Partners in improving local health

North of England Commissioning Support

Path to Excellence - Phase Two

Staff events feedback

July 2018

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Contents

1 Executive summary

As part of Phase two of the Path to Excellence programme, three events were held for staff from the following clinical areas:

- Surgery, theatres and critical care
- Medicine and emergency care
- Clinical support services

These followed the events that took place in March 2018, in which the hopes and aspirations for these clinical areas were discussed.

For both surgery, theatres and critical care and medicine and emergency care a number of options were developed for review, these were grouped into four categories;

1. Minimal change options
2. Partial consolidation options (based on hours, service and activity)
3. Full consolidation options within the healthcare group footprint
4. Full consolidation options outside the healthcare group footprint

As the event for clinical support services was held last, the options presented to these staff members were those that were discussed more favourably in both the surgery, theatres and critical care and the medicine and emergency care event.

Within this summary, staff opinion on the options have been collated, however these are presented separately for the different events later in the report.

Staff emphasised that for the next phase of events, how important it would be to have more data and figures that supports the options to allow them to make more informed decisions about their viability.

1.1 Surgery, theatres and critical care

Minimal change options

2. Continue with status quo with additional investment to address workforce gaps.

3. Status quo at both sites with single team establishment across all specialities working across both sites.

4. Status quo at both sites with acute capacity and process refinements such as pathway & process alignment and development.

Positives (Strengths)	Negatives (Weaknesses)
• Sharing of best practice	• Not much difference to leaving services as they

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• Standardisation • Workforce can move easier between sites • Small improvement from current way of working • Single team establishment might work in some areas but not all (i.e. ward & theatre staff) • One team might help improve quality	are / little improvement to quality • Both sites are struggling to deliver currently • Differing IT systems and working environments • Training implications • Misaligned resources – costs to standardise • Huge workforce gaps - staff not available to employ / high staff turnover • Added problems for recruitment – uncertainty / difficult to attract staff over two sites • Will not enable a 7-day service to be developed • No savings
Option preferences: - Comments were made during the surgery, theatres and critical care event that these options were not radical enough and would not resolve the current issues faced. - These options were therefore not presented at the clinical support services event.	

Partial consolidation option(s) (based on hours, service, activity)

5. Centralisation of Trauma and Emergency General Surgery onto a single site. Inpatient elective work for Orthopaedics and General Surgery consolidated on to the opposite site.

6. Centralisation of Trauma and Orthopaedic inpatient elective activity at one site. Move all emergency General Surgery work to the same site as above, but consolidate inpatient elective work at the opposite site.

7. Centralisation of Trauma one site with high volume inpatient elective orthopaedics at the other site. Consolidate all emergency and inpatient elective work to a single site for General Surgery.

8. Centralisation of Trauma one site and high volume, low risk day case and inpatient elective orthopaedics at the other site. For General Surgery retain emergency and major elective work at both sites in-hours; Emergency patients who require an operation will be transferred to a single designated site out-of-hours.

9. Centralisation of Trauma and inpatient elective activity at one site. For General Surgery retain emergency and major elective work at both sites in-hours; Emergency patients who require an operation will be transferred to a single designated site out-of-hours.

Positives (Strengths)	Negatives (Weaknesses)
• Creates opportunity for specialisms – improves quality and care • Allows staff to specialise • Increased patient confidence • Opportunity to move forward in integrated system with no borders • Opportunities for career progression – helps staff retention and	• Demand on one site and workload pressures • Difficulty in providing services over more than one site / dividing expertise • Would require a great deal of restructuring to ensure adequate beds and staffing • Current staff levels and capacity issues • Staff recruitment and retention

development • Pooled resources – less investment • Routine waiting lists would be improved • Protection of elective beds allows for better planning i.e. less cancellations = patient satisfaction • Positive if specialities brought back to STFT i.e. vascular	• Potential for deskilling / changes to job roles • Cross site working – training implications, childcare, travel & parking (& associated costs) • Travel for patients and visitors – poor transport links / multiple transfers required in some cases • Patient travel – transportation needed for patients after surgery, implications for rehabilitation and social care • Investment required (e.g. wards, staff & standardising practices – IT)
Option preferences: - Option 5 was considered the most feasible / sustainable / affordable in the surgery, theatres and critical care event. - At the clinical support services event – tables discussed the strengths and weaknesses of all the options with a slightly greater preference for Options 5 and 9.	

Full consolidation option(s) within the healthcare group footprint

10. Centralisation of Trauma and Emergency General Surgery onto a single site. Inpatient Elective work for Orthopaedics and General Surgery also consolidated onto this site.

Positives (Strengths)	Negatives (Weaknesses)
• Easier to manage staff flow • Better patient experience with continuity of care • Larger staff pool and better skill mix • Good for the delivery of pharmacy services	• Capacity & space on one site - difficulty to sustain • Staff reluctance to move / high staff turnover • Deskilling of staff at site 2 • Travel for staff, patients and visitors (including travel for rehabilitation) • Parking • Public opinion / resistance from community groups - patients may prefer to seek services in adjoining areas • IT would need to be consolidated and reliable • Huge impact on community services • Capacity problems would lead to cancelled elective surgeries • Patient safety – more breaches with massive impact penalties
Option preferences:	

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- This option was not discussed widely at the events with the negatives felt to outweigh the positives.

Full consolidation option(s) outside of the healthcare group footprint

11. No trauma or emergency surgery at either site.
12. No elective orthopaedics or general surgery at either site.
13. New, single hospital serving both populations.

Positives (Strengths)	Negatives (Weaknesses)
Option 11 & 12; • More favourable for patients than just one single hospital For a new hospital; • Site of excellence • Fully integrated teams • New hospital could be modelled taking into consideration increase of numbers of patients / surgeries	Option 11 & 12; • Difficulty in recruiting consultants • Staff redundancy (less beds) • Pressure placed elsewhere including community services For a new hospital; • Investment of new building • Parking • Time to build
Option preferences: - These options were not particularly favoured at the surgery, theatres and critical care event with not all tables providing comment on them. - These options were therefore not presented at the clinical support services event.	

1.2 Medicine and emergency care

Minimal change options

2. Continue with status quo with additional investment to address workforce gaps.

3. Continue with status quo with single team establishment across all specialities working across both sites.

4. Continue with status quo with workforce innovation.

5. Continue with status quo with out of hospital/ prevention developments to reduce demand (i.e. frailty outreach/virtual ward, pathway-specific demand management, GP streaming for all self-attenders, ED entry by referral only).

6. Continue with status quo with acute capacity and process refinements such as pathway & process alignment and development, enhanced frailty, ambulatory care, rapid access clinics.

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Positives (Strengths)	Negatives (Weaknesses)
• Same pathways across both sites • Provides care closer to home • Less change for patients • Improved resources and efficiencies • Bigger workforce pool – flexibility • Opportunities for staff development and growth • Staff more attracted to join a bigger trust • Shared best practice • Patient experience improved through 7-day service delivery • Provision of more medical-led hot clinics at both sites • Enhanced frailty to stop patients hitting EAU/IAU • Greater opportunities for innovation • Would work from a diagnostics perspective	• Disparity of service across the sites – difficulty of bringing together • Without consolidation - duplication will remain • Training implications & staff reluctance if working across both sites and systems not merged • Staff dissatisfaction at cross-site working – increased travel time (& costs), unfamiliarity & winter challenges • Huge workforce gaps – upskilling makes gaps elsewhere • Recruitment; lack of staff available / funding / uncertainty of merger / difficulty of recruiting to a small hospital • Staff reluctance to go to STFT for fear of closure • Differing rates of pay • Workforce innovation won't solve problems • Poor patient feedback / experience • Investment required - cost of sustaining • Not realistic to achieve within 1-2 years with staff movement and capacity
Option preferences: - Although many perceived benefits were identified at the events, a lot of the current problems were felt to not be addressed whilst also creating new issues.	

Partial consolidation option(s) (based on hours, service, activity)

7. Status quo with a selected cardiology take at one site enabling consolidation of higher-risk cardiology at a single site.

8. Status quo with a selected medical take at one site using pre-hospital risk stratification to consolidate higher risk patients at a single site. Consolidation of all overnight urgent and emergency care at a single 24/7 ED site with a 14-16 hour/7-day ED site.

9. Consolidation of all overnight urgent and emergency care at a single 24/7 ED site with a 14-16 hour/7-day ED site.

10. Consolidation of all overnight emergency care at a single 24/7 ED site with a 14-16

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hour/7-day ED supported by overnight local urgent care.

Positives (Strengths)	Negatives (Weaknesses)
• Cleaner pathway with specialised care – improved quality of care • Improved patient confidence through specialisation • Shared best practice • No investment required / potential cost savings • Benefits for larger teams (not as positive for smaller specialist teams - potential to lose benefits) • Staffing would work by changing shift pattern / safer staffing on off-duty • Staff rotation • No significant change for rehabilitation • Can be flexible where pharmacists are deployed (but would need more investment) • Opportunities to reconfigure pool of SLTs to support models and achieve benefits from a larger single team • Protects services at both hospitals • Option 7 – high risk cardiology consolidation already happening unless 'walk-in'	• Both sites currently full to capacity • Different systems in place across both sites – hard to come together i.e. IT • Additional investment and resources required for 24/7 site / pressure on 24hr service • Patients may wait until the 14-16 hr unit reopens to present • Rise in ED attendees prior to close if one site closed overnight • Patient dissatisfaction if no access to ED overnight locally • Staff travel between sites and how to manage dual roles to ensure contingency - impact on staff wellbeing/time leading to potential staff loss • Potential staff dissatisfaction if on-call working changes and they have to cover a larger area • Recruitment issues • Travel and cost implications for patients and visitors • Patients won't travel for 'cultural reasons' – will choose to go elsewhere • NEAS availability to support / cost of transferring patients between sites • Impact on patients for specific services i.e. respiratory team • Impact on podiatry if other specialised services are removed • More referrals • De-skilling

Option preferences:

- Among those who attended the medicine and emergency care event, Option 9 and 10 were only considered safe if they were well communicated and understood by patients.
- There was no real consensus on a preferred option in the clinical support services event with staff discussing the strengths and weaknesses of different options.

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Full consolidation option(s) within the healthcare group footprint

11. Status quo: 2 x EDs with fully-consolidated acute medicine at a single site.
12. Full consolidation of all Emergency Care onto a single site with 2 x acute medical sites. Non-emergency care site to be GP/NHS 111 referral based only with AEC, Acute Medicine and general medical beds.
13. Full consolidation of all Emergency Care onto a single site 2 x acute medical sites and locally accessible 24/7 Urgent Treatment Centres. Non-emergency site to include AEC and general medical beds.
14. Full consolidation of all Emergency and overnight acute medical care onto a single site with locally accessible 12-14 hour, 7-day Urgent Treatment Centre and daytime acute medical assessment, AEC at less-specialised site.
15. Full consolidation of all Emergency Care and acute medicine onto a single site with non-emergency and acute site to have 24/7 Urgent Treatment Centre, enhanced AEC and frailty assessment, general medicine OR intermediate care beds.

Positives (Strengths)	Negatives (Weaknesses)
• A more robust, sustainable service • Standardised practice • Shared best practice • Stronger workforce with good skill mix • Pooling excellence • Opportunities for staff development and growth • Less duplication and therefore more affordable services • Opportunity to develop pharmacy / pharmacists	• Demand on single ED site / capacity issues • Health impact for patients if only one ED i.e. extra travel time • Impact on patient care if urgent care, acute and ED split • Transportation of patients between the two sites / NEAS ability to support • Cost of realigning • Staff loss / retention challenges – not all staff would stay • Travel for patients and visitors • Loss of services at South Tyneside • Patient perception and experiences – patients may go to next nearest site in adjoining areas • Differing IT systems

Option preferences:

- Option 13 was considered the most sustainable, affordable and deliverable by a high number of those who attended the medicine and emergency care event.
- At the clinical support services event there was a lot of criticism about these options.

Full consolidation option(s) outside of the healthcare group footprint

16. No urgent or emergency care at either site
17. No acute medicine at either site
18. No ED or acute medicine at either site

Positives (Strengths)	Negatives (Weaknesses)
• Opportunity to develop an exceptional service • More collaborative team working • Avoids duplication of specialist services	• Patient safety – too much work required to address risks • Patient transport • Capacity – volume of patients • Changing patient behaviour

Option preferences:

- This option was only discussed by one table at the medicine and emergency care event with patient safety identified as a huge issue.
- These options were therefore not presented at the clinical support services event.

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2 Surgery, theatres and critical care

2.1 Minimal Change

2. Continue with status quo with additional investment to address workforce gaps.

3. Status quo at both sites with single team establishment across all specialities working across both sites.

4. Status quo at both sites with acute capacity and process refinements such as pathway & process alignment and development.

2.1.1 Surgery, theatres and critical care event

	Positives (Strengths)	Negatives (Weaknesses)
General comments about the options	• Shared best practice • Standardisation • Workforce can move easier between sites • Small improvement from current way of working • Single team establishment might work in some areas but not all (i.e. for ward & theatre staff) • One team might help improve quality	• Not much difference to leaving services as they are / little improvement to quality • Both sites are currently struggling to deliver services • Differing IT systems & working environments – training implications • Misaligned resources – costs to standardise • Huge workforce gaps - staff not there / available to employ • Added problems for recruitment – uncertainty / difficult to attract staff over two sites • Will not enable a 7-day service to be developed • High staff turnover • No savings – no efficiencies through not redesigning services

Considerations / other ideas	• Not radical enough – the patient pathway and the design of services needs to change • Use good examples i.e. Newcastle and Northumbria and how they have redesigned their services with surgeons travelling to and working for different locations, using a 'hopper' bus/shuttle service for staff and patients

2.1.2 Clinical support services event

These options were not presented at this event.

2.2 Partial consolidation option(s) (based on hours, service, activity)

5. Centralisation of Trauma and Emergency General Surgery onto a single site.

   Inpatient elective work for Orthopaedics and General Surgery consolidated on to the opposite site.

6. Centralisation of Trauma and Orthopaedic inpatient elective activity at one site.

   Move all emergency General Surgery work to the same site as above, but consolidate inpatient elective work at the opposite site.

7. Centralisation of Trauma one site with high volume inpatient elective orthopaedics at the other site.

   Consolidate all emergency and inpatient elective work to a single site for General Surgery.

8. Centralisation of Trauma one site and high volume, low risk day case and inpatient elective orthopaedics at the other site.

   For General Surgery retain emergency and major elective work at both sites in-hours; Emergency patients who require an operation will be transferred to a single designated site out-of-hours.

9. Centralisation of Trauma and inpatient elective activity at one site.

   For General Surgery retain emergency and major elective work at both sites in-hours; Emergency patients who require an operation will be transferred to a single designated site out-of-hours.

2.2.1 Surgery, theatres and critical care event

	Positives (Strengths)	Negatives (Weaknesses)
General comments about the options	• Creates opportunity for specialisms – improves quality and care • Increased patient confidence • Allows staff to specialise • Routine waiting lists would be improved • Protection of elective beds allows for better planning i.e. less cancellations = patient satisfaction • Access to specialist surgeon 24/7 on one site • Elective surgery - more profitable • Positive if specialities brought back to STFT i.e. vascular	• Demand on one site and workload pressures (STFT couldn't cope) • Requires a large amount of restructuring to ensure adequate beds and staffing • Current staffing levels and workforce gaps • Cross-site working – reluctance, training implications, travel & parking, childcare issues & associated costs • Potential for deskilling / changes to job roles • Potential staff redundancy • Staff fear of being anonymous (well known in their current trust) • Patient travel – transportation needed after surgery, implications for rehabilitation pathways & social care • Travel for visitors • Investment required (wards, staff & standardising practices e.g. IT) • Reluctance to lose work and pathways in place at STFT
Option 5	• Considered most feasible / sustainable / affordable by some • Occupational therapy already works well across the two sites • Develops centres of excellence • Day case on both sites	• What if a patient needs to move from elective to emergency surgery? • Impact on ED • Will the main emergency site always have enough beds? I.e. with winter pressures
Option 6		• Concerns over capacity
Option 7		• Patient safety • Concerns over capacity • Most confusing option for NEAS

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Options 8 & 9		• Financial implications • Concerns over capacity • No change to general surgery as it currently stands • Loss of trauma beds at one site
Considerations / other ideas	• Support services like social services are different for both trusts – how would that work? May increase the length of process • Rehabilitation would have to be close to home – patients want local services / more rehabilitation beds needed • Would there be enough trauma beds? Beds would need to be closed off • Can we consolidate CSSD, decontamination & sterilisation services? Even on a bigger footprint over 7 days to bring in revenue? • Consultants are needed at both sites – how would this work? • Need to consider what would happen if there was no capacity on one site • Need to look at the hospital night pathways and ways of working	

2.2.2 Clinical support services event

	Positives (Strengths)	**Negatives (Weaknesses)**
General comments about these options	• Opportunity to move forward in integrated system with no borders • Opportunities for career progression – helps staff retention and development • Pooled resources – less investment needed • Improved patient safety • Staff concentrated across sites • Occupational therapy service could be built around	• IT configuration not currently set up • Difficulty in providing services over more than one site / dividing expertise • Training issues • Travel for staff • Travel for patients – poor transport links / multiple transfers • Parking • Staff recruitment and retention • Current capacity issues at Sunderland already • Options might not work well for therapy services
Option 5	• Considered favourably by some	• Deskilling of staff – would need to rotate staff to

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	• Makes financial sense • Specialist centre of excellence – sharing of best practice • Single trauma unit can specialise on their strengths • Opportunities to rotate and work in other specialities at different sites • Improved access and increased patient care • Straight forward for electives • Useful for Band 5 development opportunities • Help to avoid staff burn-out	make skill mix fair but staff may be reluctant • Travel issues • Recruitment problems • Struggle with current staff levels • Differing IT systems • Patients can deteriorate very quickly in both T&O and general surgery and need high risk treatment
Option 6	• More specialised care • Single trauma unit can specialise on their strengths	• Higher workload at site 1 - unfair to staff • Capacity lost on site 2 • Issue of space at site 1 • Deskilling at site 2 • Repatriating patients after surgery may present difficulties around DTOC • Patient transport • Out of hospital follow-up care will detract from positive patient experience (work of orthopaedic outreach South Tyneside team will be impacted) • Patients can deteriorate very quickly in both T&O and general surgery and need high risk treatment
Option 7	• Single trauma unit can specialise on their strengths	• Less impact than other options • Deskilling of staff • Patients can deteriorate very quickly in both T&O and general surgery and need high risk treatment
Option 8	• Facilities in place currently to implement this	• Delays in treatment due to transfers • Lack of specialism
Option 9	• Considered favourably by some - lots of services on each site	• Delays in treatment due to transfers

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	• Will help sustain services • Sharing of best practice • Facilities in place currently to implement this	
Considerations / other ideas	• Emergency surgery needs to match with 24/7 ED • Consider environmental visits for discharged patients • No post-operative care mentioned • No suggestion for day case on 1 site or electives on both sites • Investment needed in staff to address workforce gaps • Where does ITU sit? • Radiology is difficult to split between medical / surgery - need to look at them together • Community support must be the same at both sites • Would rehabilitation have to pick up patients who have had treatment elsewhere? • Elective rehabilitation - where would they go? • Some services can't do certain post-operative rehabilitation and GPs already direct them to the wrong place i.e. MSK service • For the GP MSK service CHS have a service but STFT use a private company - how will that work going forward? • How will outpatients be set up to take new elective/trauma patients? The outreach at STFT would drown with this high volume (no spinal service currently available) • Need link with ambulance service to ensure patients are sent to the correct site • Will other services hosted at the sites be affected? • For T&O their best option would be; 24/7 ED & ITU on both sites, elective and day case on both sites with sub specialities and the same for general surgery • Aging equipment at Sunderland • Lack of CT scanner at STFT • Winter planning - how will resources and ward beds be allocated during higher demand periods? • Redevelopment of surgical pre-assessment and discharge is needed Questions asked specifically by podiatry; • How will staffing be managed?	

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	• How will it work in the community? • What is the patient flow? • Where do patients receive their follow-up care? • Where will the main base be? • Do we have the room / facilities at clinics? • Triage, standards and guidelines would need to be standardised

2.3 Full consolidation option(s) within the healthcare group footprint

10. Centralisation of Trauma and Emergency General Surgery onto a single site. Inpatient Elective work for Orthopaedics and General Surgery also consolidated onto this site.

2.3.1 Surgery, theatres and critical care event

Note: Not all tables provided comments on this option at this event

	Positives (Strengths)	Negatives (Weaknesses)
Option 10	• Opportunities to bring back secondments • New hospital could be a teaching facility	• Reluctance of staff to move / high staff turnover • Difficulty to sustain • Capacity and space at one site (theatre & bed space, winter pressures, outpatients) • Capacity problems would lead to cancelled elective surgeries • Patient safety – more breaches with massive impact penalties • Transport issue for staff, patients and visitors • Travel for rehabilitation • Parking
Considerations / other ideas	• Needs to handle winter pressure and be future proof - plan for future capacity.	

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2.3.2 Clinical support services event

	Positives (Strengths)	Negatives (Weaknesses)
Option 10	• Easier to manage staff flow • Better patient experience through continuity of care • Larger staff pool and better skill mix • Good for the delivery of pharmacy services	• Capacity / space available at site 1 – not sustainable • Parking • Travel for staff and patients (increased travel for community staff and potentially more costs for trusts) • Public opinion / resistance from community groups - patients will prefer to access services in adjoining areas • IT would need to be consolidated and reliable • Large impact on community services (result in movement of services) • Deskilling of staff at site 2 – staff would need to rotate rather than just cover day surgery
Considerations / other ideas	• What happens if having day care but need to stay in? • Building a new hospital is a 'better sell' to patients of all areas so everyone feels inconvenienced rather than just one set of patients	

2.4 Full consolidation option(s) outside of the healthcare group footprint

11. No trauma or emergency surgery at either site.
12. No elective orthopaedics or general surgery at either site.
13. New, single hospital serving both populations.

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2.4.1 Surgery, theatres and critical care event

Note: Not all tables provided comments on these options

	Positives (Strengths)	Negatives (Weaknesses)
Options 11 & 12	• Would be more favourable option for patients over just one new, single hospital	• More difficult to recruit consultants • Staff redundancy (less beds) • Pressure places elsewhere (i.e. on community services)
Option 13	• Site of excellence • Fully integrated teams • New hospital could be modelled taking into consideration increase of numbers of patients/surgeries.	• Investment required / new building expense • Parking • Time to build new hospital

2.4.2 Clinical support services event

These options were not presented at this event.

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3 Medicine and emergency care

3.1 Minimal change options

2. Continue with status quo with additional investment to address workforce gaps.
3. Continue with status quo with single team establishment across all specialities working across both sites.
4. Continue with status quo with workforce innovation.
5. Continue with status quo with out of hospital/ prevention developments to reduce demand (i.e. frailty outreach/virtual ward, pathway-specific demand management, GP streaming for all self-attenders, ED entry by referral only).
6. Continue with status quo with acute capacity and process refinements such as pathway & process alignment and development, enhanced frailty, ambulatory care, rapid access clinics.

3.1.1 Medicine and emergency care event

	Positives (Strengths)	Negatives (Weaknesses)
General comments on the options	• Same pathways across both sites • Improved resources and efficiencies • Bigger workforce pool • More opportunities and growth for staff • Staff more attracted to join a bigger trust • Shared best practice (e.g. Frailty at CHS, Delirium at CHS, Diabetes and ARAS at STFT) • Patient experience improved through 7-day service delivery • Provision of more medical-led hot clinics at both sites	• If systems not merged - staff would not to work across both sites (training implication) • Cross-site working might push staff out – increased travel time & cost, unfamiliarity & winter challenges • Staffing levels – huge workforce gaps • Recruitment issues; funding, uncertainty & lack of particular staff groups available (e.g. emergency nurse practitioners) • Staff reluctance to go to STFT for fear of closure • Wage difference across 2 sites • Workforce innovation won't solve problems

	• Enhanced frailty to stop patients hitting EAU/IAU • Use of interface teams – more support at home will reduce ED admissions • Greater opportunities for innovation • Would work from a diagnostics perspective	• Disparity of service across the sites • Bed management difficult at one site, very difficult across 2 sites • Potential that sites priorities admissions by geography rather than need • Investment required - cost of sustaining all departments and additional services financially • Sustainable? Struggling with current workforce numbers as is. • Unrealistic to achieve in the next 1-2 years with current capacity and staff movement (consider length of time to recruit to roles)
Considerations / other ideas	• Need the right workforce with right training • Invest in staff to improve retention • Consider rotational posts – rotate for skills and education i.e. ITU, theatres & stroke • Central hub to inform staff where they are working, what site and what department etc. – staff like to know where they will be on a day-to-day basis – want stability • Clear capacity management needed • Valid car parking to go across both sites so not having to pay twice • Clarity required around GP streaming for all self-attendees, how would it work for trauma? • 7-day Local Authority working required to support discharge to make status quo more effective • 7-day working for all services necessary • More specialist nursing input for long-term conditions (both front of house and outreach into community) • Larger complex discharge teams / more nurse-led discharge • More information for bed managers so they have more information about patients' needs - many are considered 'any medical' • Frailty outreach / virtual ward; - Have a frailty link in the community - Needs to be 7-days with specialist input - Frailty wards with a maximum 72 hour stay - Patients need to be seen as presented (not being watched on screens) this causes unnecessary ward admissions - Have a named consultant for virtual wards	

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3.1.2 Clinical support services event

	Positives (Strengths)	Negatives (Weaknesses)
General comments on the options	• Providing care closer to home • Less change for patients • Flexibility within a bigger team • Better skill mix for staff • Helps recruitment • Workforce innovation – expertise can be shared • Additional peer support as specialist physiotherapy assessments can be carried out with the help of Sunderland and South Tyneside staff	• Without consolidation duplication remains • Difficulty of bringing current services together – different models at each hospital • Where would the additional investment come from? • Potential for staff to feel overwhelmed • Travel for staff - cost & logistics • 'Minimal' is what is offered already / option 5 & 6 should be being done anyway • No changes to current services in radiology (pressure still exists) • Poor patient feedback/experience • Workforce gaps – no workforce available / upskilling staff makes gaps elsewhere / difficulty of recruiting to a small hospital • Difficult to educate patients on where to go
Option 5	• Better core pathways for patients • Reduced hospital stays • 24 hour care at both sites • Additional prevention / development to reduce demand - role for OT	• No control over where money produced • Not practical for GPs to have ED referral entry only • Requires buy-in from services outside the NHS
Considerations / other ideas	• Merging a few of the ideas would work better rather than choosing one option • A single team mentality is required • Workforce gaps need to be identified • Ambulatory care is vital to save admissions to ED – requires investment and expansion • Opportunity for lower level staff to develop by undertaking home visits (with support from more experienced staff) • To support options - STFT would need another CT scanner • Additional funding needed in dietetics - generally overlooked as a profession • Could remote working be an option for Option 3?	

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	• Look at how therapists are financed and where they are based (i.e. local authorities/frailty teams) • Logistical issues re: OT appliance delivery - if not done correctly for whichever model could have financial and HR consequences • Where will services be housed? • Is there scope for more rooms to be modelled into the plan? • Who will be providing outreach services?

3.2 Partial consolidation option(s) (based on hours, service, activity)

7. Status quo with a selected cardiology take at one site enabling consolidation of higher-risk cardiology at a single site.
8. Status quo with a selected medical take at one site using pre-hospital risk stratification to consolidate higher risk patients at a single site. Consolidation of all overnight urgent and emergency care at a single 24/7 ED site with a 14-16 hour/7-day ED site.
9. Consolidation of all overnight urgent and emergency care at a single 24/7 ED site with a 14-16 hour/7-day ED site.
10. Consolidation of all overnight emergency care at a single 24/7 ED site with a 14-16 hour/7-day ED supported by overnight local urgent care.

3.2.1 Medicine and emergency care event

	Positives (Strengths)	Negatives (Weaknesses)
General comments about the options	• Cleaner pathway with specialised care – improved patient care • Shared best practice • Option 7 – cardiology already happening unless 'walk-in' • No investment required / potential cost savings	• Both sites full to capacity – how can they support increases in space, parking etc. if operating on one site • Pressure on 24hour service - additional investment and resources required for • Patients may wait until the 14-16hr unit reopens to present • Postcode service • Staff retention and recruitment issues

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	• Benefits for larger teams (not as positive for smaller specialist teams - potential to lose benefits) • Staffing would work by changing shift pattern / safer staffing on off-duty	• Patients won't travel for 'cultural reasons' – will choose to go elsewhere in region • Patient dissatisfaction if no access to ED overnight locally • Rise in ED attendees prior to close if one site closed overnight • Travel and cost implications for patients and visitors • NEAS availability to support (paramedics still turning up at STFT with stroke patients) • Impact on patients for specific services i.e. respiratory team
Considerations / other ideas	• Only safe if communicated well - strong communication required to ensure patient enters correct pathway • Must work together more innovatively with all other agencies including social services, Local Authorities etc. • Improve intermediate care by putting doctors into those services • Investment - don't think about just buildings; think about processes, systems, pathways • If patients were admitted overnight to one site, how would they be transferred back to the other site? May impact on length of stay due to number of moves • Would referrals to STFT Ambulatory care still work in the same way if admitted to CHS? • Infrastructure around model needs to be set up to support it i.e. NEAS	

3.2.2 Clinical support services event

	Positives (Strengths)	**Negatives (Weaknesses)**
General comments on the options	• Staff rotation • Increased patient confidence through specialisation • Opportunities to look at strengths from both services and build on these • Rehabilitation wise no big significance for staff • Flexibility about where pharmacists are deployed - but more investment required • Opportunities to reconfigure pool of SLTs	• Different systems in place across both sites – hard to come together i.e. IT (will take time) • Transportation – cost of transferring patients between sites • Travel impact for patients and visitors • Staff travel between sites and how to manage dual roles to ensure contingency, particularly to cover part time workers - impact on staff wellbeing/time leading to potential staff loss • Impact on podiatry if other specialised services are removed • Potential staff dissatisfaction if on-call working changes and

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	to support models and achieve benefits from a larger single team • Protects services at both hospitals	they had to cover a larger area • More referrals • No space for additional ambulances on sites
Option 7	• Centralisation of specialised services • Best quality of care / safer care for cardiology • Easier to manage follow-ups	• Demand outweighs capacity • Deskilling of staff at less specialised site
Option 8	• Centralisation of specialised services / safer care • Higher risk patients all on one site	• Not feasible – bed pressures / demand outweighs capacity • Deskilling of staff at less specialised site
Option 9	• Some staff might prefer overnight working • Both sites retain an ED	• Requires investment in equipment and staffing • Not enough x-ray rooms at CHS • Deskilling of staff if no rotation • Low capacity at site 2 – not good for patients • Limited ED hours at one site • Confusion over timings
Option 10	• Good level of care support • Minimal change to radiology • Both sites retain an ED	• Confusion over timings • Requires investment in equipment and staffing • Not enough x-ray rooms at CHS • Limited ED hours at one site
Considerations / other ideas	• Ensure right staff / skills at each site (including radiologists to report when doing emergency work) • Staffing cover will need to be reviewed to accommodate 24/7 window - not fit for purpose currently • On-call for orthopaedics and respiratory needs to be taken into consideration • Who decides when the patients are high or low risk? What happens if low risk becomes high risk? • Where does ITU sit?	

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	• Continuity of care - ensuring patients see the same clinician even at different site or have effective IT systems so there is no impact on care • Ensure systems are standardised across both sites (Meditech not fit for purpose at CHS) • Need to consider diagnostic support / align specialist diagnostics with more complex patients • Possible learning from stroke pathway in terms of transferring deteriorating patients (post-surgical or medical) from less to more consolidated site • Need to understand the extent to which adult pathway changes may impact on paediatrics (and where paediatrics community SLT sits as part of CSR) • Having critical care on site affects pharmacy in a big way - deliverable but needs more investment and set economies of scale • Need to still enable SLT support / discussion with consultant and nursing teams • Transfer requirements for elective patients - does patient go to SLT or vice versa? Is priority the patient or staff journey? • Option to use both idea 7 & 10

3.3 Full consolidation option(s) within the healthcare group footprint

11. Status quo: 2 x EDs with fully-consolidated acute medicine at a single site.
12. Full consolidation of all Emergency Care onto a single site with 2 x acute medical sites. Non-emergency care site to be GP/NHS 111 referral based only with AEC, Acute Medicine and general medical beds.
13. Full consolidation of all Emergency Care onto a single site 2 x acute medical sites and locally accessible 24/7 Urgent Treatment Centres. Non-emergency site to include AEC and general medical beds.
14. Full consolidation of all Emergency and overnight acute medical care onto a single site with locally accessible 12-14 hour, 7-day Urgent Treatment Centre and daytime acute medical assessment, AEC at less-specialised site.
15. Full consolidation of all Emergency Care and acute medicine onto a single site with non-emergency and acute site to have 24/7 Urgent Treatment Centre, enhanced AEC and frailty assessment, general medicine OR intermediate care beds.

3.3.1 Medicine and emergency care event

	Positives (Strengths)	Negatives (Weaknesses)
General comments about the options	• Sustainable • Standardised practice • Shared best practice • Skill development and opportunities for staff • Less duplication resulting in more affordable services	• Demand on single ED site – will staff be able to cope? ED capacity already overstretched • Patient impact if only one ED i.e. extra travel time • Staff loss / retention challenges – not all staff would stay (risk to sustainability) • Communities will not travel - STFT will travel to Gateshead • Main issue of full consolidation - transportation of patients between the two sites and the NEAS ability to support this as well as travel burden for frail relatives
Option 11		• Not workable • Issues with moving patients – practicality and cost • Impact on surgery and clinical services
Option 12	• Staff concentrated in one area with more resources • Helps with social care by patients being transferred back to their own hospital for further treatment • More access to specialist treatments • Equality of access to services (video and telephone)	• Works for emergency care but not for medical • Pressure on staff – one ED • Frequent transportation across sites – patients and visitors • Patient safety issues – higher impact on services • Would require wrap around services - cost implications
Option 13	• Most sustainable / affordable / deliverable • Splits responsibilities over 2 sites • Better use of resources and workforce	

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	• With a lot of work – releases capacity across 2 sites • Could make second site more interesting through offering more services e.g. diagnostic centre, dialysis or frail site	
Option 14	• Cost savings from the reduced hours on one site	• Does not solve the problem • Extra demand on one site overnight • Low capacity • Transportation of patients during the night • Impact on social care for patients being transferred to a different locality?
Option 15	• Provides a determined pathway for patients – right people, in the right area, in medical wards on one site	• Wait for ambulances – more delays • Capacity issues on one site
Considerations / other ideas	• How do health and social care services support this model across the whole health economy? • Access to local services & CCGs needs to be joined • Infrastructure needed to support this / not deliverable without wrap around services • Need appropriate staffing and capacity i.e. to frontload ED with junior doctors • Specialist nursing input into ED • Consolidate specialties across teams, this will help reduce patient stay within hospitals - catering to staff/ward strengths • Integrated systems and technologies to help staff move between different hospitals • Need for clear delirium/dementia patients to avoid unnecessary moves • IAU trolley beds at SRH unsuitable for older people (if SRH was to become the more specialised site) • Responsibility risks for clinicians under dual acute medicine models i.e. determining when to admit/transfer out - need time and sufficient senior decision-makers to do this and competency thresholds / required time would need to be modelled (i.e. do we become more risk averse and this impacts on capacity?) • A transport 'hopper' own-Trusts' shuttle bus would alleviate travel challenges but could cost money • Parking capacity for visitors and staff • Challenge around patient perception - am I safe in the 'less specialised' site and therefore will they go to specialised site anyway? • Likely to need step-down beds to support flow through system	

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	• Ideas with a Urgent Treatment Centre could help to alleviate capacity risks at more consolidated service site but would need to be a high quality centre that patients want to go to, perhaps with admission rights, so that patients don't just travel to the ED anyway (in which case the UTC will not mitigate capacity risks) • Opportunity to support 'Cath lab' which is meant to be 24/7 but isn't due to staff, a more consolidated service will help this

3.3.2 Clinical support services event

	Positives (Strengths)	Negatives (Weaknesses)
General comments about the options	• A more robust service • Good skill mix • Stronger workforce • Pooled excellence • Opportunity to develop pharmacy / pharmacists	• Concern for patient care if urgent care, acute and ED split • NEAS responsibility for transferring patients to the right unit • Increased demand on NEAS • Cost of realigning • Patient perception and experiences • If ED not on both sites, patients go to the next nearest site in adjoining areas • Staff reluctance • Loss of services at South Tyneside • Differing IT systems
Option 11	• No change to radiology • Easy to understand for patients, staff and GPs • ED at both sites	
Option 12		• Demand for radiology too heavy at site 2 • NEAS delays • Patient safety and travel • Creates more work for pharmacy • Potential staff dissatisfaction

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		• ED removed from site 1
Option 13		• Reduced diagnostics on site 1 • Patient safety and travel • Potential staff dissatisfaction
Option 14		• Capped hours for UTC • Site 2 may struggle with demand • Patient safety and travel • Potential staff dissatisfaction
Option 15	• Easy to understand for patients, staff and GPs	
Considerations / other ideas	• Needs to be easily understandable to the public and staff • Having the right staff at each site is imperative - use of more senior staff /junior staff at locations, needs to be fair distribution • How will higher banded staff be allocated across the areas? • Where does HDU and ITU sit? • 24/7 on-call and assessment would be required at both sites • Majority of care occurs in the community - this needs to be considered • Access to urgent care centres need to be considered / finer details of urgent care required • Specialist transport service for very ill patients would be required	

3.4 Full consolidation option(s) outside of the healthcare group footprint

16. No urgent or emergency care at either site
17. No acute medicine at either site
18. No ED or acute medicine at either site

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3.4.1 Medicine and emergency care event

Note: Only one table discussed this option, their opinions are summarised in the table below

	Positives (Strengths)	Negatives (Weaknesses)
General comments about the options	• Opportunity to develop an exceptional service • More collaborative team working • Avoids duplication of specialist services • Development of pathway for frail patients	• Patient safety – too much work required to address risks • Patient transport • Capacity – volume of patients • Changing patient behaviour

3.4.2 Clinical support services event

These options were not presented at this event.

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4 General comments

The following summarises the comments made by staff which did not relate to specific options.

- A smooth patient journey is essential
- Current hospital capacity must be reviewed
- IT resources need to be considered as a priority
- Valuing staff / offering benefits will make a big difference for retention and recruitment e.g. childminding / catering facilities – staff morale not good at the moment
- NSP needs to be the same rate across both sites to address different banding for similarly skilled staff across the trusts
- Consider what will make any scenario attractive to prospective staff
- Potential links with University of Sunderland development into teaching hospital – encourage recruitment
- Clear communication is essential to avoid confusion, encourage co-operative working and dispel myths
- Teams need to meet more frequently to share best practice within specialities and across linked arrears i.e. occupational therapy and physiotherapy, providing more opportunities to network/share working practices would facilitate potential value of future workshops
- NEAS, GPs, consultants and community staff need to be involved in discussions
- Changes need to be well-communicated to patients / use this opportunity to inform the public about the range of healthcare services available to them
- STFT staff still very bruised by last restructure and have a perception that STFT is seen as 'not being as good' so models need to seek to overcome this allowing it to be as specialist a site as it possibly can
- South Tyneside residents feel like the 'poor relations' in the potential merger and services will have no priority
- Need to consider patients previous experiences at the ‘other’ hospital, this might not have been good, therefore reluctance on their part to go there
- Impact on other areas needs to be understood e.g. NEAS
- Reduce ED presenters through;

  - Patient education

- Greater resilience from PCT and GP to stop patients going to ED
- Greater community support
- Use of interface teams
- Interventions with the top ED attenders to stop them presenting i.e. mental health & drug and alcohol teams
- 12 hour GP staffing at Pallion
- Improved access to GP services

- Focus on care and nursing homes;

  - Care and nursing home staff need to be equipped to spot signs of delirium
  - Outreach support / community facilities to prevent patients being brought to the ED e.g. access to telephone advice/hot clinics
  - Specialist consultants to go out to care homes to conduct medical reviews
  - Direct referrals to falls from NEAS and wardens in care homes and in the community.

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