
- Good quality training and staff
- Culture of training and education within business as usual
- Stable service
- Holistic care – entire family
- All standards are vital for ICU – staffing levels are highest priority
- Standards for OT and dietician aren't being met
- Need to prioritise – education/training –forward/succession planning – ageing workforce

How can we fulfil our ambitions?

- Which services will be where – specific service to site to retain staff
- Already radical, to save money? In stages/time if possible
- Rotation between sites
- Consistency between sites – standard way of working – shift patterns

How do we take this work forward?

- Give us information before we plan
- Started as blank page – we need more detail to work from
- Away day with STGH ICCU when more information
- Monthly updates – pharmacy, mental health, pain, theatres
- Management structure overarching leadership
- Barriers – fear and suspicion
- Job security/change
- Anxiety – not being on board with change

Tuesday 20 March – Path to Excellence staff engagement workshop – Surgery, Theatres and Critical care

Discussion 1

- Worried Sunderland will take everything
- Nothing left for South Tyneside
- Huge gap in facilities between Sunderland and South Tyneside
- Improvement of early discharge at Sunderland
- Want a specialist community physio and more integration of specialist services at South Tyneside
- Look into what both trusts do, what works, what doesn't, review them and replicate the good features across both trusts
- Practical Considerations
- More involvement from staff at meetings
- More invites or ensuring invites are better communicated to staff
- Currently no electronic records at South Tyneside
- Concerns about how trusts work together but an opportunity to improve
- Very different methods currently

Discussion 2

- Lack of space at Sunderland for beds
- No ward based doctors at South Tyneside and lack of junior doctors
- No beds at South Tyneside
- I.T infrastructure at wards/slow computers
- High demand for computers and electronic records at Sunderland
- High demand for computers at South Tyneside also
- Too few radiologists at Sunderland
- Recruitment. People not applying for jobs because of insecurity surrounding South Tyneside
- Trauma vacancies particularly at Sunderland
- Positive. A lot of good will from staff to help at South Tyneside
- High pressures throughout the holidays
- South Tyneside struggling to fill band 6 positions
- Stretched at South Tyneside, high workload but doable through the good will of a small team. But still causes some stress among staff.
- People not getting services needed
- Impact on services by cutting corners
- Managers need to identify the problems quicker and ahead of time

- Different times a year are better for staff recruitment than others. Need for more staff.
- There are currently more nurses leaving than joining.
- Need for more students and junior doctors but currently the pressure is too high on staff to teach them
- **Risks and Safety**
- Early discharges needed at South Tyneside, however people still need care with nowhere to go
- South Tyneside staff agreed that it was a positive that they could discharge patients to Sunderland.
- Physios would like to improve the quality of the discharge process to make it more comfortable for patients
- Patients should be taken to rehab straight from hospital rather than home to lower the chance of re-admission
- Patients are often discharged too early due to lack of space for beds
- More Responsive services needed

Discussion 3

- Aspirations…
- To improve patient journey/flow
- Better training
- Better & more communication. More clarity and consistency.
- Solve the problem with confusing and misinformed information
- Come to a final decision/conclusion for Path to Excellence
- Better equity and access of care
- Improve the pharmacy building and facilities at South Tyneside
- Equity of service & consistency across both trusts
- Patients deserve a smooth service/flow and better patient care
- Will not compromise on re-admission rates or infection rates
- Prioritise the addition of more rehabilitation beds, an improved flow, getting the right people in (specialist doctors)
- Markers of success…
- Improved IT infrastructure
- Positive feedback
- Improved metrics in Pharmacy
- Patient satisfaction

Discussion 4

- Find out what each hospital wants and get ideas discussed sooner rather than later
- Let teams continue doing thing their own way but have some way of sharing knowledge to similar teams across the trust
- Make a final decision, quickly, and stick to it
- One big bang change

Tuesday 20 March – Path to Excellence staff engagement workshop – Surgery, Theatres and Critical care

Discussion 1

- Services removed from STFT (being smaller) (-)
- Lack of communication in respect of services across both sites. (-)
- STFT previous agreement of expansion of ITU/HDU on hold. (-)
- Concerns regarding timelines (-)
- Job Losses? Stability of employment/uncertainty regarding recruitment (including students) and retention (existing staff) (-)
- Share best practice (+)
- Sharing staff – good for covering shortages (+) however not everyone want to move/feel uncomfortable (-)
- Increased knowledge/Specialities (+)

Discussion 2

- Ward matrons – 'borrowing' equipment from ITU/theatres + staff (-)
- Having stability of services, helps retention + recruitment of staff
- Some areas have staff with great resilience/dedicated staff (ITU/HDU/Theatres) (+) Loyalty of staff in both trusts.
- Flexibility of staff is essential
- Number of beds
- Enhanced recovery unit
- Agency staff covering night shifts
- Management not keen on enforcing theatre staff to move locations
- Lack of communication on future services – both sites
- Do more work for less (relating to financial matters)
- Train/develop HCSW would help retain staff/pay for education/clause to stay?
- Join Educational training from both sites/investment of services/encouraging research (+)
- Attractive working environment – adaption/flexibility/childcare (+)
- Increase nurse training numbers and support HCA/Support workers into training

Discussion 3

- Aiming for excellence (+)
- More staff to facilitate training/deeper knowledge/skill mix
- Staff to enjoy work – rubs off onto patient care/staff surveys to indicate this.(+)
- Patient satisfaction = 10% - Smooth clinical pathways/better outcomes/best practice
- Sharing expertise/knowledge across trusts
- Right patient in the right place
- Enhance specialities
- One Time working together
- Better bed management
- Infection control managed/In hospital + at discharge
- Work/life balance
- Look at complaints/Compliments received
- Safe staffing levels/skills
- Improved waiting times/reduced delays/safe care
- Prioritise staff/staffing levels > better patient care

Discussion 3

- Stepped change – less risk for anomalies – gives staff/patients time to adapt – staff equipment standardised – emergencies could be compromised due to lack of knowledge/equipment for each (surgeon/speciality)
- Get to know each other/teambuilding across both sites.
- Ask for volunteers > cross site
- Skills – have specialised areas/staff in certain procedures. Develop staff for this.
- Do less of – stealing staff from specialist areas for wards

Discussion 4

- Dispel rumours
- More transparency
- Communicate with front line staff more
- Board members to visit each team for discussion – boost morale
- Sharing options/models > getting opinions
- Team meetings
- Physio
- Dieticians
- Pharcy
- Wards
- Community care
- Resistance to change – continual information sharing
- Givestaff reassurance – may be different each trust

Tuesday 20 March – Path to Excellence staff engagement workshop – Surgery, Theatres and Critical care

Discussion 1

- Will all patients be able to access service? (Equity)
- How will standards be maintained?
- How will we be able to deliver 7 day services? Workforce
- Will all services be involved in impact of changes?
- Will staff need to work on both sites?
- Exciting regarding positive demand management opportunity.

Discussion 2

- Bed Capacity/ITU beds.
- Patient safety due to the interdependency of specialities for example medical/surgical patients
- Managing staffing and skills mix
- Good leadership to manage change
- The domino effect/will staff be attracted to work in STFT
- Safety impact – would moving patients to the site mean longer waiting times
- Effect on transport services and accessibility
- Can communities cope with the deployment of services
- Communication – If the care is provided in Sunderland but community care is provided in South Tyneside
- Have anxiety of uncertainty for jobs and possible downgrading of staff
- Differences in cultures and ways of working that may cause challenges

- The perception that bigger is better?
- Workforce very resilient
- Strong leadership – to implement change and challenge barriers, everyone is sincere about the common goal.
- Busting the Myths

Discussion 3

- Aim – The best quality, safety for patients and staff (value for money, improving, efficiency)
- Discuss openly and honestly – transparency
- Reduced waiting times
- Streamlining of care + standards. To improve safety
- Bringing best practice together and learning from each other
- Sharing of resources – reducing bottle necks
- For example procurement – longer volume of ordering/cost effectiveness
- Operating the same equipment + processes
- Patients deserve the best! Staff feeling valued and providing the best care. Improved patient outcome and satisfaction.
- Excellence – marker of success, aim for no compromise on anything but to improve
- Prioritise – Quality. Patient care + safety. Managing expectations. Learning from others where there has been a success story for example eye infirmary.
- Improving staff morale – Happy workforce – staff + quality – aim for highest outcome with regulating bodies
- Communication at department level – units starting to meet and talk.

Discussion 4

- Big bang after full involvement/comms with staff
- Concern regarding domino effect on support services
- Look at other trusts for example London, what works well regarding single team across multiple sites
- Need to share information between both sites and across discipline + stop thinking as two separate teams

Discussion 5

- Cascade of information to wider teams
- Feedback from today
- Central website
- Cross fertilisation of work streams
- Speak positively as leaders about opportunities
- Look to remove barriers e.g finance, contracts etc. to enable faster pace of change.
- Conflicts of interests

Tuesday 20 March – Path to Excellence staff engagement workshop – Surgery, Theatres and Critical care

Discussion 1

- GDE Project – needs to be a big part (+)
- Resources in place electronic working – Impacts safety
- Paper documentation still important
- Currently need paper handover printed from v6
- Poor standard hardwear infrastructure
- Using two different systems – need to be working on the same systems
- GDE Timeline (-)
- Working towards electronic (+)
- Staff working across both sites (teams
- Theatre equipmentvery different – need standardisation
- Equipment procurement savings (+)
- Bigger team/career opportunities/Learning UPS

Discussion 2

- IT issues (Systems, hardware, paperless, computer access)
- Equipment issues
- Radiographers availability
- Juggling theatre list
- Scheduling theatre list
- Matching resource lists
- Lack of specific trained staff
- Problem in acute pain service (Recruitment nurses, medical time, no prospective cover)
- Opportunities to have pain service across both trusts (+)
- Theatres staffing resilient (+)
- Communication issues
- Lists not closed soon enough
- Staff retention – Younger Staff
- Aging Workforce – need a plan
- Staffing – Vulnerable demographic point of view
- Need robust workforce plan
- Felt limited opportunities in training
- Limited time for senior development
- Increase in operational pressures
- More team building (+)
- Inability to utilise audit day due to staffing
- Need more in-house training if working across both sites (+)
- Need Investment
- Sterile services – Increased pressures
- Complexities – impact on interdependencies for example laundry/porters
- Staff “de-skilled” impact on staff satisfaction
- Need emergency + urgent list
- Sharing best practices across specialities
- Need to invest in staff training education to allow development in roles
- Need thorough scheduling system (lists/resources)
- Ability to be flexible – need more resources to allow this

Discussion 3

- Efficiently ran + time of operating lists
- Start& finish on time
- Standardisation of lists, working
- Back to basics
- Patients & staff – some experience
- Right person, right time, right place
- Best practice
- Scheduling efficient
- Continuity & planning
- Team working to deliver efficient working balance/relationships and flexibility
- Procurement efficiencies – economy of scale
- Reduction in training time – using same equipment
- Get surgeons involved in decision making
- Reduction in variation
- Markers of success…
- Less cancelations on the day
- Staff morale/experience
- Better utilisation of lists
- Reduce LOS
- Reduce Costs
- Increased Income
- Fewer complications and re-admissions
- Less stress

Discussion 4

- Centralised scheduling team
- Same time operating sessions across both sites
- Streaming/Planning/Selecting shift in theatre activities
- Match demand & capacity
- Stepped approach
- Benchmark front-liners
- Pilot (Table top exercises, sub working groups, focused workshops)
- Standardised ways of working
- Training together
- Work across both sites

Discussion 5

- Integrated forums
- Face to face events
- Newsletters – distribute/intranet
- Staff meetings
- Board/Huddles meetings
- Team brief
- Simplify messages – bullet points rather paragraphs
- Cross visits at sites – identifying others
- Ice Breaker Party

- Meet & Greet
- Cross working – visiting both sites
- Barriers – Releasing people/capacity/change

Tuesday 20 March – Path to Excellence staff engagement workshop – Surgery, Theatres and Critical care

Discussion 1

- Massive impact on community. Has community been discussed enough? (+)
- Good to encourage recovery at home are more complex now + community staff are already stretched
- Concern STFT downgraded to day surgery only + impact on deskilling staff. Particularly laparoscopic bowel services
- Community staff have worked across vast boundaries
- Different ways of working between the two sites for example robots used in Sunderland not STFT
- Concern regarding post op beds
- Services need to change, this is agreed across staff across ST
- Important to promote self-care. Not being promoted currently
- Concern for staff
- Travelling to work at Sunderland. Will cause a lot of upset. Staff don't want to move base. Staff have an opinion

Discussion 2

Operational challenges

- Staffing pressures. Adverts constantly out.
- Wards closers over winter due to staff
- Procedure cancellations
  Complaints where procedures are cancelled at short notice
- It's not just winter surge anymore, it's all year round
- Staffing pressures compromise quality standards
- Staff don't want to be moved from surgery to medicine if they are trained in surgery
- Rates of pay for bank staff are unacceptable. An insult to be paid out these rates it's too low
- In STFT staff resilience based on good will
- Gaps in junior doctor rotas = pressure
- Community nurses can't stop discharge surge even when resources aren't enough
- Patients often discharged without proper planning or equipment in place
- Patients often discharged and DN's not told by hospitals. Find out from the patient they don't get meds.
- Community staff – perception that they can't say no
- No escalation plan in place for community staff
- Long working hours for community staff has put staff on their knees

Areas struggling to recruit…

- Nursing
- Junior doctors – less uptake via flat rate

- Nursing students – prescription staff is closing so nobody wants to work
- Community staff rely on bank staff and don't have the same skills, particularly at weekends
- Services not resilient when staff ask to come to come back at short notice
- Community staff highly resilient throughout snow. All turned up and walked to see patients.

Future expectations/challenges…

- Self-care
- Population in North East generally not for patients to change. They think damage already been done
- NHSP – Rates of pay
- Recruitment problems if services segregated between sites

Best outcomes for patients…

- Targets – Will we meet them?
- Better communications (Facts)
- Re-investing (Both sites)
- Training/Value staff/Give confidence
- Retention of staff/skills

Challenges…

- Workforce concerns
- Job losses
- Travel
- Re-assurance
- Car Parking

Discussion 3

Aspirations…

- Patient safety: Right patient, right place, right time
- Skills development/retention
- Safe staffing levels/training/competence/cross-cover
- Local services/Appropriate transport/Affordable transport (Taxis £35)

Markers of success…

- Decreased vacancies, improved retention, staff surveys, meeting targets, CQC feedback, external reviews
- Excellence: CEEPOD Feedback
- Standard: Who checklist, theatre count, SOPS, 18 weeks, 31/62 day targets, diagnostic tests.
- Prioritisation: "Essential care" > Insulin, bowel care, EOL care, safety in theatres, appropriate staff, who checklist, "seamless care" during transition. Self-care, education, carers. Social services

Change…

- Step change – gradual, staff involved,. Different skills, specialities, equipment across sites.
- New ways of working. Need transition time.
- People resistant to change
- Single team – need detail?
- One elective, one emergency care staff (given travelling time) because of culture

Barriers

- Culture – people will leave.
- Car parking – cost of availability
- Travel time

Unblocking

- Communication
- Family visits – more interaction, observation, shadowing
- More days like this/meetings
- Ward/department workarounds
- Easier when there is detail
- Neutral ground
- More visits – shadowing/observation
- Think about other members of the team (porters)
- Tell staff communication has not been as good as it should be. Improvements going forward.
- Communicate and engage at lower levels
- Need wider events
- Bright ideas – incentivise
- Admin – centralised appointments across trusts

3.3 Medicine and emergency care

Wednesday 21 March: The Path to Excellence - Staff Engagement Workshop – Medicine and Emergency Care

Opening bit of reflection:

- See the need for change – ST loss of service – maternity especially, loss of skills
- A&E service will still be across both sites
- Is there going to be inpatient medical care needed in both
- How will things look – ITU on both sites? – people moving sites – not good for the public
- Recruitment very hard – staff retention, staff leaving – students not coming through – lot of interest at STFT – down grading at STFT – would people want to work there?
- First round very negative from STFT point
- Public in ST hold nursing care very high
- Public perception better at ST than SLand - for nursing care
- That should be communicated as a positive message – the undercurrents are negative – people don't know what the end point is going to be

- Need to say publically that both sites will have acute
- Will I have a job? Rumours to be ended
- Mirror processes that are positive
- Medical level – will require further recruitment
- Fear that the first phase has left/end up being a cottage hospital
- Fear there'll be a loss of skill
- Reassurance of what we are working towards – for staff
- Sick of the negative feeling in ST – ST want to move forward
- New services would give positivity – staff want to move forward

What are the challenges we face?

- Current challenges – different systems – operational challenges
- Pay separate bands - IT systems training
- Lack of beds
- Reassurance that it won't all fit in SLand
- Using a lot more bank staff, staff burnt out
- Patients are moved around more – means more paper work – constant challenge
- Staffing pharmacy – drugs are delayed
- Rumours of pharmacy – staff leaving – morale very low
- SLand investment, ST no investment in pharmacy
- All down to finance – looks like SLand have everything new
- ST poor relation – is there going to be a base at ST
- Joining with SLand may help ST
- Small services don't get lost in background
- Recruitment of level 5 staff
- Just trying to keep on the day job – no time for training – build in spare capacity – 18 week pathways can't be met once weather changes
- Beds – workloads
- Paperwork check lists for surgery – challenge for the future joining both
- If both sites were equally attractive it could be a fantastic organisation to work for
- Systems were the same across both sites - covering clinics in SLand – couldn't work IT system
- Standardisation of IT
- Quality and safety – all work extra hours – worry about staff/look after staff
- New ways of working virtual clinics, big challenge, long term conditions – mental health conditions, referrals – integration of services structures
- Avoiding admission to hospital;
- Acute care team – don't have enough staff
- Need to wait for gap for IV's – staffing
- Community matrons – starting to recruit – improving – single pint - combined team
- Patient need – same across STFT and CHS
- Winter surge – respiratory – no smoking service no prevention
- Amount of acute – stop wasting time with message, stop coming to A&E – have a better service model
- Patients can't get appointments at GP
- Needs to be a process/ some allowed to go to other GOP surgeries
- Can GP support the process we are going through

What are our aspirations for the future?

- Admit patients to right bed
- Good patient outcome – well, gone home
- Good processes across both sites
- 7 days but maintaining the same quality
- Quality needs to be the same, not 5 days stretched over 7
- Less moving around of patients
- Staff want – don't want to be oved around wards – safe staffing levels and a good skills mix
- Would staff be happy to move between wards?
- Should there be a generic skill mix
- Should there be specialities – cross site learning
- Transport for patients – costs
- Achieving targets – aspiration – happy staff
- Leads to less sickness/happy workforce /happy workforce
- Clinical standards – 12 hrs consultants
- What has happened to … So patients know who they are talking to
- Targets – 24 hours review – front/back of house
- Discharge to be safe and effective
- Discharge systems in place – everything's in place
- Aspiration – is that the patient knows when they are going to go home
- Communication to patient – in a terminology that they understand
- Patients need to be happy, looks at complains and compliments – look at these to improve
- Quality and safety standards – ED safety
- Guidelines – investment in specialist nursing – home visits more quality time with patients
- Staff training – online training very difficult – difficult to access for ward based staff - IT system very difficult to use – IT skills being lost
- Training should not be compromised – shouldn't have to do it at home in own time
- Good leadership - training and development - learning from each other across the trusts
- Aspirations for staff to be proud of where they work
- Investment – too many financial constraints
- Need investment in the staff
- Have enough staff so other staff can actually attend training
- Recruitment – do something with juniors to get them to stay & ensure that they have time to have a work/life balance
- Time/opportunities/inspiration
- Staff would feel so much happier if they were appreciated – personal thank you's within teams- walk arounds by senior management
- Retention – staffing levels would make a massive difference
- Centre where people want to work and train

How can we fulfil our ambitions?

- Opportunity for staff to start rotating roles now
- How can staff get to know each other
- Training – work together, mandatory training together
- Find your peer – mirror person
- Matron away day

- Band 5 progression days together (not to have hierarchy)
- Staff need to know that they can go to another trust – (don't need honorary contract) – message needs to be out there & staff ned to be able to contact their counterpart
- Looking at how services can work together – will consultants agree to way of working (the same in each trust)
- Making personal connections
- Specialist nurses – primary and secondary care – breaking down the barriers
- Hub across both trusts – transfer of care]s
- Specialist nurse goes around wards for specific treatment COPD
- Could they do this across both trusts
- Prevention has not been mentioned , this needs to be addressed
- Shuttle bus between sites

How do we take this work forward?

- How do we involve all staff – everyone uses phones, briefing notes – social media, short staff briefings, internal Facebook page
- Closed group just for staff – electronic (Facebook)
- Notices – bullet points, boards in changing rooms & staff areas?

Wednesday 21 March: The Path to Excellence - Staff Engagement Workshop – Medicine and Emergency Care

Opening bit of reflection:

- Change is good – Sunderland is a bigger hospital
- Feel like the underdog- what can we bring to the table/what can we kee
- Fear of change
- Patients asking when STFT will close
- How will two departments become one (job losses)
- Don't hear anything, don't get feedback, rumours
- STFT (cardiology) feel that SLand staff know more than they do
- Fear of the unknown
- Project team encourages staff to talk/consult with other
- Hopes/ opportunities – both hospitals to be successful but CHS to have strengths in areas and STFT to have strengths (50/50) split
- Want to do our own part (STFT)
- Hope is that patients will go where they can get the best patient outcomes
- Could benefit a lot from each other as one team supporting
- More skills in different areas – good to learn from each other
- All working to same framework/standards – see potential benefits (bigger voice)
- Needs more diverse representatives on work streams
- Affected as a local circle as a member of staff – affected personally by the changes - need to consider this
- Concerned about services and capacity, IT services move to SLand
- Concerns around first phase still – still not clear on what's going to happen
- Reassuring to know two sites needed

What are the challenges we face?

- Consultants asking you to squeeze patients an already packed list – massive pressure on not enough staff
- Wards are getting busier – lots more GP referrals
- In patient demand
- Emergency
- Outpatient referral
- What will service provision look like
- Can't continue as we are
- Can learn from each other
- Lots of benefits from working together – increased patient need
- STFT- safe department, but staying back and go that extra step (based on goodwill)
- Different sites (especially 7 day service and out of hours)
- Staffing shortages/sickness – workforce development/more foresight and planning (cardio & phycology)
- Level at demand and activity and activity – patient need
- Clinical standards (diagnostics)
- Need to act now, not wait until 2019/20
- STFT wants to develop, but don't have time
- Ageing population, growing need for diagnostics, lack of supply and demand- staff new equipment, training and development and quality
- Staff shortages, sickness, staff are burnt out. Tying to cover
- 7 day – concern (how will it work)
- Doesn't matter where patient presents they should expect expect same level of care
- Need to harvest innovation and quality
- Appetite for staff to work more hours (cardiology – CHS)
- No funding to inject it into the system
- Foresight, succession planning lacking and need to develop skills now
- Ageing workforce
- Great demand from students to stay out of CHSFT, but no posts to give them
- Not enough in the budget to brig someone else in in and train them up
- Staff shortages – leave an impact
- STFT expected to suck it up where there are staff shortages
- If one team will there be too many secretaries/admins? How will that that work?
- Impact on admin tasks (cardio/psychology- STFT) joint patients
- Patients have more complex needs (social) - older patients, live longer)
- ST patients sometimes get interventions before SLand patients (frustrations) at CHSFT
- Demands/pressures
- Interdependencies with other services
- Opportunities to exchange skills , plug gaps (realise great benefits)
- Heart failure – need to echo with certain level of time – higher standard – pressure to keep up (more people through the door, greater need)
- New patient guidelines – all diagnostic tests

What are our aspirations for the future?

- One big team / standard care
- Best care for patients/reducing waiting lists
- Very best care/treated as an individual (personal care)
- One stop services for patients

- Generating services 0- patient pathways
- Care standardised across both sites
- Need to talk to each other more – share best practice
- Evidence based care – need to be the best for the patients (NICE guidelines)
- Helpful for both trusts to work In the same way
- Information sharing /making people go over and spread with colleagues
- Access a 7 day service
- Timely assessment
- Timely diagnostic
- Red and green days
- Define what urgent is – shared understanding need to ask is it urgent for patients – or can they go elsewhere
- Opportunity to aspire towards one team and one hospital
- Be able to empower staff and give them the space tow work it all
- Be able to turn patients quickly
- Need a resilient footprint
- Crack primary care demand
- GP led ECG time – GPs abusing the system- should to ED
- Need to understand right part for patient to be referred into

How can we fulfil our ambitions?

- If we are going to start working on a single team, we need to start working across sites and see how each other works
- Both sites need to look at strengths and what services should be situated where
- How will the teams work – how will there be equity of voice – stop them and us culture
- Good to be able to start to build relationships – need to be able to put faces to names
- All need to work as a team
- Information at STFT is not filtering down – staff just need to establish working together
- Need organisation
- Educational training needed for GPs
- Pathways – what doesn't need to come into hospital
- 7 day working – intervention side
- Benefits of bigger gene pool
- Need audit of how we currently work
- GP service – referrals ECG

How do we take this work forward?

- Interface – social care/primary
- Needs to be more diverse representation
- Could we have share more information about the reviews (all encompassing)
- Speciality specific communications shared widely at SLand but not at STFT
- Helps to address anxiety/rumours
- Staff representatives for specialities so other staff know who to contact with questions/feedback
- Feedback

Wednesday 21 March: The Path to Excellence - Staff Engagement Workshop – Medicine and Emergency Care

Opening bit of reflection:

- Different ways of working
- Uncertainty in staff retention

What are the challenges we face?

- Staffing – training future staff /progression , skill mix in nursing & medical, specialist training/non training roles, how to support each other
- Size of challenge and how it all links together

What are our aspirations for the future?

- Aims – right people, right time, right resources
- Pathways that all staff work too and patients within an area
- Right standard of care closer to home
- Time to decide
- Consistent service across both sites

How can we fulfil our ambitions?

- Staff – radical with timescale planned
- Acknowledge that things are working and learn from each other share best practice
- 24/7 diagnostic and 24/7 medical admissions- on both sites
- Direct access to speciality review
- Primary care on board – communication
- GP working in nursing home to prevent admin
- IT – big enabler
- Rules of engagement
- Increase in ambulatory care pathways
- Clinics and pathways

How do we take this work forward?

- Updates to all staff and not left to managers
- Simple and to the point
- Different levels of content for different levels of staff- what is relevant to them
- Departmental meetings

Wednesday 21 March: The Path to Excellence - Staff Engagement Workshop – Medicine and Emergency Care

Opening bit of reflection:

- SLand centric fears from ST
- Logistics with two trusts – won't work
- Presents good staffing opportunities, ST – small trust – recruitment problems – though people attracted to work across both trusts – generic work one site – specialities on another

- New staff don't want to stay – uncertainty – people need to be aware of what's going on – learn that ST isn't closing and is good place to work
- Timely management
- Career opportunities – options to work across both trusts
- Wider opportunities – not just stuck in wards
- Opportunities at ST for SLand staff – where's best place to treat patients
- Where right clinical practice should be
- Initial fear of ST closing/moving services to SLand

What are the challenges we face?

- Short staffed – medical and nursing
- Bigger and wider opportunities attract new staff
- Medical staffing – more problems than nursing
- Gaps between consultant and junior doctor level
- ST – number of diverts having to push away from ED - not ED but bed problems – high number of breaches
- Little scope for people in community so that returning visits are lessened
- Earlier discharge - which community services
- Less need for community services in ST as hospital/area so small/close together
- Certain services aren't essential
- ST – don't have speciality cover on the weekends – where SLand do
- Urology cover for ST from Newcastle rather than SLand
- Need to learn now to split different cover across both trusts
- Junior doctor training – skilling them generically rather than speciality – which is what ST needs
- Acute medicine definition differs between both trusts – means something different for both
- Resilience would improve if so many hours don't have to be worked
- Workforce between two trusts could improve resilience
- Working as one team – should work in same way
- ST – ageing workforce – higher amount of older staff – nurses can go at 55, about keeping them longer
- Clinical systems – time taken to do things, though everything in one place – cross site working – improvements
- IT systems improve flexibility in time, ease
- Chasing rotas/filling gaps = time consuming
- Acute medicine need time to consult and review
- Hospitals work in different ways – assessment /work to be double checked / done again – time consuming
- Staffing retention issues / retain and attract
- Clinical documentation – equality
- Where patients need to be treated for best care
- Frailty service differs across trusts

What are our aspirations for the future?

- Working as one team, no area where truly working as one – shouldn't wait until process is done – should start now
- Right place, right person right time, right care

- More permanent staff – the right staff – got time to do training – competency – right skills
- Difference between emergency care nurses and medicine
- Excellence is about patient feedback – does the patient feel does the patient feel they're getting good outcome and experience
- Staff – good culture , want to develop
- Excellence measured in staff culture , leadership – reflects on patients
- Learning from all aspects, complaints, etc
- Cant compromise on 4 hr targets – effective patient treatment
- 7 day standards – 14 hrs
- Not having borders
- National and local standards on patients differ- different outcomes
- Across whole health community, STFT& CHS- challenge in being able to facilitate discharge knowing the right people –better integration in that would help
- Streamlines, need a common pathway
- Need consistency here with more integration
- Different relationships across trusts with CCGs, authorities etc
- Easy access to authorities for ST but not SLand, need to improve access
- Pathways and relationships
- Always going to be differences , but need systems above them to be the same, so everyone is on the same wavelength
- If need to go to one trust, they're needs to be a quick discharge back to where they need to be

How can we fulfil our ambitions?

- Education – stepped towards
- Difficult Q to answer
- Where can they provide services
- Dow we breakdown by individual teams
- Which locality is good for which service
- Standardising the way that they work
- Quicker and easier for some patients to go to ambulatory care rather than GPs
- Changed behaviour of GPs
- What support can there be pre hospital even if activity was on one site, still need back up for ED
- Clinicians to decide capacity – how do you put your resources to the right place to deliver right service
- Need two EDS – SLand can't take ST capacity, but who has what where?
- If clinical standards are met, where are resources going to be?

How do we take this work forward?

- Trust communication – short , key messages not loots of information
- Text/tweet sized with link to bigger message
- Events are key – staff get information and clarification, though proves difficult – time away from work
- Staff availability between certain hours to raise Qs
- Staff were here on day off (PTE workshop)
- Capture info/ Qs quickly
- Daily catch ups with biggest thing that's happened – for discussion/least staff know

Wednesday 21 March: The Path to Excellence - Staff Engagement Workshop – Medicine and Emergency Care

Opening bit of reflection:

- Initial changes for loss of skills and emergency , of ST
- Clarity on dispelling rumours
- Plan for change – inevitable timescales help ease anxiety
- Anxiety around ED – good to know – workforce, skills across both sites
- Clarity on ICCU
- Causing more retention problems – people leaving or not applying
- First phase negative - STFT – put out end goal – reassurance on services on both sides
- Public perception on nursing care better
- Learning community models of care - learning and bringing across
- Care on current staffing – equal levels at both sites
- Staff rotation

What are the challenges we face?

- Different paperwork and IT systems – standardisation needed for future and crossover
- Agreement and payment needed
- Beds- capacity
- Staffing – more agency , burnout, morale, recruitment challenges
- Flow through
- Investment in estates and facilities
- Financial constraints
- Rumours
- Health care scientist – difficulties in recruitment, national problem, extra hours to keep up basics
- No R&D, higher level training
- Capacity for surge
- Make both sites as attractive
- Long term conditions – virtual clinics, integrating with people, multiple co-moralities – integration of services
- Admission avoidance – acute are capacity
- Intermediate care are long term conditions
- Health prevention – smoking sessions – stopped, community reach
- Activity of patients increasing
- Patient demand and expectations
- Capacity – community – GP – impact on ED
- Linking work together across all streams and CCGs

What are our aspirations for the future?

- Right bed, first time – speciality input – admitted and discharged from same area
- Treated, home, cured, good outcome – processes that lead to that
- 1 day services- some on sat morning as two afternoon – same level of quality
- Aspire for same across both sites

- Safe staffing levels and right skill mix/sets
- Learning across sites
- Transport – support to patients that need to travel
- Target delivery – different ways of working – nursing and communications
- Happy staff – recruitment and retention
- 14 hr review – acute admission
- Communications to patients in advance around discharge, patients involved and removing delays
- Happy patients
- Quality and safety – same measurement and tools across both sites
- Access to specialist teams – specialist nurses 7 day
- Staff training and development -shift needs
- Proud of where they work
- Centre of learning – opportunities for growth and inspire innovation
- Attract staff and get a work life balance
- Show what we do well and share that around development - staff feel valued
- Visibility
- Happy workforce – retention – innovative workforce and training
- 7 days access to specialities
- Population

How can we fulfil our ambitions?

- Opportunities for staff to rotate new – all voices equal
- Joint training to bring staff together
- Removal of barriers
- Personal connections
- Integrated flow across primary & secondary – destroy – specialist nurse input
- Speciality in reach available
- Activity levels of patients – speciality contact
- Visiting across both sites – easier to move staff than patients
- Embed prevention into every model
- Opportunities for streaming – longer access hours

How do we take this work forward?

- Proper briefings to be delivered – key areas start of every day
- Internal Facebook for staff – social media communications
- Messages on payslip
- Bullet points – word of mouth

Wednesday 21 March: The Path to Excellence - Staff Engagement Workshop – Medicine and Emergency Care

<u>Discussion 1 open reflections</u>

Concerns new services will be Sunderland centric. No to a hot and cold site model

Uncertain about the impact on nurses

How will the right place for the right services for the right patients be determined?

Clinicians would be concerned about adopting the Northumberland model

Opportunities incl. bigger pool of staff

Expect that recruitment/ retention will become easier/more attractive because of working across two sites and opportunities to move between specialist and general

Discussion 1 part 2

How can rationalisation take place if both trusts have advance ambulatory care and admissions continuity?

What can LA do? e.g. care overnight, rehab – keeping people at home and allow for early discharge

Need to look at frailty offer across two areas to improve admission avoidance

1 challenge aspiration – to easily discharge people need a better integrated facilitated discharge e.g. false stroke

For design principles we need LA buy in to work in partnership with the new one team

Consider the human element of people being displaced

Happy patients, happy staff

How do we get staff to invest in the success of an organisation e.g. a new social contract between staff and the organisation?

Discussion 3

How do we take forward the best of both – health pathways at ST and Consult and connect in Sunderland?

Discussion 4

Shorter messages from the trust

Prefer events to engage staff

Canteen information stalls to engage all staff

Notes from Path to excellence staff engagement event - Medicine and emergency care staff engagement workshop

Discussion 1 (Part 1) – Opening Reflection

- Thought emergency department from South Tyneside were moving to Sunderland but that's not what Caroline said on her presentation. What does that mean? Same as South Tyneside now? 24 hour cover? Sunderland can't take more as it's at capacity now
- Concerns regarding capacity & change
- Communication awful from phase 1 – phase 2 must be better
- Past stroke unit moved, clinically was the right thing to do.

- 7 days? Shaz said how would that affect admin? Would be more back of house?

Discussion 1 (Part 2) Challenges

- Staffing issues among both trusts
- Medical staffing, hard if not main consultant
- Support series – SALT waiting a long time, physios as well. (7 days would be good and that respect)
- Better discharge if STAR centre was open
- Vacancy rates an issue – recruitment retention
- Word on the street South Tyneside is going!
- Staff scared to apply for jobs advertised because of insecurity as South Tyneside could potentially be based at Sunderland
- Staff pressures e.g ward manager doing 67 hours
- Agency staff don't turn up, agency department don't tell you – or agency staff pick and choose what ward they want to be in.
- Knock on effect on audit not getting done as managers on floor
- Gaps in charts in bed and nobody to do it
- Staff resilience & morale
- Need work to improve services but can't release staff to do service reviews as staff are too busy

Future expectations…

- Come together as one, how do that, staff on board feel brunt of it
- One system (I.T)
- Sharing good practice

Future challenges

- Loads of guidance coming out on older person but can't work because it is too busy
- Dementia South Tyneside challenges for examples dementia nurse patients. For For example colour of doors (ST) over a year to get painted.
- Elderly care needs regig – not fit for purpose

Feedback

- 7 day cover issues/therapy care/STAR centre
- Junior staff/Senior nurses have to hire support staff
- Service development
- One big team – challenge
- Communication involved/networking – challenge

Discussion 2

- Aim – Better care outcome for patients in which ever hospital – equity/quality
- Waiting times – aim
- Shouldn't be disadvantaged for living in North East, 5 year forward vie, health promotion
- Lung cancer – how to access services at night (education)

Must do's…

- Adequate staffing levels, not sustainable, nurse/medical staff at breaking point
- Communications – waiting times, patients have example two week wait just to see A&E
- What services we need for local people, review of services matching capacity to health needs.
- Provision of elderly care services South Tyneside.

Success

- Patient + feedback improved
- Outcomes currently failing on – measure
- Speciality care like dementia, streamline community services
- Need integration of care for example borders

Excellence

- Right patient, right place, right time – Right capacity, understand out capacity/demand.
- Equal opportunity
- Patient flow
- Saftey
- Examples from STFT – Model & Success

Standards

- Patient safety/care standards
- Waiting times
- Local Standards
- Patient letter and appointments given there and then. Sunderland do this and South Tyneside have just started – need to maintain it
- Best experience for patients. Results a big thing

Health Outcomes

- Health needs assessment
- Education
- Schools
- Staffing Levels

Discussion 3

Current/Future Challenges

- Communicate
- Infrastructure IT/Communication systems
- Work together now for example different IT systems causing an – Barrier for example network
- Nee more events like this to start understanding each other's roles
- Recruitment premium
- No progress in elderly care/losing staff to specialist care teams

Single team

- Define elderly care, South Tyneside and Sunderland trusts might have different ideas
- Trust profile of what each foundation trust provides
- More – Rehabilitation – Sunderland have a ward
- Less – rehab – how quick can the patients move on
- Less – Capacity of demand in patients discharged

Discussion 4

- "Us" going to the ward as staff can't be released
- You said, we did
- Social media "closed group"
- Tweets
- App

Notes from Path to excellence staff engagement event - Medicine and emergency care staff engagement workshop

Discussion 1 (Part 1) – Opening Reflection

- Fear the unknown
- Not knowing what the future is
- Recruitment/Retention
- Skill mix challenges
- Commissions making decisions from options suggested to shape services
- Public perception
- Difficult to work across both sites staff find hard to "vote with feet"
- Lack of standardisation i.e. NHSP pay more
- Visiting Consultants – follow ups etc. patients positive feedback (+)
- No transition corporate teams working across sites – mandatory training/payroll

Discussion 1 (Part 2)

- Fear the unknown
- Not liking change
- Challenge – staff not wanting to move across both sites
- Consistency of work flow (future expectation)
- Public transport
- Challenge – Capacity/Standards – 16 hour review/7 day review
- Patients not choosing to have care at STFT due to fear of closure
- Maintaining junior Dr roles
- Vast variation of skill mix + specialisation "nurse practitioners in all areas"

Operational challenges

- Staffing – sickness etc.
- Skill mix
- How would this be transferable across sites
- Differing mind sets
- Different ways of working

- Joint working at the moment/Working well (+)
- Sustainability of workforce
- Identifying and managing progression for staff (+)
- ED – Different levels of medical workforce/organisational differences
- Training grades bring different skill mix
- (+) Cardio nurses into department all done at one time – middle ground to aid medics not having to wait for appointments/transfers arranged
- Challenge how to move workforce going forward

Discussion 2

- Best quality care for patients
- Timely and effective interventions – right people, right place, right time and access to resources (+)
- Ideally 24/7
- "Nice to" over two sites – most important to achieve standards of care for patients
- Standardisation – no matter what site
- Correct pathways – standard/specialities (+)
- Right standard of care close to home (+)
- Stop working in SILOS – move around departments/cross working
- Ability to assess ambulatory patients within own speciality.

Markers of success…

- Rate of discharge across the profile of the week
- Time standards
- Quality standards
- Time to see consultant
- Time discharge in day
- No patients lingering in emergency department or beds in hospitals
- Making correct referrals
- Patient feedback – LOS
- Discharge from ED
- Develop better non – admission pathways (+)
- Robust pathways nee
- Need d for re-attendees

Discussion 3

Ideas

- Individual teams from different trusts coming together
- Get a better understanding of each other's roles and ideas. Learn how each other work
- More outpatient care
- Main – point – need more communications between trusts
- One manager overseeing both trusts
- How will it work facility wise?
- Couldn't have one trust on call and another one the next. Not enough resources at South Tyneside.

What would work well?

- Recognition across the two trusts
- Public communication/Let the public know both hospitals are working together
- **Feedback*** - Explain what emergency care is at the start of the presentation

Discussion 4

- Using social media
- Improve GP screens with information about meetings. Not all staff are currently interested
- Team meeting or road shows
- Lunch time sessions
- Designated times/schedules for staff
- Visiting time best are the best times to engage with porters & domestics
- Focus on clinical teams. Get the message to them.

Path to Excellence – Medicine and emergency care - staff engagement workshop - Wednesday 21 March 2018

Facilitator: Judith McGuinness, NECS

Scribe: Lynne Cooke. NECS

Table make-up: South Tyneside staff – 5 Sunderland staff - 1

Discussion 1 (part one) – Opening reflections

Sentiment	Comments
=	• "This is huge"
-	• It's going to be a challenge to try and unpick this
-	• Size is a concern as the two services are already under staffed and in debt – how do they bring them together?
?	
-	• No recruitment drive in area, therefore staff shortages
-	• Workforce issues will make it difficult to achieve
=	• There's more a feeling of uncertainty than negativity
+	• Opportunities – to share good practice. Look at both organisations and see what works best. Need to explore the positives and what works
-	• Distance is an issues, especially for staff that don't drive
-	• Not sure how the other trust works. IT systems etc. – the unknown is worrying
-	• Maybe harder to recruit
-	• Locums vulnerable to clinical error
-	• Different IT infrastructures on both hospitals – Sunderland are all electronic and South Tyneside are still using paper
=	• Management structures very different
?	• Different discharge pathways and different local authorities – how's it all going to work?
+	• Hoping there will be more opportunities for new staff coming in working across both sites. Could be good for staff development
-	• It's going to be difficult merging two systems
?	• Concerns were raised about clinical staff being released from work to attend these engagement sessions. How will this happen?

Discussion 1 (part two) – What are the challenges we face?

Sentiment	Comments
-	• Nurse staffing and retention of staff
-	• Bed vacancies
=	• Need to be working on the same IT systems
?	• 7 day working – is it manageable? Some services do and some don't. It should be a true 7 day service
-	• Not sure where Sunderland hospital is
-	• Patient safety is at risk when patients are staying in hospital for longer as other services aren't available for them
-	• Aging population – community services have struggled over the winter period. Hospitals seen as default
-	• Unrealistic expectations of patients
-	• Unmet mental health needs is an issue. There seems to be a lot of bouncing MH patients around between GPs, hospitals and community services
-	• GPs not following pathways so automatically default to the hospital. GPs need to break the cycle. They need to stop telling patients they will be admitted and set realistic expectations
-	• Lack of co-ordination. Still room for improvement in primary and secondary care. Pathways are there but aren't being used
+	• Staff workforce is really resilient – working on a lot of good will from staff
=	• More staff needed as nurses are aging, retiring or are burnt out in their mid-50's. Too much pressure and demand. Different to how it used to be. Many nurses aren't staying in the service very long as there are more attractive opportunities out there
=	• More local recruitment programmes are needed
-	• Concerns were raised that many young people are wanting the true student experience, and they won't get that by coming into nursing as it's a four year degree and working shifts
-	• Many newly qualified staff are disillusioned and are not staying after they obtain their degree. They moving to Australia, working on cruise ships and other private organisations
-	• Crowding – there is a congestive system due to patients increased length of stay
=	• Local Authorities (LA) and CCGs need to be more aligned
-	• South Tyneside don't have step down beds, whereas Sunderland do
-	• LAs don't help in times of escalation. Lack of co-ordination between LAs and Hospitals
-	• Staff in South Tyneside are frustrated with the amount of time they spend on paperwork instead of being able to focus on the patients and being able to keep them safe and offer them a good experience
-	• South Tyneside IT systems are slow and need to be upgraded
+	• Changes will be difficult in the short term but better in the long term
+	• Majority of staff would welcome these changes

Discussion 2 – What are our aspirations for the future?

Sentiment	Comments
+	• "One Vision – we all work together"
+	

+	• People with critical needs get the service when they need it
+	• Care closer to home
+	• Assess to secondary care alternatives – putting in pathways and access
+	• Important to have diagnostics closer to home
+	• Need a sound infrastructure to under pin all this
+	• Communication from the onset – giving patients realistic information so they know what to expect when they arrive at hospital
+	• Need one single system e.g. IT, HR, policies etc.
+	• Low absence, low turnover of staff, better retention of staff more recruitment – give incentives (measurable by better staff survey results)
+	• Better patient experience and satisfaction, free from harm and a good reputation. Offering a service that was better than expected
+	• Shared decision making – personalisation of care
+	• Mostly dealing with the elderly so all their needs to be met i.e. social care etc.
+	• Advanced care planning – this does make a difference
-	• Empowering people to self-care – introducing cost effective interventions
	• Safety – falls, preventing harm, adequate training
+	• Priorities of training to be improved. Information governance takes precedence over clinical training
+	
-	• Consider offering nurse apprenticeships to encourage new nurses into the service
=	• Self care, education and more diagnostic testing to be made more available
	• Public Health not joined up
-	• Personally, staff want to be confident that they have a role and feel appreciated. It's important that staff morale be built back up
+	
	• "Too many changes – don't fix it if it's not broken"
	• Invest in what works well

Discussion 3 – How can we fulfil our ambitions and address the challenges?

Sentiment	Comments
+	• Standardisation
-	• Consultants at Shields aren't on the specialist register, so can't look after trainees, there poses a challenge
-	• Need a standardised recommended 16 hour cover. Sunderland have only just achieved this themselves so there won't be enough to have over both sites so this would mean one site would run below the national criteria. Can't work as a single team
-	• All services may not stay on both sites. Moving specialist services to one site – this has already started to happen. South Tyneside staff are worried that services are just moving one way. There needs more work done to explore what services can be hosted by South Tyneside. This would offer some reassurance
+	• Single teams across two sites will work
=	• More services need to be offered in the community, it's not always suitable in an acute environment. Ambulatory care, GP referrals – need different ways of working
	• Not allowing patients to self-refer to ED. Making them go through 111 or 999
+	• Stop holding review clinics in A & E
+	• True delirium pathways needed between MH and hospitals
+	

Discussion 4 – How do we take this work forward?

Sentiment	Comments
+	• Need input from MH teams, NEAS, OT, Physio, Local Authorities
+	• Communicate with staff by: ○ via email ○ during the 15 minutes weekday huddles ○ shift handovers ○ intranet ○ attaching important information to the staff e-roster where they regularly go to check their shifts ○ attaching information to the electronic pay slip
+	• Staff need to take ownership as well and look for information and get involved

Notes from Path to excellence staff engagement event - Medicine and emergency care staff engagement workshop

Discussion 1 (Part 1) – Opening Reflection

- Will there be the same level of emergency services at South Tyneside.
- Communication and engagement not the best at Sunderland
- Appreciate it when the information is valid to inform patients
- More clarity on 7 day service

Challenges…

- Staffing/medical staff
- Should get equipment delivered on a Saturday
- Waiting for social care
- Issue: Recruitment/staff leaving through worry about job security
- Myth about South Tyneside closing
- Communication: Staff understand the need for change but the public don't

Discussion 1 (Part 2)

- Staff not turning up for work leaving remaining staff struggling
- Managers can't focus on own tasks because they to cover for absent colleagues
- Better training
- Lack of staff to achieve targets
- Lack of resources
- Lack of specialists at South Tyneside
- Communication to combine the trusts

How to solve

- Must link the trusts
- Better IT infrastructure – use the same system
- Need to see how other trusts are run
- Junior staff/but they need more help/more coaching
- Dementia wards – environment not appropriate

- Keeping people involved, if staff contribute to the changes they're more likely to stick with them
- Better communication between the two trusts

Discussion 2

- Best care for patients
- Best outcomes
- Reduced waiting times
- Educate patients on what services to use equity of standards among both trusts

Must

- Staff (Improve levels)
- More communication between GP's and hospitals
- Most consistency among GP appointments across the North East

Markers for success

- Patient feedback
- Looking at the outcomes we are currently failing on and monitoring them

How

- Pathway from discharge to social care
- Better understanding of the demand
- Better facilities
- Right staff and people in the right place, right time
- Better communication on what is currently there

Standards

- Patient safety

Notes from Path to excellence staff engagement event - Medicine and emergency care staff engagement workshop

Discussion 1 (Part 1) – Opening Reflection

- Understand need for change. Work streams – What community representation in work streams?
- Members in clinical review groups. What comments/support in community
- Recognition of pressures in communities – finance etc. No additional resources – what does this mean? No capacity to take extra patients
- More patients seen quicker/strength in numbers
- Patient choice
- Different process, less duplication.
- One system will do.
- Different policies
- Rationalisation/Opp to save on management posts
- Slowly things are coming together/ideal time to check standards

- Locality issues – transport issues – care close to home will be impacted
- Clinical quality – maintain
- Community representation in work stream

Discussion 1 (Part 2)

- Is it community teams or pushed back to GP's
- GP refers to community teams
- Mood to increase GP led care
- Time to get GP appointments
- Staff are overworked
- National staffing challenge
- Worried that services should not be compromised.
- Maintain nurses in the region
- Make organisation attractive for people to work the organisation
- Cost cutting measures – ultimately more expensive if staff leave
- Unseen investment in staff
- Staff morale
- Developing staff
- Don't cut staff numbers
- Staff engagement
- Always looking for a quick fix – invest in staff
- Budgets – worried NHS is going to be reactive and task focused
- Managing – proactive
- Aspire to maintain highest standard
- Staffing vacancies, retention, demand
- Annual leave/sickness
- Minimal resilience in system
- Ageing workforce
- Back flow/vacancies
- Training – is it available in back areas
- Staff capacity – time to train new staff
- Sunderland travel impact for training
- Workload – demand – capacity
- Emergency admission
- People are living longer
- Is community care more expensive that acute care?
- More cost effective to care in hospital
- Poaching staff
- Gaps in community care
- Damaging morale in staff
- Service resilience & individual resilience
- Uncertainty – people want to work where they originally worked.
- Specialist nurses going into GP's

Discussion 2

- Maintaining and improving quality services
- Getting pathways slicker

- Getting rid of waste
- Meeting patient expectation
- Patients safety
- Building on existing relationships
- Good communication
- Opportunity to see staff under same umbrella. Utilising existing staff.
- Agree common standards
- Meet standards
- Good IT systems
- Corporate issues/staffing
- Respecting employee choice of location and work.
- Give employees choice – facilitate
- Patient safety above all
- Make jobs quicker to do
- Adopt John Lewis style – learn from industry.
- Provider of choice + employer of choice
- Wider arrangement with staff
- Staff survey not good enough
- More in-depth engagement via focus groups – frontline staff
- No time for staff to complete surveys
- Given time to do focus groups – would attend
- You said we did after staff surveys
- Sharing information better
- Impairing communication between staff
- Staff should be aware of who the senior/executive team is?
- Surveys always in an email – not the most effective way of getting across – gets lost in emails
- IT Systems – to have imagery – to show who people are
- Harmonise uniforms?!

Discussion 3

- Social media – closed groups – to get message out views to be shared /intranet/FB/twitter) – regulated
- Work phone quick message
- Need to know feedback of how we're impacted/been involved. You said, we did
- Smaller staff in organisation – standards of care
- Seeking the right views / involving the correct people
- Work in localities on site
- Look at models from other trusts
- Push back out and showcase patient self-care
- Encourage self-care
- Be proactive
- Technology for patients to ask questions – rather than mailing appointment – care closer to home
- Giving service to those who would use it
- Skype consultations with GPs
- Technology in NHS not moving quick enough
- Good electronic systems
- Get on with it – radical reform

- Too many mergers – stop having to reapply for jobs
- Get to wherever we need to be ASAP
- More action, less talk
- There will be time needed in clinical areas, but make plan so that people know where they will be
- Organisational change before one has already finished
- Specialities are linked but people feel differently
- Worried about uncertainty
- Things have already started to change
- Previous times – 2 years too long for change
- Created anxiety /worry of uncertainty
- Working in different environments already – facilities are some but all work in different teams
- Financial implications – IT systems – world of difference for moving through services
- May not impact people in such a big way
- Many people/staff unaware of what is happening
- Is it was quick you would know and get on with it

Discussion 4

- Engaging and involving with the right people – reassuring the right people
- Department managers to be linked up with ward staff
- The managers need to be aware and replying to the message
- Encouragement from director of managers to visit counterpart in acute hospital
- Use the buddy approach for both sites to get engaged
- Use key people on ward to meet counterpart
- Decide on 1 emerging manager rather than more than 1, corporate level has been done – incorporate into lower level
- Staff suspicious because they are unsure/ clear about what is actually happening
- Do it from the first get go
- Relevant for staff at different levels

Notes from Path to excellence staff engagement event - Medicine and emergency care staff engagement workshop

	What are your thoughts, hopes, worries and fears for the programme?
+	I am reassured that S. Tyneside is not closing.
=	It's a shame services such as personnel need to move from S Tyneside
+	It would be interesting to talk to someone from Sunderland to see what they do
+	A new start – it's a positive thing
-	In S. Tyneside there are lots of rumours – they have changed the pay day and personnel have all gone off site and we are not sure why? We feel rail roaded as S. Tyneside had its own recognition
=	We now know that S. Tyneside is not closing and we will have to do things differently – don't see how it will stream together
-	It could have been done differently – there was no lead up to personnel going to Sunderland, it happened overnight and we were just told.

	What opportunities does it present?

+	We need to pull together – share experiences. It's a two way thing – similar to York/Scarborough
	What are the challenges or concerns you have at this point?
-	Healthcare is very close knit. There is a perception that different messages are given to both sites.
-	Because staff are hearing different messages between the two sites it is hard to keep staff positive. Comms needs to be clearer.
+	Staff want to know what's happening and are happy to work together for the good of the people.
	What are the current problems?
-	<u>Staffing:</u> On some days beds can change from 28 – 34 and there is not enough staff to cope. Using agency staff causes additional pressure as they are not part of the team and don't know the system as we do. There are not enough staff nurses and you are constantly on a knife edge coping with sickness and agency staff. The pool of bank nurses is not big enough and we rely too much on agency staff. Things were much slicker when we had our own bank – much harder now that we have to use NHSP. There is no incentive for agency staff – the pay is too low. They make a decision to come in based on what they have heard about the shift. <u>Discharges:</u> These are an absolute nightmare. Many people slip through the system and end up waiting in the discharge room for up to 6 hours or go home without their DNAR medication. If something goes wrong on the discharge lounge – people end up being re-admitted and there is added pressure as there is usually someone knew in their bed. You end up still looking after the person you have discharged until they go home. They can be in the discharge lounge for many hours and there are no private areas. It would be interesting to see if Sunderland and S. Tyneside have the same problems. There are problems signing off discharges if the nurse has finished her shift for example – and is not happy to sign the discharge papers the next day. Sometimes it is not appropriate to send someone to the discharge lounge. If they are diabetic or elderly and confused. Sometimes they miss having their insulin. <u>IT</u> There are massive problems with people arriving on a ward and having no passwords. What does the 4 day induction do – they should be ready to start after that. In S. Tyneside we now have to book any operational training as separate sessions. It used to be 1 day. It is less efficient now and the system does not make it easy. We have no time to book all the training for staff. Sunderland book their own
	How resilient is our workforce?
-	Sickness: The system is not robust enough. It is so easy to ring in sick with d&v to any ward. You know it's going to be the same people – no pay would stop this immediately. Some people take off more than 48 hours because they know they will get paid if they stay off longer.

	There is a core of staff in S. Tyneside who run on goodwill, however, the gap will come further along when these people retire. When patients are nearing the 'trigger' for half pay or no pay a letter is sent out from HR. This letter does not take the individual's reason into consideration and is just computer generated. This causes lots of problems as there is no notice of this coming to managers who could justify the reason – e.g. long term sick What do you worry about? Quality of care Safety – how we share information across both sites could be considered a risk. S Tyneside use a different number to Sunderland to identify people – we should all use an NHS number. In S. Tyneside we are still prescribing on paper – doses sometimes get mixed up as you can't read the handwriting etc. Moving to Sunderland's electronic version is much better. Pharmacists are choosing to go to Sunderland and not S. Tyneside because of this. We need to align complaints between the two sites.

Section 2
What is our aspiration? To be sustainable, robust and provide high quality work delivered by well trained and supported staff.
What clinical and national standards will we not compromise on? • Patient safety • Patient centred care – design meaningful services from their needs and enable them to make an informed decision • How often do we meet those criteria – do we have the correct staff to meet them? • Can't generally standardise • Working to the same principles • You need the right staff at the right time or you won't meet any of these Other comments: • You need time to do 1:1's – make staff feel valued and encouraged • Make sure we allow managers time to discuss staff's aspirations – at the minute we are fire-fighting • Bed managers – only see bed as a space, potentially you could move a patient 6 times and this might mean waking them up in the early hours to do so. • At the minute we move patients to the consultant – they could end up with a virus. Why not reverse this and take the consultant to the patient. • Bed availability on a daily basis in rushed. • Comes back to patient experience – what is right route for that patient. Some people don't fit into any speciality • S. Tyneside hospital is very short sighted – they only see the quick fix

- Patients are only seen as a business. They should be managed in a 'not time critical' way.
- It is impossible to work with 100% occupancy
- Every time you move a patient you lose a little time. If you do this every day it is not efficient.
- Get the patient care right and life is easier for staff. This should be a given.

What are the must do's?
Patient safety

What will we not compromise on?

- Service improvement
- Organisational development
- Education/development

How will we do this?

- We need to be proactive in getting info from patients and staff
- We need an action plan – we seem to be saying the same things all the time e.g. get more nurses/ free parking

What are the makers of success?

- Being able to deliver 1st class services all the time by the right people
- National reputation
- Going to other hospitals to see good examples of how they have done things.
- Pharmacy – prompt medication review: each hospital has prescribing guidelines but they need to be homogenised and follow the same treatment pathways. Pharmacists like procedures! Set pathway – set conditions means patients get exactly the same. Electronic prescriptions will improve this but won't improve the clinical decision. More consistency is need – at the minute it is very frustrating.
- We need to stop moving patients around so much – should we have length of stay standards e.g. 6 days target and make length of stay visible
- Warfarin targets are impossible to hit but they have a range to work to
- Where do you draw the line – it is very demoralising for staff.

Acute Medicine & Emergency Care Staff Engagement Workshop – 21/03/18

Discussion 1 – Reflections so far

- Ready for change
- A lot of patient worries around stroke from STFT to CHS regarding third party social care etc
- (Hope's) Patients who border both trusts will be given easier access to services designed around patients and their locations. Better designed services shared over both sites.
- (Worries) Only having 1 ED. NEAS going between sites will have long waits. A NEAS rep should be here to give assurance around pressures and their coping strategies.
- How will all of the services work together as 1? Including social and after care.
- Will CHS be the main trust? Will STFT be the lesser trust?
- Will it be a seamless service?
- Will staff be expected to work across both sites?

Dicussion 2 – Challenges

- Staffing resources
- Will it be 1 management structure across both trusts?
- STFT – currently have more patients and more complex cases but it is still running as a small service. Now have longer length of stay and there is more work involved then previously.
- Discharge difficulties / bed difficulties
- The 2 hospitals have different services, ways of working & community care. Needs to be streamlined into 1 way of working.
- Hospice patients; can STFT/CHS patients go into both sites from either trust?
- Do we have capacity for a 1 for all service?
- External provider challenges with mixed area patients
- Handover struggles with different system and notes
- Diagnostic orders are difficult and difficult to see the results (especially when carried out at 1 trust and transferred to another)
- IT challenges – need to be on 1 system
- Staff pressures to change the ways of working while training on new systems
- Patient expectations (which trust is better)
- Travel & Transport for patients and staff. Wide area – very broad distance
- Need more information filtering back to staff of what is going on to be able to pass this on to the patients. (newsletters for staff, on the news for patients)
- Big impact on staffing for night staff. Matrons/night manager doing more different roles to cover absence which has a knock on effect. Maybe use pool shifts/flexi shifts to cover. Staff only want to cover their own areas.
- A lot of time is spent on night rotas and there is not enough cover
- Staff do not want to join the trust as they think we are closing. Staff are moving on to ‘secure trusts’.
- Older staff does not want to go through changes and re-training (on systems) so are retiring instead of staying or retuning
- Trusts are not being made to look attractive for recruitment
- STFT social media is terrible and could be better used to make us look better. Staff makes suggestions but are always knocked back. Social media is a good opportunity to make us look better.
- Very negative press and media on both trusts
- CHS staff are very resilient – during the snow days the staff were determined to get to work. Staff should be commended for these things.
- Patients want the best service but close to them. Patients need to know that what is happening is for the best patient care and not to save money.
- Too many rumors about what is happening and no-one actually knows the truth.

Discussion 3 – Aspirations

- Working together while delivering the same quality of care for patients

- Best standard of care possible
- Patient/family satisfaction
- To have shared learning and inter-working across both trusts
- Continuous improvement for a better service
- Learning from each trust what they can do better
- Using lessons learnt from each other
- Learning about each trust and what services they offer
- Giving patients as much information as possible that we have specialised services and the benefits of traveling to each trust
- Services like Chemotherapy shouldn't patient should not have to travel for
- Could enable us to develop new services that's neither trust currently have
- STFT is a deprived area and will be expensive to travel for patients. Better travel services need to be in place.
- Communication to the public needs to be more robust and informative
- How do we engage patients in the 2 trusts as 1
- Better health promotion; patients to have better health/lifestyle knowledge
- Patients deserve the best service we can possibly give
- Better community/primary care treatment available before they reach hospital
- Better GP education for referrals – outside providers are unnecessarily referring patients to hospital
- Have patients in the right place at the right time, seen in the correct waiting times and moved to the right area within the timescale
- Managing patient expectations of all services
- Right bed, right ward, right time with the correct workforce and resources to deliver the care needed
- Patient feedback
- It is important to feedback praise to the staff as this improves morale
- STFT used to have an email every Friday from the Chief Executive with the good feedback and it kept the morale up; they no longer have anything like this and it is missed by staff
- No serious incidents r patient risks
- Better triage for patients
- Good decision-making for patient treatment
- Patients don't want to stay or be admitted but there are no access to services to be able to discharge at certain time of the day/week