The Path to Excellence focused event on maternity, women's and children's healthcare services on Saturday 15th July was attended by 46 people and there were 8 tables in the room for facilitated discussions.

If a comment is said with a positive sentiment a + has been used and if it is said with concern or negativity a – sign was used, for a neutral comment a = sign was used.

If you have any concerns or feel anything was missed from your table please contact us via email at: nhs.excellence@nhs.net and we will investigate this further for you.

Questions from the room

Maternity

- Choices – they're not real choices. What people want is not what they get. There are strict inclusion criteria from MLU care. Also, for homebirth. Some women will choose to stay at home at any cost. This will have a huge impact on community midwifery – in terms of time (2 midwives on call for 3 weeks delivery) and puts midwives at risk because of duty of care.
- Nurse/midwife development. Most proposals increase nurse/midwife led care - where are the staff coming from? Just cutting the services all of the time, there's little development for individuals or "time", for further appropriate training, there's few opportunities for promotion and role enhancement.
- Maternity services in the NHS reform December 2005 quote, "The justification for the centralisation has been to save money and improve patient safety but it is far from clear that this has been achieved." What is the evidence that money has been saved and patient safety has been improved?
- How can you decide whether a planned pregnancy will be a normal delivery or an emergency? Best site for whom?
- Does Sunderland have capacity to take patients for short stay or longer?
- Is Sunderland only willing to be in 'alliance' if all services are at Sunderland?
- NICE recommends all women have a choice of birth setting. Home, consultant –led, alongside MWU, stand-alone MWU. Option 2, does not do this.
- What is the classification used for low risk births?
- Low risk births, who decides who is low risk? Women's voice?
- Day case surgery – complications require overnight stay. Elective C-sections. Postnatal requiring hospital readmissions.
- Maternity services in the NHS reform Dec 2005, quote that the executive summary recommends, "An end to the drive towards larger, more centralised delivery units across the UK." In the UK, we're largely driven by staffing problems of small neonatal intensive care units. Other EU countries use improved neonatal transport networks to achieve excellent outcomes – has this been looked at?
- Why isn't there an option to provide low risk care for South Tyneside and Sunderland women at South Tyneside and all high risk to go to Sunderland.
- South Tyneside rate is approximately 45% so how are the majority of women low risk?
- The majority of South Tyneside women are not low risk based on factors such as high BMI. Dr Wahid said otherwise.

- How does a mother who goes into labour know if she is high or low risk?
- The issues about the changing health picture of the nation doesn't really apply to maternity services. Money – is the issue. STFT have the highest normal birth rate in the northern region. We provide a high-quality maternity provision.
- We know from what we do now that the women of South Tyneside do not make a choice to go to CHS to have their babies – the impact of this change in provision will be greater on the RVI and the QEH. Women already have a choice – CHS is too hard to get to compared to the other choices available.
- How do you know women would want to give birth at Sunderland?
- Patient Choice! – some don't have faith in STFT and would rather travel further. Quality of care/staff at STDH.
- South Tyneside logo is 'choose.' Where is the choice? Choice what choice? Transport – NEAS. South Tyneside would have no choice at all.
- Seeing enough patient numbers to ensure we provide safe care …. This is not an issue in maternity.
- What are the stats on the closing of MLU's? Particularly ones that have been changed from consultant led to midwife led?
- Evidence that free standing MLU's are sustainable? North Tyneside as an example.
- Numbers of South Tyneside women who currently choose SRH to deliver? Question for experts?
- In terms of patient safety what is the perinatal and morbidity rates for SRH and STDH respectively?
- What if numbers of patients are too low to maintain a MLU?
- Why invest in a MLU for say 2-3 years? Down the line it folds and services are having to be moved?
- Difference going to eye appointment as to travelling daily to see baby in neonatal unit for weeks/months.
- Are we in danger of losing our A&E services? No back up from acute services?
- What are the current figures for one to one care at SRH?
- If these services are transferred to Sunderland, who benefits? Will this not put more pressure on SRH?
- Dr Wahid said maternity network system received options – what is this? Who is this? Is it just South Tyneside based?
- Average new mum is 'older' - are they classed as 'high risk'? This is increasing in number, can Sunderland sustain this increase?
- Dr Wahid said at initial launch, we saw no negatives for the move to SRH. New mothers travelling daily to Sunderland Royal Hospital is a negative.

Model

- How much will it cost to implement these changes?
- Need to be clear on what we can and cannot change!
- Have you modelled the services on population and demographic projections?
- If there's planned day care services – who would provide this? Non-consultant. Why aren't the specialist consultants giving the presentation? Are they on the board?
- Concerns with agency staff working in adult A&E. Doctors and nursing staff.
- Do you all at the top table still keep your jobs?

- Specifically – how will these changes improve recruitment particularly in areas which have national shortages?
- EPAS service and AAS- how can they run without medical staff?
- Dr Wahid stated the term 'they' will receive better care at SRH. Insult to staff at STDH.
- What will happen to current South Tyneside staff – will everybody be offered/given a job?
- Is money available to invest in MLU at STDH and the ward?
- Who was it on the team looking at figures? Who looks after children after 8pm? Transport?
- How were the staff chosen? More adverts put out for staff to give their views?
- Termination of pregnancy service, NHS in Sunderland, sometimes patients need in-patient care. South Tyneside is this private provider (Marie Stopes)? People at South Tyneside and Sunderland should have a similar service available.
- Are the other hospitals able to cope with those who don't choose Sunderland? Savings – mentioned on page 67?
- As we are all employed by Sunderland and South Tyneside HCT will all the jobs be available for all staff in South Tyneside and Sunderland or will Sunderland staff be safe?
- There aren't any options to retain consultants at South Tyneside – what will be provided at South Tyneside? This would have been more palatable if we could see what is going to stay at South Tyneside in this mix.
- Why is Sunderland the best site - lack of investment in South Tyneside?
- Travel and transport – some issues. This consultation cannot influence transport providers.
- How can you support an A&E department when no acute services are in STDH?
- General public are supposed to be able to access services in an equal capacity. This is not so, as people who live far and less away have less equal access than people who are closer.
- They are cutting the buses services from South Shields to Sunderland. This is a concern with not all members of the public having transport of their own. There are a lot of unemployed people in South Tyneside.
- Now bus services are under review (Stagecoach), how are parents expected to get to SRH? The link service is being removed!
- Cost of travel to Sunderland? Cost of parking? Physical trauma of travel? NEAS – not able to meet needs. Accessibility!
- How is the ambulance service going to resource the impact of huge changes?
- Travel – what are the proposed terms of travelling from South Tyneside to Sunderland? Especially after 8pm? South Tyneside is a deprived area and the cost of transport services.
- Does NEAS have capacity for increase in the 999 calls from South Tyneside patients?
- SRH is notoriously short of parking spaces – how will this be addressed? NB. Providing travel information to patients is not an option.
- Head injury patients attending at night, 6pm, needing 6-hour observation – what happens?
- What about patient choice? These proposals are reducing choice.
- Older staff can't cope at nights! I think ageism is inappropriate (ask our consultants).

Consultation

- Why are public numbers being limited when it is meant to be a public consultation?

- Why is the ambulance service not here to directly answer questions?
- We were not involved in any of the process -paediatrics A&E. The public knew more than we did.
- Consider basing a specialist on each table?
- Not enough time to cover all aspects in this session.
- Working on a mixed table - members of public finding this very helpful and think it is worth considering.
- It feels as if all of the decisions have been made and the consultation added afterwards.
- Staff warned about job losses.
- Will Sunderland staff also have to relocate roles? Or only South Tyneside staff?
- How many nursing staff from maternity and children's services in initial team represent STDH and how many from SRH? How many consultants working in maternity and children's from STH and how many from SRH were involved in team?
- Nurses were not asked or included in any of the consultations. We were informed of options when general public were informed.
- Please note that the room is not appropriate, sound quality is very poor. Even when talking around the table it is difficult to hear.
- This is a consultation on the fact that there is going to be change – you are not consulting fully on how or what these changes will be.
- If you control the numbers attending how are you going to know the strength of feeling or numbers that may have attended an open meeting?
- Registering on line is difficult for people with disabilities and for those with English as a 2nd language.
- Comment: Dr Lawson's honesty is appreciated and helpful.
- How will people without an email address receive feedback from today?
- Why has the system not allowed status quo to be an option?
- Include South Tyneside Women's Voluntary Groups – consider engagement with them.
- Process: vetting of questions public don't believe would be answered 'cherry picking'.
- The room was not appropriate for such a meeting. It was very difficult to have a discussion around the table because of poor acoustic, so issues with communication.

Paediatrics:

- How are you planning to educate the parents of children in an emergency situation on where to take their child in crisis? After 8pm? People are still going to Palmers!
- People (general public) are not being educated about where to go in an emergency.
- How are SRH going to look after 39,000 children – double? How many beds? How many nurses?
- Can Sunderland cope with a 95% increase in attendances?
- Proportionate to populations, STDH seems to have more children's A&E attendances. On the options presented how will these be adequately accommodated?
- Was the Care Quality Commission's 'inadequate' rating of children's services last year in STDH symptomatic of the problems of recruitment?
- After hours – who will look after paediatric patients who walk in with no paediatric trained staff? They are not small adults and have differing pathophysiology depending on age and psychosocial needs.
- Who deemed 8pm to be closure time? This is our busiest time of the day.

- What training will be provided for adult staff so they can recognise a seriously ill child? I took an additional 1 year course (full time) - this won't be viable.
- Why do we need to have experts in fields in order to run 'safely'? It's not safe if there is no service in South Shields.
- If adult A&E treat paediatric patients overnight, have the nurses in adult A&E been consulted? What happens if something goes wrong? (i.e. their registration is at risk?).
- South Tyneside is a deprived area so what will happen to the sick child when the parent can't afford night time transport? For example: taxis - costs etc. The strain then that will be put on NEAS.
- Where are the consultants from South Tyneside for paediatrics at these consultations? On the board panel? Or NEAS representation?
- Why can't South Tyneside be included in the medical rota with Sunderland?
- On the shop floor – where do the children in the department go physically when we close?
- Where is the evidence that this will improve care?
- Concerns for single parent females with other children - how are they going to get there through the night with no transport? They might wait until the next day until they can get other children minded and it could be too late.
- Pharmacists – what role to alleviate pressure can they play?
- Dr Hamilton states patients require specific specialist care, how is it safer for paediatric patients to be cared for by adult trained staff in an emergency situation overnight at a time when they need paediatric experienced staff?
- Option 1 – will there be a consultant on call?
- How is no paediatric overnight cover 'better than current service arrangements' for the children and families of South Tyneside?
- Why was the paediatric department opened back up to 24-hour service from a 12-hour service?
- You're proposing department close at 8pm? The middle of peak time. Where will the children in the department at that time go if they don't require full inpatient facility?
- We were told by Dr Wahid that he has told South Tyneside staff that the unit would not stay in both options, yet Mr Lawson has said they will. What is the right answer?
- How do they propose that children get to SRH? Children will be more ill as they will wait until morning. Impact on ambulance service. How does it cost £370k to take away a service? How will it cost £370k to lose a night time service (option 1)?
- Where are journey times taken from? AA route planner says it takes 20 minutes from South Shields to SRH. Book says average car journey to STDH 6 minutes and 6 minutes extra average = 12 minutes. Hebburn postcode to SRH is 22 minutes. Average time in booklet is 21 minutes, although states this may vary. Does this take other traffic into consideration, length of time it takes to get a car parking space inside or outside of the hospital, time it takes to walk in with a poorly child and people on buses with poorly children? Bus times shown – what about the time it takes to get to a bus stop?
- 11A highlighted less risk of deterioration, people are going to wait until morning rather than pay for a taxi (no money)/or getting an ambulance overnight or waiting hours for an ambulance – more risk of deterioration. More pain and distress due to length of time going to a hospital further away. How will there be less admissions – our hospital has less admissions per population than Sunderland? STDH out 18,500 – 1400 admissions for short stay. SRH out of 20,500 – 2400 admissions for short stay.

SCBU

- What options were considered and rejected for SCBU?
- Ability to influence decisions made! What about SCBU, no influence will change outcome?
- Bonding/attachment process between mother and baby will be affected – they'll not be able to visit as often or for as lone if baby at SRH.
- 123 admissions to SCBU last year… 11 to SRH and 8 to ITU beds. 40% of which were full term, low risk babies. Where do you intend to house these kinds of numbers when neonatal beds are already at their maximum capacity?
- Special care is a speciality, why no mention?
- When Patrick Garner announced 27/4 that SCBU were closing why were SCBU staff told we weren't on 4/5 by Ceri Bentham when she knew what had been proposed?
- Why can't a third model/option be looked at for SCBU to provide "transitional' phase for pre-term babies for weeks/months before discharge (at STDH).
- If Dr Lawson is confident Doctors will be recruited to cover both hospital sites, why can't they cover transitional ward for SCBU babies?
- Could you clarify what will happen to the 40% of term, low risk babies that currently need SCBU admission when unit is closed?

General Comments

- Transfers to Sunderland – who benefits? Patients will have to travel. Concerns about sustainability to have midwife led unit. We want to try as people want that, what proportion would you be expecting? 320 people to make it sustainable. Where from? National experience offering women choice. Let our women know all of the facts. 1,300.
- 10-12 babies collapse at birth. As long as we understand that this is a risk then that's fine. Women need to know the risk.
- FAO Peter Sutton, Patrick Garner, David Gallagher. People of South Shields, this is the time to stand up and support your rights for healthcare. The options given mean women in established labour travelling to Sunderland, Newcastle, Gateshead or Cramlington to give birth at the most vulnerable time in their lives. Not everyone has the luxury of a care, in-fact our client case has a substantial number of people in poverty who may never own a car. How then do you propose that people can easily attend in labour? Ambulance services are at 'breaking point', only yesterday in the press were discussions of 40 minute waits for stroke and heart attack patients if they're with a medical practice despite 'every minute counts campaign.' Our ambulance service covers 3200 miles and a population of 2.6 million, with 107 ambulances covering the area. How can we guarantee that public transport service will be improved over a 24-hour period for those in need so our oversubscribed ambulance service is not further put upon? Also, if patients with medical practitioners capable of CPR are not a priority – where does that leave the estimated more than 10% who will require transfer to a consultant led unit from MLU when labour deviates from the norm?

Date	15th July 2017
Venue	Clervaux Exchange, South Tyneside
Event	Focused event on maternity, women's and children's services
Time	10am – 12.30pm
No. of people on table	5
People	2 x patients/public, 2 x NHS staff and 1 x Councillor
Facilitator	Emma Taylor
Scribe	Alex Rodger
+	Positive sentiment
-	Negative sentiment
=	Neutral sentiment

Table rules set:

- No bad language
- One person speaks at a time
- Respect each other's opinion
- Raise hand with questions
- Speak up

Thoughts on what we have heard so far?
= It is what it is, for years people are getting older. - Not much about maternity, focus on stroke. - Hard taking time to see doctor from work, working in hospital we can see struggles. - I want to see services in my local hospital. - Why is it Sunderland? Why is the acute service investment in Sunderland and not South Tyneside? - I see from public and staff perspective, as a parent of a young child. = David speaking about the budget, we know Govt. cuts are having this effect. We are going to become diagnostic.

Table discussion on maternity (obstetrics) and women's healthcare (gynaecology) services

Option 1 – Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 1?
+ First child was born in Cleveland, James Cook and North Tees. We were low risk and there were complications, but if this was us now, we would choose to go to Sunderland. = I would prefer all options, in one hospital for safety. - Needs to be a safe service. = Does Sunderland have enough capacity to take the whole of South Tyneside? = I've heard that a few hospitals have developed.

What are the positive aspects of this option?
+ Option 1 needs to be in Sunderland, we have an SCBU at STDH and this will not influence.
What are the negative aspects of the option?
- If the consultant moves to Sunderland, we can't have SCBU in option 2. - If MLU is going to close in a few years then what's the point?
What could be improved?
- Is there the option to invest in the ward in option 1? The ward at STDH needs investment.

Option 2 – Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 2?
= The QE is already a women's centre of excellence = More older mam's now so more high risk
What are the positive aspects of this option?
+ I would go for MLU if I had another child.
What are the negative aspects of the option?
- No more sand dancers born, everyone would be a mackem. - My dad would be devastated if my child was born a mackem.
What could be improved?

Table discussion on children and young people's (urgent and emergency paediatrics) services

Option 1 and **Option 2** – Children and young people's (urgent and emergency paediatrics) services. (one person left table for part of this question)
What are your initial thoughts on option 1 and option 2?
+ Amazing paediatrics A&E in STDH. + It was specifically built so a waste of money. - Why was it changed from 24-hour to 12-hour and then back again? = NEAS capacity from 999 calls? = What services will be retained at STDH? = I don't think wider public know that this is happening.
What are the positive aspects of this option?
+ Senior medical care is the issue. + We want option 1, if this is what we have to choose from. To retain what we already have.
What are the negative aspects of the option?
- 8am -8pm is GP opening hours and overnight children can deteriorate. 111 is useless. = Overnight we will go to Sunderland of 8am-8pm hours. - I would drive my daughter 7 minutes to STDH but not 25 minutes to SRH. - Walk in centre is similar, no matter what we need and want - transport will not always be provided. - From Hebburn you would go to Gateshead not Sunderland. - If children do need to be kept in? We were seen in STDH, Sunderland was full and we ended up at RVI as observation beds were full. At the time, I didn't care but after the initial day it was difficult. - Money, what does it cost at the moment? It reads as if it will cost more.

- South Tyneside is a socially deprived area for extra travel.
What could be improved?
- Should be set out better, current cost, as against budget and spend. - Why can't we put STDH and SRH on same medical rota? - If you need 5 consultants at STDH and you only have 2, then why can't South Tyneside be in same medical rota as SRH?

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Event	Focused event on maternity, women's and children's services
Time	10am – 12 noon
No. of people on table	6
People	Patients/public, NHS staff and Councillor
Facilitator	Bev Frankland
Scribe	Hannah Jeffrey
+	Positive sentiment
-	Negative sentiment
=	Neutral sentiment

Thoughts on what we have heard so far?
- As a midwife, concerns about bed numbers. Currently struggle. Only 13 beds. Sunderland numbers are at capacity and to delivery to South Tyneside patients as well? - Staffing number to deliver on one site. = How reviews are done? What is the process followed? How are staff and public involved in process? How were services prioritised to identify what's done first? = Publicity. = How are public informed? = What termination of pregnancy services are delivered in South Tyneside? Will this be impacted on if gynaecology services move?

Table discussion on maternity (obstetrics) and women's healthcare (gynaecology) services

Option 1 – Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 1?
- Free led maternity unit – concern this is a stop gap. How long will this be there for? + Option 1 gives women more choice. = Links with paediatrics are important.
What are the positive aspects of this option?
+ Sunderland midwife – therefore would choose this option. + Expertise in MLU.
What are the negative aspects of the option?
- Patients who start as low risk and then become high risk – concern! How quickly can staff respond particularly on nights when there are less staff? - What medical cover is there to support midwives? - How sustainable as a 24/7 unit? - Provision for babies who become high risk before they're transferred to Sunderland. What facilities available at STFT?
What could be improved?
= Include minorities in service reviews.

= Population demographics, projection and planning for future. = Support structures around changes e.g. transport.

Option 2 – Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 2?
- Limited choice - No hospital delivery in South Tyneside.
What are the positive aspects of this option?
+ Some people don't always choose nearest unit now.
What are the negative aspects of the option?
- Home birth – risk of baby bleeding. - What NEAS support for home births? - What NEAS support for low risk babies becoming high risk? - People of South Tyneside being robbed in option 2.
What could be improved?

Table discussion on children and young people's (urgent and emergency paediatrics) services

Option 1 – Children and young people's (urgent and emergency paediatrics) services.
What are your initial thoughts on option 1?
- Practicality of 8am-8pm hours. If you turn up at 7:30pm what happens to my child? - Concern about number of patients that will be seen to maintain skills in South Tyneside service. = Facilities for families outside of 8am-8pm hours? = Communication – how will the public be told? = Transport after 8pm? = Need to clarify what short-stay is? = How does primary care fit with these options? (GP in A&E).
What are the positive aspects of this option?
What are the negative aspects of the option?
- Feel like we're moving backwards with paediatric models we want paediatric service in South Tyneside. - If patient turns up outside of 8am-8pm hours what happens to the child (family wait in adults waiting areas)? Could they be sat with or prioritised below e.g. drunk adult
What could be improved?
= Educate the public to go to right place, how can this be done? = Public needs to know about GP working in A&E – what hours?

Option 2 – Children and young people's (urgent and emergency paediatrics) services
What are your initial thoughts on option 2?
= Services used as buffer when families are in crisis

= As member of the public I would like to know where I need to go? = What is the case mix for attendances? = Is short-stay included in option 2? Needs to be in both options. = Primary care taking patients.
What are the positive aspects of this option?
+ Encourage use of pharmacy.
What are the negative aspects of the option?
- Capacity – how can Sunderland cope? How can paediatrics A&E in Sunderland future proof for increased activity? - Impacts of cost on family e.g. transport. Time as well.
What could be improved?
= Need to make sure all services including 111 have correct information about where to go.

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Time	10am – 12 noon
No. of people on table	6
People	1 x patients/public, 5 x NHS staff
Facilitator	Susan Clark
Scribe	Michael Barlow
+	Positive sentiment
-	Negative sentiment
=	Neutral sentiment

Thoughts on what we have heard so far?
= When and where will answers to questions be published? = Transport issues will be huge – this needs to be reflected with accurate data. Recent announcement of withdrawal of bus routes by Stagecoach – affects staff and patients before any changes. - Frustration from staff at lack of understanding of how services were on the ground. No nurse involvement in review.

Table discussion on maternity (obstetrics) and women's healthcare (gynaecology) services

Option 1 and **Option 2** – Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 1 and option 2?
= Low risk can become high risk in latter stages. Who looks after baby initially? = Impact on beds – extra capacity? = Ambulance service impact? i.e. specialised retrieval team. = Safety and outcome is paramount.
What are the positive aspects of this option?
What are the negative aspects of the option?
- Where would extra funding come from to increase facilities in Sunderland? - Distance and transport to Sunderland is an issue, especially during the night. - Home births – will ambulance services be able to cope with extra distances and times if low risk home births become high risk?
What could be improved?
= Could the specialised teams not work across two sites? This approach happens in Newcastle.

Table discussion on children and young people's (urgent and emergency paediatrics) services

Option 1 – Children and young people's (urgent and emergency paediatrics) services.
What are your initial thoughts on option 1?
- Safety element of children overnight – this will be compromised by being looked after by an adult physician. = If child is under observation and unit closes at 8pm, what happens to care after that time?
What are the positive aspects of this option?
What are the negative aspects of the option?
- Proposal times i.e. 8pm closure, do not reflect busy times which is 6pm – midnight. - NMC code is work within limitations – how is this possible if staff (adult trained) have to look after children without training? - Safety elements for children – after 8pm would children then have to mix with adult A&E (drunk/aggression etc.)
What could be improved?

Option 2 – Children and young people's (urgent and emergency paediatrics) services
What are your initial thoughts on option 2?
= No day unit for children was mentioned at a staff session. Today the opposite was stated for Monday-Friday. Currently day unit is not open Monday- Friday. = Unclear whether nurse practitioner led or nurse led? This difference needs to be understood.
What are the positive aspects of this option?
What are the negative aspects of the option?
- No positives for overnight care especially for safeguarding. - This feels / is a backward step. - Adult practitioners feel uneasy about having to care for children. - Emergency situation - public will instinctively go to nearest facility. - Will a public awareness campaign to facilitate change actually work to get people to the right place? Currently campaigns to keep minor ailments away from A&E don't appear to be working. - Who will care for a septic 6-week old child who presents with parents at 1am (genuine scenario) if the unit closed at 8pm?
What could be improved?

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Event	Focused event on maternity, women's and children's services
Time	10am – 12 noon
No. of people on table	5
People	3 x patients/public, 1 x NHS staff and 1 x Councillor
Facilitator	Aine McCarthy
Scribe	Gail Cobb
+	Positive sentiment
-	Negative sentiment
=	Neutral sentiment

Thoughts on what we have heard so far?
= Why did David not explain about maternity and why it can't stay the same? David said it will be covered later. David came over and explained it's about workforce and national standards, not enough workforce in South Tyneside. All over the country it's the same. - Feeling on the table that the focus is on stroke and perception and the analysis has been done around stroke. + Lady thanked David and felt better. = Why not a stand-alone neonatal? = Choices. = Are we saying for staffing it's just consult and not midwifery staff? Middle grade – don't have many. Struggle more for consultants. Proposal to put all consultants and medical staff in once place.

Table discussion on maternity (obstetrics) and women's healthcare (gynaecology) services

Option 1– Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 1?
= If MLU, will there be a consultation call? Concerns about safety? = If they put on extra ambulances – where will the come from? = Was South Tyneside and Sunderland balance equal? = Outpatients care – remain. Investigations – remain. Overnight – paediatric care economical and sustainable. = Table didn't want to choose between options, wanted a 3rd option status quo.
What are the positive aspects of this option?
What are the negative aspects of the option?
- Why is status quo (not able to give my views on this) not an option? - Feeling lessons haven't been learnt from WIC closure – not listening about what people want - Not South Tyneside - financial - why can't we find consultants e.g. stroke unit? - how much money was spent on recruitment?

- I don't feel this is a consultation – there has not been as much staff input as there should have been. How many were on the initial panel that came up with options? - CCG leadership – how many of workforce are involved – consultant and each lead nurse. - General feeling that not enough staff involved in developing options. - I hear disquiet amongst staff that they didn't feel consulted. - Table feel a small panel that developed the options is not representative of views. - Ambulances – not guarantee availability of transfer times. This will put a certain percentage at risk. - It will be safe but may not be of same quality. - Changes to quality of care? I would challenge research. - What information is available on closure of MLU'? Don't have to hand but shows that they are viable. - Homebirths – need to consider protecting midwives if they feel this is not the right option for the expectant Mum. - Why didn't we have the option that things remain the same? Preferred option to me. Struggling with HW at STDH if you don't change – you take a chance on how things turn out. Need to take a chance. - Would they just say sorry we are closed if you turn up at 9pm? - How come it costs more? - Option 1 is misleading from what is being said, it's making a saving. Is it losing or saving money?
What could be improved?
- Trainees and recruitment – there's no retention here. Maybe hold them to working here for 5 years. Head of CCG says it's difficult to recruit midwives. Is he wrong?

Option 2 – Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 2?
= Percentage of midwives – have national compliment.
What are the positive aspects of this option?
What are the negative aspects of the option?
- It is just a WIC. I feel that I have a hospital on the doorstep, but I have to travel to Sunderland. - I would be fearful as a parent. Many don't own a car. If a child is ill in the middle of the night you can't get care. I think it's not on. - As a grandma both options are frightening. - Already have ambulance crisis. How do I know I can get an ambulance? - Why is the ambulance crew not here?
What could be improved?

Table discussion on children and young people's (urgent and emergency paediatrics) services

Option 1 – Children and young people's (urgent and emergency paediatrics) services. (one person left table for part of this question)
What are your initial thoughts on option 1?

What are the positive aspects of this option?
What are the negative aspects of the option?
- Hospital transport may result in the misuse of ambulances. - Why didn't you think about staff events before the start? - Can Sunderland cop 95% in attendances?
What could be improved?
= if this is going to work – waiting times need to be kept down by primary care.

Option 2 – Children and young people's (urgent and emergency paediatrics) services
What are your initial thoughts on option 2?
What are the positive aspects of this option?
What are the negative aspects of the option?
- What are the other hospitals going to do to cope if people don't want to go to Sunderland? - STP beds, A&E 5-10 years. I'm not sure what their intentions are. They have assured us they'll be able to absorb. - Travelling – to Sunderland to breastfeed – nightmare if you have to travel
What could be improved?
= Taking admissions from STDH we would not expect admissions to increase. Need for more clinical staff – reflects in funding.

Date	15th July 2017
Venue	Clervaux Exchange, South Tyneside
Event	Focused event on maternity, women's and children's services
Time	10am – 12 noon
No. of people on table	7
People	2 x patients/public, 4 x NHS staff and 1 x Councillor
Facilitator	Matt Brown
Scribe	Andrea Hetherington
+	Positive sentiment
-	Negative sentiment
=	Neutral sentiment

Thoughts on what we have heard so far?
- Concerns about timeliness of issuing consultation material prior to launch – didn't give people the opportunity to read in advance. - Only mentioned stroke – can get the centralisation around stroke but not for paediatrics = Want evidence that it has worked before – maternity reform services in the NHS document doesn't say there is any evidence that centralisation works in maternity.

Table discussion on maternity (obstetrics) and women's healthcare (gynaecology) services

Option 1 and **Option 2** – Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 1 and option 2?
= STFT has the highest normal birth rate in the northern region – we provide a high-quality maternity provision. = In terms of patient safety what is the perinatal and morbidity rates for CHSFT and STFT respectively? = Centralisation has been on the cards for a long time – it's nothing new. = International evidence = People do actually have a choice and they are choosing based on quality of service. = What is the preferred option of the management teams of both hospitals?
What are the positive aspects of this option?
+ Evidence that MLU's are sustainable? North Tyneside for example.
What are the negative aspects of the option?
- Talking about safety – but normal birth can move to emergency – where's the safety in having to transfer to another hospital? - Normal delivery but placenta wasn't delivered – requires surgery – would have to wait for an ambulance. Currently waiting up to, and even more than an hour for blue light ambulance. - 7 minutes from STDH – DRH – not reality – takes far longer. - Staffing – don't understand how things changing will encourage people to want to come to STDH. - David Hambleton talks about 7/7 service but maternity is already 7/7 service.

- Midwifery/ paediatric staff were not consulted about the options. - Registration requirement will have put people off attending. - One senior midwife at STDH consulted/involved. - The issues of changing the health picture of the nation, doesn't really apply to maternity services. - Money is the issue. -We know the women of South Tyneside don't make a choice to go to CHSFT to have their babies – the impact of this change in provision will be greater on the RVI and the QEH. Women already have a choice – CHSFT is too hard to get to compared to the other choices available. - "Seeing enough patient numbers to ensure we provide safe care" – this is not an issue in maternity. - Disingenuous to say no financial pressures. It is an issue. - Not accessible to everyone – 40% of people in the North East don't have cars. Public transport cost? Visitors impacted? - Women do have a choice already – people don't choose to go to SRH. Impact on community midwifery huge. - Issue about are born in South Tyneside anymore, what will happen to South Tyneside? - Access to services should be equal to all members of the public. - Car parking is an issue at Sunderland. - Direct public transport is better to get to other hospitals e.g. RVI, QEH – no direct buses to SRH. - Consultation document – pg. 96 advising that they will give bus information to patients isn't helpful – it doesn't resolve the problem. - Regardless of what option is chosen there will need to be some investment at Sunderland. - Theatre capacity at Sunderland? - Sunderland has no more space to expand. - There will be strict inclusion criteria for MLU – not everyone will have their choice because of this. - What happens to the elective sections? - Gynaecology – what happens if a patient is needing an emergency readmission – will they have to pass STDH and go to Sunderland? - Capacity and impact of NEAS? - transfer of home homebirths? Currently not a priority. - The number of low risk women will decrease because of change in induction date. - Homebirths – having baby in South Tyneside - if homebirth is the only way to do this then some women who perhaps shouldn't from a safety point of view, may choose to do so. Safety risk for both them and the staff. - Questioning safety of transfer from MLU/home birth rather than home birth or MLU themselves.
What could be improved?
- Education of public about where to go in an emergency.

Table discussion on children and young people's (urgent and emergency paediatrics) services

Option 1 and **Option 2**– Children and young people's (urgent and emergency paediatrics) services. (one person left table for part of this question)
What are your initial thoughts on option 1 and option 2?
- Out of hours families will have to travel to SRH – how is that fair? - If Sunderland is able to recruit consultants why can't they be rotated to work across both organisations without changing services (also for other services)? - Geoff Lawson – very patronising re women and older medics having to stay up overnight. = As a resident I would go to the QEH if these changes are made. - STFT is in a better financial position – is this to resolve this? Is STFT bailing Sunderland out?
What are the positive aspects of this option?
What are the negative aspects of the option?
- Even in a MLU there will be occasions when you need to call on a paediatric nurse practitioner or paediatrician – what will happen if they are not available overnight? - As a resident who used the service, how can you get there if you don't have transport? - Health inequalities assessment – talks about 'rarely significant' pg. 85 – it's not insignificant if you have a sick child. - Haven't taken in to account the culture of South Tyneside. - Inequalities Impact Assessment hasn't addressed the impact of distance from/to services. - What happens if someone turns up after 8pm? Non-emergency, no car, no means to get to Sunderland etc.? - Communication of changes – how will the public know where to go? - Capacity – Paediatrics excellent at STDH – will increase the number of children going to SRH. How can they deal with the children quickly? How can 18,500 children be accommodated? - How can we plan for where people are going to go? Need to ask the people of South Tyneside where they will go? Are QEH ready for the change? What happens if the modelling is wrong? - Organisational change – spend millions on changes only for it to be changed back. - How can option 1 cost money and option 2 save money? - Feel no one is answering these questions in any detail. - How are you ensuring that enough people see the documents and have an opportunity to give views? - Concern NEAS won't be able to maintain the service/ provide a good enough service - Are we in danger of losing our A&E services? No back up from acute services?
What could be improved?
- Need to show that you are listening – make some changes to this process – ensure everyone can have their say. = Need to ensure teams don't lose their own ownership/identity.

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Time	10am – 12 noon
No. of people on table	7
People	NHS staff
Facilitator	Alison McNally
Scribe	Jeanette Scott-Thomas
+	Positive sentiment
-	Negative sentiment
=	Neutral sentiment

Table rules set:

- Phones on silent
- Listening and respecting each other's views.
- Write down questions or anything the scribe misses on post-it notes.
- Make sure scribe captures views
- Capture positive and negative comments on proposed options
- If you want a drink/comfort break – just do it!

Thoughts on what we have heard so far?
- Travel times – ridiculous. 40% don't have a car, according to an average independent review. What if you use public transport especially out of hours. How would you get an ambulance to Sunderland in an emergency? - Response times and travel times – can experience long delays, where are the journey times taken from? AA route planner says 20 minutes STFT to CRS. Booklet says 12 minutes. Hebburn to CHS – 22 minutes – booklet says 12 minutes? Heavy traffic and car parking time allowed – then walk to department. - It is about money. - Shaz Wahid – clinical oversight, challenged for example: STFT staff involvement in process. = How were the services for review chosen. Scrutiny – 4 key tests (NHSE/commissioners' regulators) = Clinical experts – agreeing viable options to be consulted on. Considered local needs assessment as well as other key information. = Maternity care – some parts of pathway will remain unchanged. Key focus on SCBU. = Gynaecology – again, some services will remain unchanged. Emergency or planned needing overnight stay – review options.

Table discussion on maternity (obstetrics) and women's healthcare (gynaecology) services

Option 1 – Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 1?
= High risk births (SCBU) – consultant led care

= MLU – low risk births = Gynaecology IP and day case MLU, Antenatal and prenatal care, gynaecology day care – STFT. Maternity and gynaecology GP clinics = Was any other options considered for SCBU? Safety issues for free standing SCBU – no example available – network expert sought.
What are the positive aspects of this option?
+ Anything positive about either option? Only positive noted is financial saving.
What are the negative aspects of the option?
- Lack of staff engagement in development of proposals - MLU's – how many retrospective 'true' low risk births actually compared with initial assessment? - Low risk versus high risk birth – medical/mental health conditions, familial risk factors considered. - Pressure on ambulance service – overall (in utero transfer 'hot' transfer of neonatal) - Transfer times when risk changes during labour or post-delivery. - Separation of mother and infant? More likely. - Additional staff training required – MLU's. - What if high risk mothers present at MLU in STFT for convenience? - What about women who book at RVI? If STFT is not available – has impact on RVI been considered? - Comparison with London and Manchester re centralising of services unrealistic – different infrastructure. - Concerns that seriously underestimated impact on NEAS. - Why is transport being considered later? Impacts on everything. - Are the options chosen because of availability of Doctors rather than midwives? - Can Sunderland and (RVI/Gateshead) manage with additional births – midwifery numbers (staffing). - Demographic of midwifery of workforce – will STFT be able to attract midwives? Including students? = MLU – research – Did it separate stand-alone MLU? Most successful MLU have been attached to consultant led units with a transfer time of minutes. - Safe and sustainable – quality at South Tyneside can't be replicated? Challenged by Derek C – NICE guidance and study findings don't support this. Document – review of MLU's over 10-year period demonstrates MLU's are safe. Want to offer excellent, quality care across South Tyneside and Sunderland.
What could be improved?
= Clinical experts – need to promote MLU to ensure viability (part of choice). Women need to have all of the facts – informed choice. Very skilled/experienced midwifery workforce. Ambulances can't guarantee response/ transfer times – needs to be considered.

Option 2 – Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 2?
= All maternity care – CHS (including SCBU, NICU), = Gynaecology, IP and day care – CHS = Maternity and gynaecology GP clinic – CHS

= Antenatal and prenatal, gynaecology day case surgery, maternity and gynaecology, GP clinics - STFT
What are the positive aspects of this option?
What are the negative aspects of the option?
- Doesn't offer choice of place of birth. Also issues of transport.
What could be improved?

Table discussion on children and young people's (urgent and emergency paediatrics) services

Option 1 and **Option 2** – Children and young people's (urgent and emergency paediatrics) services.
What are your initial thoughts on option 1 and option 2?
=Geoff Lawson – Clinical expert – consideration of best practice – in patient care/urgent care. =Rapid access/OP clinic remain at STFT – Day Unit. Stay at STFY Monday-Friday. Recruitment of paediatric workforce in UK difficulties in recruiting to North East generally 12-hour period chosen due to activity numbers. = Is this a 'done deal'? Only these 2 options or would other options be considered as a result of consultation exercise?
What are the positive aspects of this option?
What are the negative aspects of the option?
- How will CHS deal with 95% increase in paediatric attendances? - Viability and sustainability of overnight services – at STFT – How many ANP's would be needed to provide overnight service? Would it be viable? - Why are we going 'backwards' when we have a service currently? - Primary Care needs to 'absorb' lots of the current activity. - Closed children's ward in STFT in 2012 – tragic what is happening. - Why does option 1 cost more, but option 2 would generate savings? - No increase in IP beds in CHS – is that naïve? - Who would see a sick child after 8pm under both options for STFT? Adult nurse/medical staff – has skills gap been considered? 3 day ALS (paediatric) – cost and time involved. - Paediatric cover for O/P clinics – CHS consultants happy to cover, but would not work in STFT – 'would leave. - What about current nursing/medical agency/locum cover use – will they be required to have ALS skills? - How will 39,000 children be seen at CHS – beds? Nurses? - Will parents travel with a sick child or wait? Risk? - What about cost of travel? Impact on parents on low income may be disproportionate. - Will parents access GP/primary care services or still present at ED? - What about CQC 'inadequate' rating – impact of staffing levels? - Already difficult to get paediatric bed during winter. - What about impact on RVI and Gateshead or parental choice? Assurances have been sought and received. - Negative impact of bonding/attachment when baby/mother are in different places.

- Concerns not enough time is allocated to Children Services Pathway Proposal. – questions cut short. Suggesting single topic events. - Concerns that decision are already made regarding closure of SCBU at STFT before consultation process started.
What could be improved?
= Option 3 – remain open overnight staffed by ANP's 8pm – 8am (variation of option 1 – currently happening).

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Venue	Clervaux Exchange, South Tyneside
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Time	10am – 12 noon
No. of people on table	6
People	NHS staff
Facilitator	Debra Collins
Scribe	Sheena McGeorge
+	Positive sentiment
-	Negative sentiment
=	Neutral sentiment

Table rules set:

- Respect each other's opinions

Thoughts on what we have heard so far?
- Wasted 30 minutes of meeting talking about stroke session. - Transport is a significant challenge. - Not a safe service. - Not enough staff. - Not acknowledged. - Told it is at full quota, everyone is doing overtime and we have agency staff. - They're not advertising for posts – kept them in paediatrics. - Deliberately understaff in the special care. - 5-year plan – they've not made it attractive, they've deliberately run it down until we get to this point. - Aging workforce on ground, nursing staff. - Need band 6 staff to have change, recruited band 5 – they need 2 years to get up to speed. - Threats to close Special Care Unit if no one does it. 16 staff for 24/7. - Register to come here – farcical. - Not enough time to answer questions. - Special care mum not allowed to speak. People with hands up being ignored.

Table discussion on maternity (obstetrics) and women's healthcare (gynaecology) services

Option 1– Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 1?
- Only 1 senior midwife from South Tyneside consulted. - Already been decided – going to Sunderland. - 40% of admissions are for ladies with low risk. Low risk takes the most nursing input.
What are the positive aspects of this option?
What are the negative aspects of the option?

- Parents – breastfeeding mums, travelling 5-6 times a day. - People can't afford to travel. - Post natal depression – cost to parents. - Public holidays – taxis – very expensive. - no cars – poor area. - What happens if not enough mum's use MLU – numbers too low?
What could be improved?
= Asking for a place for babies to come back to for 6 weeks, before they go home – SCBU. = Transitional services for the long term SCBU admissions – don't need obstetrician – don't have input from clinicians. Cross consultant cover – have had this. = Satellite unit? Preparing babies for home frees up ITU and MICU beds. NICU and SCBU are totally different.

Option 2 – Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 2?
- Initial thoughts – nothing good to say. - Hebburn/Jarrow will go to Newcastle. - Has Sunderland got capacity? Quite often patients are sent to Middlesbrough as no beds in South Tyneside.
What are the positive aspects of this option?
What are the negative aspects of the option?
- No mother in South Tyneside has a choice.
What could be improved?
= Same as option 1.

Table discussion on children and young people's (urgent and emergency paediatrics) services

Option 1 an**d Option 2** – Children and young people's (urgent and emergency paediatrics) services. (one person left table for part of this question)
What are your initial thoughts on option 1 and option 2?
= CD has said as women get older they don't want to stay up all night – who does he mean? Nurses? Medical staff? - Timings – public transport. - Going backwards – unit has just opened 6 -7 years ago and now closing? - Children with disabilities will present more frequently - distance?
What are the positive aspects of this option?
What are the negative aspects of the option?
- Worried for children/grandchildren. - The times for public transport if no ambulance is available. - From day one we've been abused by the GP's re numbers they send in. 8/10 don't get admitted. - takes pressure of the GP's. - From 8pm no other service? – using it as a WIC.

What could be improved?
= 3rd option – nursing model for SCBU can be considered. Hazel to submit options to Shaz. = Better communication before submitting proposals, these meetings would have been better. = Observations/extra.

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Event	Focused event on maternity, women's and children's services
Time	10am – 12 noon
No. of people on table	6
People	1 x patients/public, 5 x NHS staff and
Facilitator	Jenny Musgrave
Scribe	Jenna Thompson
+	Positive sentiment
-	Negative sentiment
=	Neutral sentiment

Thoughts on what we have heard so far?
- Recruitment of medical and midwifery nurses not unique to South Tyneside, it's a regional thing, Sunderland have issues. - Why can't we have a rota? - When they say the service to Sunderland that's correct. - No one is coming to South Tyneside. + Low c-section rate at South Tyneside. = Why can't we move full low risk services to South Tyneside? = Discussion should be more open than table discussions. = In the general election there has, despite the result, been a resounding objection to cut backs in the NHS. At what point are peoples/service users really given any power? - Has the fact that South Tyneside maternity in the North East having a highest normal birth weight, lowest c–section rate, lowest instrument rate been taken into account when options published?

Table discussion on maternity (obstetrics) and women's healthcare (gynaecology) services

Option 1– Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 1?
= Lots of people already travel a distance… not always in labour though. - Static, what Shaz said. Where are the statistics? A lot of high risk, where is the choice really?
What are the positive aspects of this option?
+ South Tyneside women won't have to travel far for antenatal and prenatal.
What are the negative aspects of the option?
- People ruled out of MLU – are the public truly aware of what they mean? Asthma high risk, endocrine high risk, BMI over 35 high risk, previous retained placenta high risk, vaginal bleeding high risk, meconium high risk etc. See NICE guidelines. Who do we have left for MLU? - Patient safety – 80% within one hour public transport journey to Sunderland Royal (yet these are high risk women 24-hour service). Is this good enough? - In an obstetric emergency how quickly can you guarantee ambulance transfer?

- Saying less risk with MLU NICE says. However, should dystocia PPH occur, that can occur in any low risk woman, you have 7 minutes to deliver the baby. What happens here – is this best practice? - Why are pregnant South Tyneside patients being made to travel to SRH – why can Sunderland patients not travel to STFT for antenatal care? Also, if triage to stay at STFT they need to retain obstetric Doctor for bleeding/ abdominal pain etc. or will all services including antenatal assessment/scans/triage be made to SRH too? - No direct metros. - A&E admission/attendance with PV bleed/signs of ectopic pregnancy and no gynaecology/ obst doctors. Does this mean emergency travel to SRH? Theatre at STFT? - How can you keep assessment unit without doctor if there is a bleed? - Concerns about safety and ambulance services. - Midwife can't prescribe medications. - How long to wait for ambulance service, 5 hours waited once. = Not one of the midwives on table are concerned about jobs, they're all concerned about saving hospital services. - Option 1 is unsafe and unfair. - Low risk can turn to high risk quick. - You will only be put as MED if not breathing. - Don't want to be responsible for women's safety under these options. - So, Sunderland hasn't got a midwifery unit at the minute. What are the costs in creating one? - Talk about saving money, overlooking training, improvement unit, travel costs for staff. - South Tyneside clinical midwife on table. This won't work as it's dangerous unless transport issue (ambulance) resolved. = What about eme. cer. Told "that's a risk women take" Are women aware of the risk?
What could be improved?
= Some services we could combine e.g. training which would save money. Are we looking at other cost saving things? = If South Tyneside are getting rid of other services why can't the maternity services be extended at South Tyneside instead of going to Sunderland?

Option 2 – Maternity (obstetrics) and women's healthcare (gynaecology)
What are your initial thoughts on option 2?
- Costs will be great. - South Tyneside women are proud of status, they don't want a Sunderland baby.
What are the positive aspects of this option?
+ Costs for short term will increase but long-term reductions.
What are the negative aspects of the option?
- Letting women of South Tyneside down. - Domestic violence patients go for respite. Safeguarding issue. - Safety of women and babies is our main issue.
What could be improved?

Table discussion on children and young people's (urgent and emergency paediatrics) services

Option 1 – Children and young people's (urgent and emergency paediatrics) services.
What are your initial thoughts on option 1?
- How will Sunderland cope with the influx? They were closed to deliveries the other day. - Difficulties in recruitment. Zero hour contracts. Temporary not permanent contracts given. - Staff recruitment issues midwife put to table – actually zero hour /minimal contracts and staff begging for contracts. - Promotion of public events is questionable – no sign of promotion in Hebburn at all and minimal in Jarrow. - Many of the public are not able to access computers. Registering for tickets is seen as a hassle – use bigger venues and probably have more accessible promotion – banners, posters in GP, schools, work places, spread in newspapers etc. - Qualitative research is as important as quantitative, why hasn't every patient/service user been given a comment sheet without pre-ticked options.
What are the positive aspects of this option?
What are the negative aspects of the option?
- Few numbers attending paediatrics overnight (Jeff) – everyone counts! - Breathing – respiratory/anaphylaxis times is of the essence. - Reducing hours 8am-8pm – surely when you really need help it is the middle of the night with children. - Ambulance use again? - More mature staff can't cope with overnight services? Getting old! Insulting and insinuating staff are unsafe. Saying older staff can't handle nights is ageism. - Paediatric nurses are specialised nurses. Is the adult nurse outside their sphere of practice? - Can't have something 8am-8pm, in the day you can go to your GP. - Ambulance service get abused as you have no transport. - Closure of WIC's - Transport abuse. - South Tyneside not getting services. - Parents of South Tyneside children will be nervous as children are ill outside of 8am-8pm. - Directions are hard to follow from South Tyneside to Sunderland in car. - What if people don't have a car? - No options at all. - Poor options for South Tyneside.
What could be improved?

Option 2 – Children and young people's (urgent and emergency paediatrics) services
What are your initial thoughts on option 2?
- Both are only 8am-8pm - no night-cover.
What are the positive aspects of this option?
+ More mature staff don't have to work nights. + Cost as people will choose not to go to South Tyneside.
What are the negative aspects of the option?

- Worse than option 1 as no one to prescribe meds. - No night-cover. - What happens when you are travelling to Sunderland and there is an accident. How are staff going to feel to be sent off? - Nurse led clinics are restricted. - Does it mean that the more routine cases go to Sunderland for a second opinion? - Concerns for nurse safety in decision making. = What was the Price Water House Coopers including clinic liaison team exercise, resident cost to trust? = What is the cost of consultation? - Why weren't all staff consulted before public? I have a friends and family document. - Pre-consult patients in maternity restriction on what they could answer, no free text. - Obs team biased to option 1, with exception to STFT consultants. - no promotion of STDH on social, medical or website.
What could be improved?
= Make 24 hours – night time is when parents are most alone. = I.T. should be used more efficiently so triage with speciality from any A&E (Skype, ice, scan, reports etc.), so can start treatment without transfer of care and possibly reduce recruitment pressures in stroke and paed's.