The path to excellence

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NHS
North of England Commissioning Support Unit

Path to Excellence
Phase 2

Applying the Evaluation Criteria
Feedback Analysis Report

Report

June 2019

Executive Summary

The Path to Excellence is a five-year transformation of healthcare services across South Tyneside and Sunderland. It has been set up to secure the future of local NHS services and to identify new and innovative ways of delivering safe, high quality, joined up, sustainable care that will benefit the population of South Tyneside and Sunderland both now and in the future.

Phase One of the Path to Excellence reported in December 2017. Details can be found at www.pathtoexcellence.org.uk. The focus of Phase Two of this process, which has been progressing throughout 2018, is:

- **Emergency care and acute medicine** – the care provided when patients arrive at the Emergency Department or need emergency admission to hospital
- **Emergency surgery** – the care provided when patients are admitted to hospital as an emergency and require an immediate operation
- **Planned care (including surgery and outpatients)** – the care provided when patients are referred to hospital by their GP for a test, scan, treatment or operation.
- **Clinical support services** – across both hospitals such as therapy services, clinical pharmacy and radiology services.

A listening exercise and widespread engagement activities carried out on the Draft Case for Change (published July 2018) heard views from patients, the public, staff and stakeholders. A thematic review of all feedback was carried out to help understand the most important issues which were heard during this engagement activity and which the local NHS wishes to consider as part of Phase Two. Using insights gained from this engagement process, a set of draft desirable 'evaluation criteria' were developed to help assess the 'working ideas' so far for Phase Two. These draft desirable 'evaluation criteria' were tested during a second phase of widespread engagement activities on the updated Draft Case for Change (published February 2019). To date the engagement activity has involved over 12,000 patients, staff or stakeholders in the process.

A four-step process for this pre-consultation engagement activity was set out and this report is part of step 3 – further narrowing or determining strengths/weaknesses of working ideas to identify a viable short list of scenarios with the objective to narrow the list of working ideas to those that best meet the stated objectives of the Path to Excellence programme.

Elements of these draft desirable 'evaluation criteria' were considered in a series of staff engagement events held in March 2019 with 160 staff in attendance followed by a series of stakeholder events in April/May 2019 with 32 stakeholders in attendance.

Event participants were asked to consider the three working ideas – **MINIMAL** change, **SOME** change and **GREATER** change - using two of five (staff) and four of five (stakeholders) draft desirable evaluation criteria or 'domains' developed. The exercise was intended to test

the evaluation method approach as well as provide useful insight from a range of clinical disciplines, engaging staff and stakeholders as expert opinion holders. The three working ideas were also Red-Amber-Green RAG rated.

Feedback from the engagement events was independently analysed using a thematic review approach with a series of themes emerging for all three of the 'working ideas'. Ten themes (four priority and six secondary) were noted in the staff analysis and a further two secondary themes and an additional general theme were added following stakeholder comment analysis.

Priority themes:

1. Capacity
2. Staffing, recruitment and retention
3. Travel and transport
4. Patient flow and prioritisation

Secondary themes

5. Medical, surgical and admin
6. Patient choice and access
7. Emergency surgery and elective surgery sites (hot/cold site split)
8. Referral and joined up provision
9. Efficiencies and duplication
10. System management
11. Communication, definitions and planning for change
12. Impact and future-proofing

Additional general theme:

Clarity of information and framing (added)

Whilst there were some differences in the feedback under the three working ideas, the themes generally applied to most, if not all scenarios. The most detailed area of discussion amongst staff participants was within the theme of staffing, recruitment and retention, where there were more defined differences by working idea. The most commonly discussed area for stakeholders was the travel and transport theme.

Concerns about staffing focused on the need to recruit and retain staff, as well as supporting all through the transition. Establishing a Centre of Surgical Excellence at South Tyneside (STDH) was seen as a positive development opportunity which could secure much needed specialist staff and there was support for bigger teams operating integrated systems. The concept of sites being developed to focus on emergency surgery or elective (planned) surgery, known colloquially in the NHS as a 'hot/cold' site split, was welcomed and associated efficiencies anticipated, though concerns about de-skilling at South Tyneside remained.

Staff training/re-training was an area of tension, with a realistic approach which recognises the scale of the task being called for. Ultimately, creating provision in which accurately predicted patient flow is matched with appropriate staff competencies and levels was aspired to. More detailed workforce development plans and patient flow modelling were requested in this respect.

A top priority for the staff participants was patient safety. The need to achieve clinically safe transfer times in the SOME change and GREATER change scenarios was married with a request for more liaison with the Ambulance Service in planning for change. The need to work with public transport providers and assessment of estates space needs were also raised. Comments about the impacts of potential change in terms of travel and transport, including car parking, were mixed, with a request that the most vulnerable such as the elderly offered special consideration in planning for change. This was a particular focus of discussion and questions from stakeholders, with a call for more detail on how travel and transport would be dealt with, including patient travel and plans for the North East Ambulance Service (NEAS) to support any changes.

In terms of the working ideas, all attracted Amber RAG ratings in the highest numbers, though this was most prominent in the SOME change scenario when considered by staff, where the most questions were raised. The SOME change working idea was seen as potentially beneficial but not necessarily implementable from the current information available, with staff and stakeholders expressing reservations around the lack of detail on how it would be delivered.

MINIMAL change attracted the most Red RAG ratings from staff of all the working ideas although there was more support for this amongst stakeholders. Whilst there were some supportive comments, this level of change was not generally seen as enough to make the impacts on healthcare needed longer term by the majority of staff and stakeholders.

GREATER change was the only scenario to be given Green RAG ratings by some staff, though it was also categorised as Red by others and stakeholders were not as supportive of this working idea. Caveated with concerns about some staffing issues, in particular the disproportionately negative effect on the least senior staff such as some admin and clerical staff, the GREATER change scenario generally elicited the most positive response out of the three from the staff participants involved. For both staff and stakeholders, most saw it as the most ambitious, with the potential to achieve the impact desired.

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1 Background

The Path to Excellence is a five-year transformation of healthcare services across South Tyneside and Sunderland. It has been set up to secure the future of local NHS services and to identify new and innovative ways of delivering safe, high quality, joined up, sustainable care that will benefit the population of South Tyneside and Sunderland both now and in the future. Partners in the Path to Excellence are:

- South Tyneside Clinical Commissioning Group
- Sunderland Clinical Commissioning Group
- South Tyneside and Sunderland NHS Foundation Trust (formerly City Hospitals Sunderland NHS Foundation Trusts and South Tyneside NHS Foundation Trust)

Decisions were made on Phase One of the Path to Excellence in February 2018. Details can be found here. The focus of Phase Two of this process is on:

- **Emergency care and acute medicine** – the care provided when patients arrive at the Emergency Department or need emergency admission to hospital
- **Emergency surgery** – the care provided when patients are admitted to hospital as an emergency and require an immediate operation
- **Planned care (including surgery and outpatients)** – the care provided when patients are referred to hospital by their GP for a test, scan, treatment or operation.
- **Clinical support services** – across both hospitals such as therapy services, clinical pharmacy and radiology services.

Through this Phase Two process, the partners have ambitions to deliver care differently in future, citing aims to:

- Work towards achieving 7-day consultant-led emergency care services
- Deliver the right care, at the right time, by the right person, in the right place
- Maximize the skills and expertise of staff
- Improve access to services in the community
- Use technology to increase efficiency and improve patient experience
- Drive out duplication and waste

Phase Two has been progressing throughout 2018 with clinical service review design teams, made up of frontline staff from both hospitals, meeting regularly since December 2017.

In order to support a logical process of developing ideas for change, a staged approach has been followed so that each element feeds into and influences the next, ensuring the opportunity for stakeholder involvement.

Stakeholders included NHS staff working in the hospitals (not involved in the clinical design groups), wider NHS professionals, community and voluntary groups, elected members and other interested parties.

The four-step process for this is set out in the 'Service Change Scenario Development and Selection' report which was shared with the Joint Overview and Scrutiny Committee and endorsed by both clinical commissioning group's governing bodies.

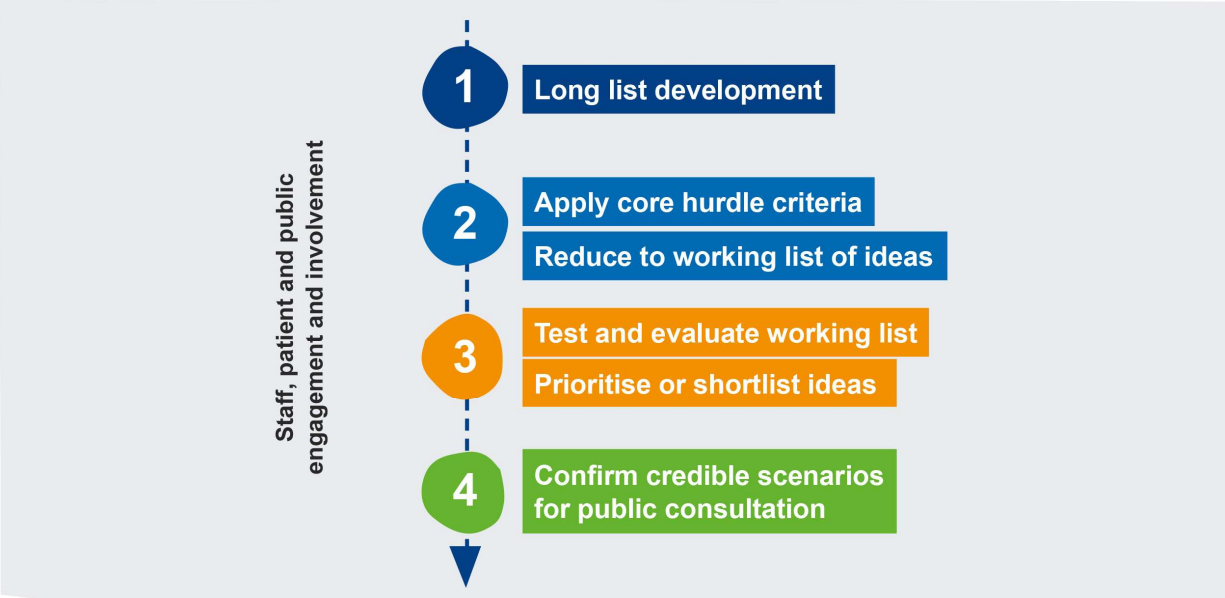
This report is part of step 3 – further narrowing or determining strengths/weaknesses of working ideas to identify a viable short list of scenarios with the objective to narrow the list of working ideas to those that best meet the stated objectives of the Path to Excellence programme.

The draft desirable evaluation criteria are those elements of the working ideas over which stakeholders have influence: the choice elements of the redesign that would be desirable.

The final evaluation criteria will combine with the core hurdle criteria to become final decision-making criteria to enable the Clinical Commissioning Groups to determine appropriate future service arrangements, once consultation feedback has been conscientiously considered.

The listening phase and widespread engagement activities undertaken throughout 2018 and into 2019 have captured over 12,000 views and involved panel events, workshops, interviews and various surveys (online and face-to-face) with members of the public, patients, staff and stakeholders. Feedback has been systematically fed back to the clinical service review design teams after each round of engagement activity to ensure key themes and insights have been factored into the design process. The clinical design process has also included two clinical due diligence sessions bringing together clinical teams across each workstream to systematically cross check on the design developments as work progresses in each clinical area.

From the range of engagement activities, a list of general themes was produced in relation to what members of the public, patients, staff and stakeholders want from future services i.e. creating a 'desirable' list of factors to help inform the clinical service review process for Phase Two. These were developed into draft desirable 'evaluation criteria' to be used to help evaluate the working ideas in the next stages in the transformation process. The design process in reaching the working ideas is described below:



Design process for the working ideas

The core hurdle criteria referred to were for the working ideas to:

1. Be sustainable and resilient,
2. Be affordable,
3. Deliver high quality, safe care, and
4. Be achievable.

These core hurdle criteria were developed in line with the wider aims of the Path to Excellence programme and informed by service change best practice and national guidance from NHS England and NHS Improvement. These same criteria were used in Phase One, and were also tested with the public during the Phase One public consultation (report found here).

The core hurdle criteria detail can be found in *APPENDIX 1*

More about the process of developing the 'working ideas' can be found at the Path to Excellence website www.pathtoexcellence.org.uk.

A series of staff and stakeholder events were then planned to facilitate testing of the draft desirable 'evaluation criteria' against the 'working ideas'.

It is worth noting that these staff and stakeholder engagement events form part of the solutions generation and evaluation process and are not the formal public consultation. They were held to share early thinking and provide an opportunity for staff and stakeholders to be involved in assessing the working ideas, incorporating learning from Phase One in line with Consultation Institute best practice.

2 The Events

The programme's stakeholder advisory panel reviewed the evaluation methodology on 21st March. Members are from organisations and individuals with specific interest in the Path to Excellence including trade unions, community and voluntary organisations, HealthWatch and other parties with interest in the programme. The discussions at the stakeholder advisory panel are not part of this report, but were considered before finalising the materials for the subsequent staff and stakeholder events.

Staff events followed this across South Tyneside and Sunderland in late March 2019. The sessions were widely advertised and open to all staff working in the Phase Two services areas who were employed in the then separate Trusts of City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust, although these Trusts have since merged[1].

Stakeholder events took place in late April/early May 2019. These events invited participants from a range of local organisations with the aim of achieving a 'balanced room' for discussion, in line with The Consultation Institute's best practice guidance[2].

[1] On 1st April 2019 the Trusts merged to form South Tyneside and Sunderland NHS Foundation Trust.

[2] A 'balanced room' is representative groups from a targeted stakeholder analysis (range of interested parties with an interest and element of expertise), recommended by the Consultation Institute.

The aim of the events was to both test methodology, focusing on evaluation impact assessment around deliverability by using the expert skill, knowledge and experience of staff and stakeholders, as well as capture their views about the developing working list of ideas. A wide range of staff attended.

The events were cabaret style with tables of 6-8 participants supported by a table facilitator and a scribe. An introduction to the session included presentations on the working ideas and the rationale for their selection. Staff from the Path to Excellence programme team and clinical experts were available throughout the sessions.

The staff events took place on:

- **Monday 25th March** – Clarion Hotel, Boldon - 8.30-12.30 (*71 participants*)
- **Thursday 28th March** – Clarion Hotel, Boldon - 8.30-12.30 (*34 participants*)
- **Friday 29th March** – Clarion Hotel, Boldon - 8.30-12.30 (*55 participants*)

The stakeholder events took place on:

- **Wednesday 24th April** – Clerveaux Exchange, Jarrow - 12.30-4 (*10 participants*)
- **Friday 26th April** –- Hope St Exchange - 9.30-1 (*10 participants*)
- **Tuesday 30th April** – Hebburn Central - 5.30-9 (*6 participants*)
- **Friday 3rd May** – Hope St Exchange – 12.30-4 (13 participants)

Objectives of the events were to:

- Obtain staff/stakeholder views to support evaluation and impact assessment of working list of ideas
- Use consensus approach to review and RAG rate each working idea
- Record what staff regard as important and why they think it is important for designing the best solutions

A total of **160 members of staff** took part across the three events, feedback back from 23 separate tables and **32 stakeholders** participated across 9 tables in the more focused stakeholder events.

The occupations of participants in the staff events were varied, covering a good range of medical and non-medical staff and services from different departments working across the two Trusts, including:

- A&E nursing staff
- Administrative staff
- Medical Consultants
- Occupational Therapists
- Physiotherapists

- Radiologists
- Senior Nurse Practitioners
- Surgical Consultants
- Ward nursing staff

For the stakeholder events, attendees included participants from:

- Community or voluntary interest groups
- Patient reference / Patient support groups (E.g. Alzheimer's, diabetes, cancer, heart, lungs)
- HealthWatch
- Campaign or special interest groups
- Hospital governors
- Social workers / social care support
- Local Authority staff

An example of the timetable (for staff events) is included in *APPENDIX 2*.

3 Proposals under consideration

3.1 Working ideas

Three 'working ideas' were considered:

- **MINIMAL** change (also sometimes referred to as 'Least' change)
- **SOME** change
- **GREATER** change

Infographics detail the proposals for each in APPENDIX 3.

It was noted in all three working ideas that capital investment will be required and that any future scenarios taken forward to formal public consultation would depend on the level of capital investment available. The event participants were asked to assume this would be available for the purpose of discussing the proposals. This therefore allowed staff and stakeholders to focus on elements of the draft desirable evaluation criteria where their expertise and knowledge would be of most benefit (i.e. discussing issues around quality, safety and clinical sustainability and deliverability).

The role of 'Same Day Emergency care'[3] (referred to clinically as Ambulatory Care) was specifically highlighted in the event presentations as this features heavily in national policy and the NHS Long Term Plan. It was reported that the national view is that around half a million more patients a year across England could be assessed, diagnosed, treated and allowed to return home without the need for an overnight stay by increasing Same Day Emergency Care (SDEC). (To note that work

[3] 'Same Day Emergency Care' means having the right staff and infrastructure in place to treat people the same day, rather than admitting them to hospital. Includes conditions such as Asthma, COPD, Cellulitis of limb, DVT, Pulmonary embolism etc.

on improving SDEC will happen even if the working ideas do not progress to consultation, however they will also support the working ideas.)

3.2 Evaluation criteria

The working ideas were considered alongside the draft desirable 'evaluation criteria' also referred to as 'Domains':

Domain1: Quality, Safety and clinical sustainability

Domain2: Access and choice

Domain3: Impact on equality, health and health inequalities

Domain4: Deliverability

Domain5: Financial sustainability

Domain1 and **Domain4** were considered at the staff events, chosen because these are key elements that staff have a lot of knowledge about in order to provide more detailed information about each working idea.

Domain1, Domain2, Domain3 and Domain4 were considered at the stakeholder events.

A fifth Domain, around Financial sustainability was seen as outside the scope of these events.

The Domains each included a series of 'sub-criteria'. The full detail of all domains and their sub-criteria can be found in APPENDIX 4.

3.3 Recording feedback and RAG rating

At the three staff events, each of the 23/9 tables was allocated a working idea (from either MINIMAL, SOME or GREATER change) to consider. The tables were instructed to consider both Domain1 and Domain4 for their allocated working idea.

In the stakeholder events, tables were also asked to consider a working idea (from either MINIMAL, SOME or GREATER change), though they were asked to consider Domains 1-4; all apart from financial.

Participants were asked to first discuss and then RAG rate the working idea as RED, AMBER or GREEN for the chosen domains.

NOTE: Assigning a RAG rating to the working idea was intended primarily as a discussion tool. The ratings are not intended as scientific absolutes and their use as a way to compare the 'working ideas' should be indicative only.

Discussions were recorded on the printed 'tools' provided, with space to record feedback about the domain under consideration and the RAG rating assigned. In addition, comments recorded were noted as positive (+ve), negative (-ve) or neutral (+/-ve) by the scribes.

The RAG ratings can be defined as:

Rating label	Value	Definition of rating
High Degree of Confidence	GREEN	• High degree of confidence/evidence in the scenario's ability to do what is stated through a thorough and detailed understanding of what is being requested. • Responses/findings demonstrate that the scenario can achieve requirements. • Responses are detailed and supported by evidence as appropriate. • Potential system/stakeholder benefits described with evidence/rationale.
Meets Requirements	AMBER	• Evidence/findings demonstrates an understanding of the issues and requirements. • Scenario addresses issues appropriately with sufficient information, but lacking reliable substance. • Only some confidence that the scenario will be able to deliver in line with expectations. • Potential system/stakeholder benefits may be described but with limited evidence or rationale.
Low Degree of Confidence	RED	• Some misunderstanding demonstrated and limited on relevant information, detail, and evidence. • Does not provide sufficient confidence/support that the scenario can fulfil or meet the requirements in line with expectations.

Tables of participants were asked to try to reach a consensus on the collective RAG rating given, by the end of their discussion.

In practice, though not specifically asked to do so, some tables also chose to RAG rate the sub-criteria within a domain. However, for the most part the participant tables still considered an overall RAG rating for their allocated working idea and domain, which were fed back in a plenary session at the end of the event.

The Some change RAG ratings were classified as 'AMBER-RED' or 'AMBER-GREEN' – or occasionally terms like 'Blood orange'. These were grouped accordingly in the analysis.

4 Analysis

4.1 Analysis methodology

Analysis of the qualitative feedback captured at the staff engagement events was carried out between 5th – 17th April and for the stakeholder events between 21st – 28th May 2019.

Analysis of the findings from the discussion-based activities is based on a thematic review approach, where the data from the session notes is analysed and responses grouped into themes that most closely represent the sentiment expressed[4]. This allows the findings to be reported based on an accurate reflection of the sentiments expressed. Where marked in the scribes notes, the +ve, -ve or +/-ve nature of the comments has been noted. Where quotes and comments are shown, these have been chosen to represent the centre of the sentiment expressed within that theme, if needed[5].

The dominant variable for presenting analysed findings was to be the working idea – i.e. MINIMAL, SOME or GREATER change, however the themes are pre-dominantly relevant across all three working ideas and therefore the themes are more general. The most significant area of discussion for participants was staffing, and summary of the comments by working idea is presented under this theme.

In addition to the qualitative analysis and thematic review, the report structure includes a summary of key RAG rating comments for each working idea and an overall summary of the findings.

The summary RAG ratings, offered at the end of discussion on each working idea, are presented in tabular form in the Appendices.

4.2 Reflections on the events

Considering the events, several reflections illustrate the approach taken, which can be considered in tandem with the resultant themes.

1. Staff participants were recruited from a wide range of disciplines across both Trusts and efforts were made to 'mix up' the disciplines on each table in order to provide a range of different clinical perspectives on the table. This was not intended to be systematic, nor scientifically representative of the whole staff mix, though a wide range of staff took part. A 'balanced view' approach was applied to the stakeholder events held in May.

2. Although the working ideas are being considered in terms of surgical services, emergency care and acute medicine and for clinical support services, the tools did not separate these issues out for the recording of feedback. Therefore, the analysis by these factors is limited.

[4] The approach is based in the employment of Classic Grounded Theory.

[5] Note that these quotes may be verbatim from a participant or the words of the scribe in summing up debate.

3. The discussions on each table were facilitated by a moderator and notes were taken by a scribe. Both moderator and scribe received a briefing on paper and a verbal briefing on the day. Paper based 'tools' were used to capture feedback. The staff sessions were designed to test the evaluation process as well as gather feedback. Table discussions were lively and rich information was captured on issues relating to the change ideas, to inform the next stages of the process. Facilitators fed back that participants would also benefit from more time at the outset discussion all the working ideas in the round before considering their allocated change idea/domain, and this was implemented in the subsequent stakeholder sessions.

4. The flow of the discussion meant that the issues raised were usually general and not always related to the specific working idea. Therefore, whilst some clear themes emerged which are useful to inform the next stages, these tend to be general (i.e. these were not always directly related to participant's views about the impacts of the working idea under consideration.)

5. The table discussions were moderated but participant-led, therefore feedback via scribes varied in terms of detail and style and was handwritten. Some feedback was summarised and some almost verbatim. +ve/-ve were sometimes but not always recorded, or not recorded consistently by each table scribe, therefore a systematic relative analysis of these is not appropriate for this data. No recordings were made, as this was a workshop style event held in one space.

6. Occasionally, the RAG ratings recorded by scribes in the discussion sessions were amended by the tables once further room discussion had taken place, arriving at a RAG rating which was fed back to the room in the plenary session. Where this was observed, this plenary RAG rating took precedence for the analysis and the final breakdown.

Learnings were taken from the staff sessions and adapted for the stakeholder events that followed, for example by introducing a 'warm-up' exercise, giving all participants the opportunity to air views about all the delivery and tables being asked to record a final summary sentence/bullet point list of the reasons for their chosen RAG rating. They will also be used in development of the next stages in the Phase Two process.

5 Findings

5.1 Development of themes

The staff event participants considered all three working ideas – MINIMAL, SOME and GREATER change, focusing on Domain1 and Domain4 to evaluate them.

The discussions generally followed the format of the domains, usually considering all the sub-criteria in order and the majority of the table discussions commented on each individually, though some made more general comments or grouped sub-criteria together when expressing a view.

There was considerable debate within the table discussions as well as differences of opinion, which stimulated the discussion of positive and negative impacts. This is useful in formulating overarching themes, though relevance to the working idea under consideration was not always clear and the discussion was commonly of a more general nature.

In considering all the feedback, a number of priority and secondary themes emerged. These were commonly reported across all the working ideas and have been presented collectively. More comments from participants were given around Theme 2 than any other, therefore specific sections relating to each working idea have been presented separately for this.

NOTE:

- *Comments in quotations are a combination of verbatim quotes from participants – either [staff] or [stakeholder] and collective feedback summarised by the scribes.*
- *If the comment is specific to a working idea, this has also been marked as [Minimal], [Some] OR [Greater], though many are unmarked as the comment represents an issue which cuts across more than one working idea.*
- *The Domain under discussion for each comment is marked in brackets, e.g. [D1]*

An infographic detailing the three working ideas can be found in *APPENDIX 3.*

At the staff events, the MINIMAL change working idea was considered by 6 tables in total across the three events, SOME change by 8 and GREATER change by 9 tables.

At the stakeholder events, MIMIMAL change was considered by 5 tables, SOME change one and GREATER change by 4 tables.

Each working idea was debated fully and an overarching RAG rating was given for each domain in all cases during staff events and in some cases from stakeholders. The sub-domains were discussed by all, though only RAG rated as an aid to discussion rather than universally.

Priority themes

1. Capacity
2. Staffing, recruitment and retention
3. Travel and transport
4. Patient flow and prioritisation

5.2 Theme 1: Capacity

Many of the staff participants fed back concerns about the physical environment and the ability for the current sites to expand, citing that there is limited space to do so. Estates capacity was therefore seen as a limiting factor – in terms of the overall footprint and the number of beds/ward space, as well as space for the associated increase in staff numbers needed. This was felt to a greater or lesser degree across all the working ideas.

> *"Is there space to expand? - doesn't fit as it is!" Staff, [D1]*
>
> *"Physical capacity – limits what's possible" [Staff, D1]*
>
> *"Need a bigger ward. No side rooms for assessments" [Staff, D1]*
>
> *"Can a new site accommodate the staff?" [Staff, D1]*
>
> *"A&E struggling now with capacity (not hitting targets). Will need expansion but landlocked so how will this be achieved?"[Staff, Some, D4]*

There were conflicting comments on space available in surgical/ward settings.

> *"The ward in SRH is huge. Should be able to create for extra A&E patients" [Staff, Some D4]*
>
> vs
>
> *"They'd need at least a couple of extra Theatres to cope with demand" [Staff, Some D4]*

There was concern about patient numbers, currently and in the future.

> *"Not enough staff or beds at the moment – need to improve the current situation before making any changes" [Staff, D1]*
>
> *"Should we plan for over-capacity, to accommodate imagined increasing demand?" [Staff, D1]*

In terms of capacity and deliverability, some suggested that efficiency could be improved through more flexibility within the bigger teams created and associated better use of currently under-used spaces – see also *Theme 5: Efficiencies and duplication* below.

"Using buildings more efficiently is a forward step" [Staff, D4]"

There was less comment on capacity from stakeholders than staff and very little on any potential estates issues.

"Potential concerns around capacity of emergency when based at Sunderland especially with walk in centres planned to close." (Stakeholder, Some)

"Capacity will be biggest problem at both hospitals [for Greater change]. Not enough assurance that there will be enough capacity." (Stakeholder, Greater)

Feedback on staff capacity is highlighted further in *Theme 2: Staffing, recruitment and retention* and *Theme 4: Patient flow and prioritisation,* below.

5.3 Theme 2: Staffing, recruitment and retention

Staffing was a big area of discussion, both generally and woven into many of the sub-criteria feedback for Domain1 and to a lesser extent, Domain4.

All the staff table discussions fed back concern about current staffing, recruitment and retention issues within the NHS generally.

"There's a national shortage of nursing staff – recruitment and retention is a problem now!" [Staff, D1]

"Need adequate staffing levels regardless of model" [Staff, D1]

There was an appetite to get the staffing issues right whatever the model, recognising the risks but giving their support to actions to mitigate them, for example through staff training.

"We need appropriate staffing numbers and skill set. We need to recognise that challenges will persist, as per the national picture" [Staff, D1]

"Concerns for the skill mix – not just the right numbers but the right competencies" [Staff, D1]

"We need to be pro-active now with regards to staffing - training and expanding roles" [Staff, D1]

Some stakeholders felt that staffing issues were not fully addressed in the models, but comment was minimal compared with the staff feedback received previously.

"Workforce issues are not addressed" (Stakeholder)

"Are the staff workforces happy to work across both sites? How will they commute?" (Stakeholder)

"Recruitment - are we doing anything to support students with bursary cuts?" (Stakeholder)

"Huge issue around staff recruitment." (Stakeholder, Minimal)

All the working ideas attracted some level of support in terms of improving opportunities for staff recruitment. Working for a larger Trust and the presence of a 'Centre of Surgical Excellence' at South Tyneside (STDH) were seen as favourable by staff participants, although given the national picture and the difficulty in judging recruitment and retention, recruitment was still seen as a significant risk.

"Bigger teams could create more opportunities" [Staff, D1]

"Better for recruitment to work for a larger Trust – more experience" [Staff, D1]

"Attractive if a Centre of Excellence" [Staff, D1]

Reflecting this staff feedback, stakeholders also saw this as positive.

"In a bigger trust there would be more opportunities for specialism/innovation" (Stakeholder, Some, D1)

"Bigger teams give more flexibility" (Stakeholder, Some, D1)

Where the hot/cold split[6] was proposed, advantages could generally be seen in terms of staff skills development at Sunderland, though concerns were expressed about staff recruitment and development opportunities at South Tyneside.

"South Tyneside may struggle to recruit – attractiveness diminished" [Staff, D1]

"Potential to de-skill staff e.g. would staff still achieve HCPC professional standard (Paeds/physio)?" [Staff, D1]

In addition, there were comments about staff morale being low and the effects of uncertainty. The impact of change per se, as well as the likelihood that this would be different on different staff groups, was also commented on. There was a recognition that some aspects would be strengthened and some weakened.

"Resentment within teams affected by the changes" [Staff, D1]

[6] Hot/cold split refers to the concept of sites being developed to focus on emergency surgery or elective (planned) surgery, know colloquially as a 'hot/cold' site split

"Good for some. Not so good for others" [Staff, D1]

"Continuity issues and belonging" [Staff, D1]

Specific comments arose about diagnosis of patients and the ability of staff to both stabilise and support them at South Tyneside if their conditions were more serious than first thought.

"Under-diagnosed patients would need to be stabilised at South Tyneside then moved to Sunderland – there is a potential that the skills won't be there for this" [Staff, Some, D1]

The working ideas were seen by staff as having opportunities for improving waiting times because of the site/service split and the surgery changes.

"If more efficient, could improve waiting times for patients as elective/emergency separate" [Staff, Some, D1]

"Split sites are more efficient" [Staff, Some, D4]

"Current wastage with electives being cancelled – would reduce with hot/cold sites" [Staff, Some, D4]

But staff fed back that if South Tyneside was not seen as 'attractive', there could be impacts on recruitment. The potential for less challenging work at South Tyneside was also thought by stakeholders likely to impact on staff retention.

"Doesn't improve recruitment and retention; lose the chance of professional development and research" (Stakeholder, Minimal)

There were also concerns from stakeholders about this, including that this working idea might create a two tier staff system in terms of staff skills, development/training opportunities etc., though others disagreed.

"Creates inequalities between workplaces" [Staff, Greater, D1]

vs

"By bringing services together you get more of a levelling of the workforce" [Staff, Greater, D4]

There was concern for staff in terms of workload and staff management and more evidence on workforce planning was again requested.

"Hot-side: staffing issues are burn out, whereas cold-side it will be more 9-5" [Staff, Some, D1]

"Development plans should be started now, to improve retention and morale' [Staff, Some, D4]

"E.g. If surgical lists are cancelled due to winter pressure or medical problems – what to do with staff? Need to plan for this" [Staff, Some, D1]

There were staff concerns about reducing the skill base and workforce management, including rotation.

"De-skilling is an issue if there are limited A&E cases at South Tyneside" [Staff, Some, D1]

"It will be difficult to move staff on a day to day basis" [Staff, Some, D1]

"Risk losing staff if rotation needed across sites" [Staff, Some, D4]

"Theatre staff – not an advantage to rotate" [Staff, Some, D1]

Supporting staff through the transition was seen as important.

"How will this affect family life for staff?" [Staff, Some, D1]

"Team building should be seen as essential' [Staff, Some, D4]

Risks to patient safety were specifically cited, with comments expressing concern that walk-in patients at South Tyneside would be more at risk without specialist opinion.

"No emergency surgery at South Tyneside means no expert opinion on site, which is a risk to patient safety" [Staff, Some, D1]

"E.g. a South Tyneside patient may be classed as a minor but may not be once arrives – such as Orthopaedics - but there is no specialist there to assess. Will the patient be sent to Sunderland for assessment?" [Staff, Some, D1]

"Would this mean increased assessment times at Sunderland?" [Staff, Some, D1]

However, there was also recognition amongst staff that the changes could be positive overall, taking the best of both sites in terms of processes.

"More access to specialist opinion" [Staff, Some, D1]

"Triage is done at Northumberland/Hartlepool now and works well" [Staff, Some, D1]

"Planned care - beneficial" [Staff, Some, D1]

Feedback also highlighted the need to assess impacts on Pharmacy services.

"More surgery = significant impact on Pharmacy… risk to patients" [Staff, Some, D1]

"Pharmacy needs will increase – we need to respond" [S D4]

The positive feedback given included views that there could be more opportunities, including for recruitment, and that staff could see efficiencies, though some felt the changes may reduce staff retention.

"More opportunities for staff recruitment" *[Staff, Minimal, D1]*

"Could be efficiencies if rota design was to change" *[Staff, Minimal, D1]*

"Bigger teams work better for on-call" *[Staff, Minimal, D1]*

"Will improve networking" *[Staff, Minimal, D1]*

There was feedback from staff that recruitment but not retention would be improved.

"Will improve recruitment but not retention" *[Staff, Minimal, D1]*

Risks to patient safety were highlighted in terms of pressures of staff skills/ratios and there were questions about working patterns.

"Workforce challenges a real threat in Minimal change approach" *[Staff, Minimal, D1]*

"Potential safeguarding issues, where staff don't know patients" *[Staff, Minimal, D1]*

"Will part-time workers loose out? What about split roles, covering both urgent and community care?" [M D4]

Training needs were seen as important by staff, with the suggestion that this may be a significant need.

"We need to be realistic with the amount of development/training that staff will need" *[Staff, Minimal, D1]*

"There will be staff training issues – e.g. need to be qualified in using the equipment which may differ at the different sites" *[Staff, Minimal, D1]*

Anxiety about staff being moved across sites was expressed for the Minimal change model. Some reported concern about a lack of opportunity or potential unwillingness to change.

"Workforce balance needs to be considered – regarding travel, time, dependents etc." [Staff, Minimal, D1]

"Staff may not want to move" [Staff, Minimal, D4]

"Some e.g. South Tyneside Theatre staff are flexi-retired – they might not want to develop or change" [Staff, Minimal, D1]

"There will be no development opportunities in South Tyneside" [Staff, Minimal D1]

There was an additional concern that skills would be lost in the Minimal change approach due in part to staff working across two sites.

"Moving staff around reduces the likelihood of competences." *[Staff, Minimal, D1]*

"Skills may be lost/not developed – i.e. if only see Trauma, not a variety of patients" *[Staff, Minimal, D1]*

"Losing services = losing much needed specialisms" *[Staff, Minimal, D4]*

"As a clinician, there is a potential to be de-skilled – less variety of opportunity to develop" *[Staff, Minimal, D1]*

However this was not always the view, with some suggesting opportunities.

"Speciality wards = better CPD" [Staff, Minimal, D4]

"It's easier to work in one department than two" [Staff, Minimal, D4]

There were questions from staff about how this would work when interacting between sites and with off-site services.

"What will happen to community-based services like Bunny Hill?" [Staff, D4]

"Processes/diagnostics are different at the two sites – we need to agree a model for both, using a consistent approach" [Staff, Minimal, D1]

"Need to consider work practices, taking the best of both sites e.g. ED links with the discharge teams – currently working well" [Staff, Minimal, D1]

The Greater change idea was seen as the most ambitious, but this was generally embraced by staff in terms of staffing issues. It was seen as the best chance for successful recruitment.

"Better chance of recruiting consultants/specialists" [Staff, Greater, D1]

"Could also be attractive in terms of nurse practitioners not wanting to do urgent" [Staff, Greater, D1]

"Specialist opportunities increase e.g. much needed radiologists" [Staff, Greater, D1]

"This is a positive change from ICU and Orthopaedics point of view" [Staff, Greater, D1]

"More elective orthopaedics/trauma etc. means more scope to develop and better staff retention" [Staff, Greater, D1]

"Staff may be happier if they can choose" [Staff, Greater D1]

There was also a concern that this Greater change approach may have a higher impact on the lower grade and admin staff. Feedback from staff cited the change as a cause of anxiety for staff, although other comments countered this.

"Admin staff are more concerned about job security" [Staff, Greater, D4]

"What about staff not able to drive?" [Staff, Greater, D1]

"Nursing/medical staff it could be attractive for, but not others e.g. therapies" [Staff, Greater, D1]

"Staff anxieties over the changes, travel and job security" [Staff, Greater, D1]

vs

Not a fear of losing jobs but of moving Trusts after being used to the one they're at" [Staff, Greater, D4]

Greater change was seen as positive for staff in Sunderland but not in South Tyneside by stakeholders.

"Could be more benefits at SRH site for staff progression." (Stakeholder, Greater, D1)

"Less likely to want to work at STDH. Would need staff progression at STDH site." (Stakeholder, Greater, D1)

"It could enhance recruitment at Sunderland but STDH will be less attractive place to work" (Stakeholder, Greater)

Some supported Greater change as it fits with what is happening already through current collaboration. Again a workforce development plan was requested, though it was appreciated that this was difficult as there were so many unknowns. The aging workforce was highlighted.

"We have an aging workforce – where are the workforce development plans for the next generation?' [Staff, Greater, D4]

Patient flow was linked to staffing issues and the need to understand and act around this (see *Theme 4: Patient flow and prioritisation*). Specifically, the concern around unexpected complication in minor surgery was expressed. This also relates to queries about adequate response times from Ambulance transfers. Though raised in Greater change, the issue applies to all three working ideas.

"Issues with patients and unexpected complications during surgery?" [Staff, Greater, D1]

Again, reference to the relationship with community services was cited, as was the need for appropriate Pharmacy services

"We need all community services to work effectively – Out of Hospital and community are key to managing hospital numbers" [Staff, Greater, D4]

"Small specialist rehab teams may struggle to cover acute and community" [Staff, Greater, D1]

"Pharmacy in South Tyneside will be affected and will need resources in SRH" [Staff, Greater, D1]

Overall, there was a feeling that the Greater change working idea would provide better specialist help and though hurdles to get over, could accommodate the issues and have an impact.

"Patients have access to professionals they didn't have before" [Staff, Greater, D1]

"Model gives room for patients to arrive at the wrong place and be transferred" [Staff, Greater, D1]

5.4 Theme 3: Travel and transport

Travel and transport, staff and patient and including car parking, was a key area of discussion across the staff and stakeholder sessions. It also strongly links to patient access (see *Theme 7: Patient choice and access*).

Travel concerns were prominent in the stakeholder discussions. Stakeholders felt that there was a lack of clarity around transport and that this aspect of the working ideas had not been covered in the documentation provided.

"Transport - what's happening as it has not been mentioned." (Stakeholder)

"What transport provisions will be available for same day patients?" (Stakeholder)

Stakeholder generally felt that travel and transport issues were not accounted for in the working ideas.

"Travel issues still not been addressed – time, affordability and patient transport cutbacks. This can mean missed appointments or non-presenting." (Stakeholder, Minimal, D2)

They also commented on the potential differences between South Tyneside and Sunderland.

"South Tyneside residents - no access to emergency treatment as currently can access and self-present in minutes at ED. Will have to travel more to Sunderland." (Stakeholder, Greater, D1)

"Equally negative impact on Sunderland residents travelling to South Tyneside." (Stakeholder, Greater, D2)

Generally, there was concern amongst all about capacity for car parking – staff and patients – for all working ideas either because of the need to travel between sites, because some services are extended opening or because capacity would be increasing in Sunderland in particular.

"Car parking needs to be considered" [Staff, D1]

"Are the car parks big enough?" (Stakeholder, Greater, D2)

"What do the public want? Transport, parking, good services" [Staff, Some, D1]

"There are inconsistencies – staff car parking is £32 per month in Sunderland and £15 per month in South Tyneside, which needs to be considered if staff move" [Staff, Minimal, D4]

The need for a public transport system which supports the changes was frequently fed back. The need to work with the local public transport providers to plan appropriate timetables was seen as essential.

"Travel time – what impact will this have on patients?" [Staff, Minimal, D1]

"There is no direct public transport link between the two sites and this has been raised by the public before" [Staff, Some, D1]

"Services need to link with local transport companies" [Staff, D1]

"There will be more complaints" [Staff, D1]

The stakeholder's concerns also included patient transport, commenting on the current situation around the criteria for this.

"Public transport – need more confidence in travel assessments and that Patients will get to where they need to be. Public's owns circumstances will determine if they will travel." (Stakeholder, Greater, D2)

"This is not just public transport that is an issue. Not all patients are eligible for patient transport as the criteria keeps changing and these patients will have to pay which can be costly for them and also for visiting families." (Stakeholder)

"Criteria – needs to be much more tangible, measurable and specific as open to interpretation and articulating this for patients re clinical travel time – what is that?

"Compare journey for both South Tyneside and Sunderland patients." (Stakeholder, Minimal)

Attention on communities where travelling is difficult was also raised by stakeholders.

"Transport should be more specifically looked into for some difficult to reach areas." (Stakeholder)

"Concerns over access particularly for patients from areas with high deprivation – no details on public transport to enable access" (Stakeholder, Some, D2)

There was also a fear from stakeholders that travel barriers (living more rurally, not having a car, number of buses, cost etc.) may stop people from going to hospital.

"There is a travel impact (CG) for patients from Seaham who would have to travel to STDH for diagnostics – 20 miles?" (Stakeholder)

"Young mums' with children could also experience difficulties." (Stakeholder Campaign Group, Greater)

"Older people could experience more difficulties i.e. they could be less likely to drive themselves, however they could also be more able to afford buses/taxis or have younger relatives who can drive them." (Stakeholder Campaign Group, Greater)

"Concern patients won't attend appointments if not local due to financial implications/time to travel." (Stakeholder, Greater)

"Idea: development of patient transport between sites." (Stakeholder, Greater)

Staff transport was also an issue in the comments, with staff citing issues with the current staff transport system which need attention.

"9-5 staff shuttle needs extending for early clinics/night time visiting" [Staff, Minimal, D4]

"Staff buses - not well managed. Development opportunity" [Staff, Minimal, D4]

The need for travel and transport to be accessible to those with mobility issues, the elderly and families, was also part of this theme and a recognition of what is faced by patients' if attending hospital when this involves complicated, difficult or longer journeys.

"Concern about vulnerable patients' travel time" [Staff, Minimal, D4]

"What about transport for specialist services?' [Staff, D1]

"Need to consider transport for older/frail patients – not only in emergency but day transport too" [Staff, Greater, D1]

"Elderly population – travel requirements / difficulty accessing services, though family can help out." (Stakeholder, Greater, D3)

"On-site parking is a big issue too, including a lack of disabled spaces and parking charges." (Stakeholder, Minimal)

However, it was also suggested this would not be a problem by some staff and transport was also seen as both positive and negative by stakeholders i.e. some agree that this is an issue and some don't. Travel for 'specialist services' seemed more acceptable.

"We are used to travelling, if we want the best care we will travel for it" (Stakeholder, Greater)

"Transport and access would be no issue for majority, but a few might struggle with transport." (Stakeholder, Minimal, D2)

"Travel is irrelevant as patients will travel where they need to" [Staff, Minimal, D1]

"Would travelling put patients off? Or would they prefer to travel to a Centre of Excellence?" [Staff, Greater, D1]

"Sunderland and South Tyneside are relatively close, compared to other areas in the UK" [Staff, Some, D1]

The concept of travelling by Ambulance and the links to NEAS were also cited. There was concern about Ambulance transfer times, in particular from South Tyneside to Sunderland to receive more urgent or specialist care in an emergency.

"How will this impact on emergency care? We don't know yet" [Staff, Some, D1]

"Need to work with NEAS and local transport providers to ensure patient transport between sites" [Staff, D1]

"No evidence that Ambulances transferring would work" [Staff, Some, D4]

"More Ambulance transfers = less safe vs fewer transfers; get to the right place first time" [Staff, Greater, D1]

The issue of what is a 'clinically safe transfer time' was raised by several and a direct question asked of the Programme team on this – more information was requested around transfer of patients. In particular, the vulnerability of dementia patients was flagged.

"There is an issue if a patient needs a transfer but is seen as 'at a place of safety' by Ambulance services which could lead to a delay – but there would not be the right skills on that site?" [Staff, Some, D1]

"Can NEAS cope with demand?" [Staff, Some, D1]

Further comments related to the transfer of patients highlighted the current arrangements and thoughts on the biggest risk being walk-in patients.

"Transfers currently work though e.g. SRH to Newcastle" [Staff, Greater, D1]

"Greatest risk is walk-ins" [Staff, Greater, D1]

Practically, participants asked how the new arrangement would be accommodated in terms of targets, particularly in the Greater change scenario.

"Will the clock be reset on transfer?" [Staff, Greater, D1]

5.5 Theme 4: Patient flow and prioritisation

This theme cut across the other three priority themes and has been given priority for this reason.

The main issues fed back by both staff and stakeholders were around concerns that a better understanding of the modelling of patient flow in each change idea was still needed, and that the accuracy of this modelling would be the key to for success.

"Need to get patient modelling flow right" [Staff, Some, D4]

"Need to understand what the capacity and pace of service delivery will look like. Clarity of the full patient flow required." (Stakeholder, Minimal, D1)

It was felt that patient flow would impact on many other areas of service provision and care, including presentation, diagnosis, specialist need, transport/transfer, bed and care management and discharge. The need to consider flow from other hospitals was also raised.

"Risk of clogging and impact on ICU" [Staff, D4]

"We need to work with nursing homes to support elderly care and discharge" [Staff, Some, D4]

"Not enough capacity for flow from other hospitals" [Staff, Minimal, D4]

Additional comments linked the issue of capacity to patient flow. There were suggestions around consideration of linked therapy and support services such as AHPs, care homes etc.

"The main area of concern is A&E – and not knowing how much A&E will increase" [Staff, Some, D4]

"If not doing emergency surgery, need fewer ICU/ITU beds. This will have an impact on AHPs e.g. Physio, OT, diagnostics." [Staff, Some, D4]

"Day cases will affect therapy services – we will need to increase/reconfigure staffing" [Staff, D1]

The availability of basic kit such as pillows and the staff available to enable patient flow to be managed in a timely manner such as porters, was seen as a risk.

There was some discussion about additional pressure on Sunderland and how this would be accommodated. In particular, 'Step down' beds were raised as part of this – and the need to use bed stock at South Tyneside, with questions around how this might work in practice.

"Step down beds – where and how transferred?" [G D1]

There was also concern about how patients would be prioritised if there was competition for services including transport and transfer by NEAS, specialist services and beds. In particular, there were questions about who would make these decisions on a practical level.

There were many comments and queries from stakeholders around the capacity and preparedness of NEAS were fed back in terms of the service and risk management, including concern about conversations with NEAS being operationalised.

"There will be challenges in the ambulance service being able to get people to hospital in a safe time." (Stakeholder Campaign Group)

"How will people get to hospital in the idea [Greater]? Are we reliant on the ambulance service deciding and, if so, what happens if a less serious case becomes more serious? There is a concern that we have no control over the ambulance service which is essential to the idea working as it should." (Stakeholder, Greater)

"There is a risk of patients going to STDH with seemingly minor problems that are actually more serious and needing to be transferred." (Stakeholder, Greater)

"Concerns that routine elective surgery could escalate into an emergency surgical need i.e. planned ulcer surgery which becomes an ulcer bleed – what would happen to the patient?" (Stakeholder)

"Risk around transport of patients – how will this be managed to minimise wait?" (Stakeholder, Minimal)

In addition to the management of patient risk, comments about NEAS staffing (paramedics') and pressure on them was expressed by stakeholders.

> *"The ambulance service is currently short of paramedics which will mean they will struggle to support the ideas." (Stakeholder)*

> *"Does this mean that the paramedics will be making decisions on the urgency of patients? If so what if any extra specialist training will they be receiving?" (Stakeholder)*

It was felt that more information on how this would work for the different working ideas was needed to assess impact.

Secondary themes

5. Medical, surgical and admin
6. Patient choice and access
7. Hot/cold site split (added)
8. Referral and joined up provision (added)
9. Efficiencies and duplication
10. System management
11. Communication, definitions and planning for change
12. Impact and future-proofing

5.6 Theme 5: Medical, surgical and admin

Throughout there were differences in feedback in terms of Sunderland or South Tyneside as hospital sites. However, there were also some comments about difference in disciplines within the hospital sites. These cut across several themes.

Feedback was general on this issue, citing the need for both clinical and surgical models to operate effectively in any working idea.

> *"Medical/surgical staffing model differs – but both would need to work in the model" [Staff, Some, D4]*

> *"This model is easier to plan workforce however medical/surgical staffing model differs" [Staff, Some, D4]*

> *"Currently surgical nurse practitioners do not feel adequately utilised with regards experience and knowledge" [Staff, Minimal, D4]*

There were comments relating specifically to surgical procedures for the working ideas.

> *"Surgical changes have not considered endoscopy out of hours." [Staff, Minimal, D1]*

> *"Taking more beds from surgical dept. to treat elsewhere" [Staff, Minimal, D1]*

> *"Needs to be short surgical procedures to hit targets" [Staff, Greater, D1]*

Nursing staff offered different comments which focused on sharing good practice and preparing for change.

> *"More active engagement is required between both hospitals in the sharing of ideas and processes. It would be very refreshing to have a ward manager that is forward thinking*

enough to say to their staff - take some time off to go and speak to the other hospital." [Staff, Some, D4]

"Is there somewhere else in the country where this has worked, that can be used as a measure/example for getting this change right?" [Staff, Some, D1]

Nursing staff felt the changes could be positive, including for recruitment, mostly for the Greater change approach through being attractive for moving up the scale and providing opportunities, though there were some alternative negative views about the changes in practice.

"Very positive from nurse view, model gives confidence due to collaboration" [Staff, Greater, D4]

"Nurse led services on both sites coming together could improve all over efficiency by combining site staff" [Staff, Greater, D1]

"They feel they'd work less hours and are excited about working together. [Staff, Greater, D4]

vs

"Who's going to be at the bottom picking up the slack as nurse quantities would be stretched by existing nurses specialising. [Staff, Greater, D4]

"There's an issue of continuity of care. Yes, Pathways are currently in place, but there's an issue of working over two sites." [Staff, Some, D1]

"Nurses will need to move; massive staff reductions" [Staff, Greater, D1]

There was a comment from stakeholders which suggests more information is needed about the surgical benefits. This could be simple a communications issue, if the evidence or opinion is available.

"We're not hearing from surgical staff that the surgical changes will improve health outcomes." (Stakeholder, Greater)

However, the Greater change working idea attracted positivity from some (Note: stakeholder group but ex-surgeon)

"Quality of care would be better at Sunderland due to availability of senior staff, plus more consistency of senior cover." (Stakeholder, Greater, D1)

"From a clinician view point this [Greater change, Domain1] would be rated green. Changes like this have been made elsewhere; we come to know what quality to expect." (Stakeholder, Greater, D1)

"Making a surgical plan will improve outcome for patient and risk of cancellations, less stressful for patient." (Stakeholder, Greater, D3)

"Improvement in quality of care. Consistency of access due to having right staff in right place." (Stakeholder, Greater, D3)

There were mixed views about the rotation of staff from stakeholders, in relation to different staff groups.

"No rotation, in turn will not promote development. Might be ok for top clinical staff, but might not go down well with other staff e.g. Nursery staff." (Stakeholder, Minimal, D1)

Administration, non-clinical staff or those who are disadvantaged were seen to be potentially most affected by the changes – in particular for the Greater change model.

"Admin are concerned about job security" [Staff, Greater, D4]

"Two trusts allow more opportunities from nurse/medical point of view, but not for admin clerical staff. No succession or development opportunities." [Staff, Greater, D4]

RAG ratings were sometimes split by professional area.

"E.g. Green for medical/nursing, Blood orange for Admin staff" [Staff, Greater, D4]

5.7 Theme 6: Patient choice and access

Patient choice was an issue raised in the majority of staff and stakeholder discussions. Access by patients – physically and to service provision, is also considered within this.

All the working ideas received comments around not providing patient choice.

"Where is the patient choice?" [Staff, Greater, D1]

'No longer able to choose local hospital" [Staff, Greater, D1]

"No patient choice" [Staff, Some, D1]

"Minimal change doesn't necessarily provide patient choice." [Staff, Minimal, D1]

"Patient choice not deliverable in this model' [Minimal, D1]

"Taking away care close to home which is already established – is a reduction in choice." (Stakeholder, Some)

Though there was also recognition amongst staff that there may not be great choice as things stand and it would be unrealistic to meet every patient's choice.

Appropriate access was a recurring theme; feedback was received from staff on the possibility of patients choosing the site closest to home when there is no provision for them, especially elderly patients or those with disabilities where travel between sites is more of a challenge.

> *"How will elderly patients cope with care from two services?' [Staff, Some, D4]*
>
> *"Patients not always able bodied – transport further is more difficult" [Staff, Some, D4]*
>
> *"Anxiety for patients – need to manage expectations/experience" [Staff, Greater, D1]*
>
> *"A 'hidden group of people' not able to access services or ask right questions to continue patient choice." (Stakeholder, Some)*

Feedback on considerations for those with additional needs included comment on the existing provision for people with hearing difficulties. Concern around access to the correct care, as well as for example the booking of BSL interpreters was raised.

> *"ED access – major issues with hearing problems patients. Staff may not be able to book a BSL interpreter." (Stakeholder)*
>
> *"They [patients] often have to book their own interpreters/support to be able to communicate fully." (Stakeholder)*

There was also concern that BSL users' needs for communication support needed attention and that a breakdown in communication for these patients had impacts on care.

> *"Communication throughout the hospital is an issue as most are viewed as just elderly not actual BSL users. Deaf patients have often 'not needed' longer stays due to these communication breakdowns." (Stakeholder)*

There was a call for integration of BSL services to support this.

> *"STFT & CHS use different companies [for communication support]; they need to have one across both sites, preferably BSL." (Stakeholder)*

There was also comment on the cultural considerations for the process of change, in particular a question was raised as to how engaged people from Bangladeshi communities are in this process. The importance of the woman in the house having knowledge about accessing services was highlighted, particularly if the man of the house falls ill, was noted.

> *"They [Bangladeshi community] knew very little about phase 1 and know very little about these ideas." (Stakeholder campaign group)*

The need to make provision for disabled patients was raised by stakeholders.

> *"Disabilities are not being considered." (Stakeholder)*

> *"More interpreting and info services for ethnic minorities and refugees needed." (Stakeholder, Minimal, D3)*

> *"More facilities and services needed for disabled people – especially around travel." (Stakeholder, Minimal, D3)*

> *"Whole process is so detailed and complex that it risks excluding a huge part of the population." (Stakeholder, Minimal, D3)*

There was comment from some stakeholders who felt that the staff views presented do not represent all.

> *"Perception that the staff views are of senior people not of broader staff base or patient groups." (Stakeholder, Minimal, D4)*

The comments represented in *Theme 2: Travel and Transport* include issues for those who are vulnerable, but further comment was made by stakeholders.

> *"Planned surgery will now be additional distance for some; nothing in plans how vulnerable groups of people can access" (Staff, Some, D2)*

Stakeholder views on the Greater change working idea highlighted the potential to reduce access and choice. The removal of some provision at South Tyneside was not welcomed by several from the Stakeholder group discussions.

> *"Having no medical admissions would make it like a 'cottage hospital'." (Stakeholder)*

> *"Vital services should remain at STDH and vital services include an A&E." (Stakeholder, Greater)*

> *"No HDU at STFT will impact what is deliverable in planned surgery. "(Stakeholder)*

Other stakeholders felt more positive about the Greater change working idea, though this was caveated with the requirement that NEAS can provide appropriate Ambulance services to support the change.

> *"Improves training as Junior Drs will be working with more senior Drs. Junior Drs won't be left on their own." (Stakeholder, Greater)*

> *"Consultant rotas across both – positive" (Stakeholder, Greater)*

Stakeholders also wanted to ensure all patient groups were considered in the planning.

> *"No patient centred visions all around the services." (Stakeholder)*

Finally, there were comments from stakeholders about accepting change.

> *"Patients theoretically have less choice, but if the choice is 'best care' or 'choice of hospital' – you'd choose best care!" (Stakeholder, Greater, D1)*

> *"Public need to accept that there is one place for elective and another place for emergencies." (Stakeholder, Minimal)*

> *"Sometimes the best decision is not to give people a choice or decision - too much choice for people." (Stakeholder)*

This issue was linked to patient flow and the need for accurate modelling to plan for change – see *Theme 4: Patient flow and prioritisation*. It was also suggested by staff that what's needed is a 'change of mind-set' of patients with regard to how they access services.

5.8 Theme 7: Hot/cold site split

The development of an Integrated Diagnostic and Imaging Centre at South Tyneside was seen as a positive element by staff.

> *"The integrated diagnostic centre is positive to increase capacity/ability to respond to demand" [Staff, Minimal, D1]*

> *"This is positive for clinical changes and for patients" [Staff, Minimal, D1]*

> *"Positive – state of the art" [Staff, Greater, D1]*

The view of the Centre for Surgical Excellence at South Tyneside also very positive amongst stakeholders.

> *"Centre for Excellence – very good idea. Diagnostic Centre is very good and will improve current waiting times." (Stakeholder, Minimal)*

> *"Doesn't matter what site it's on as long as it delivers and improves." (Stakeholder, Minimal)*

> *"People will accept going to a specific location for specific ailments, if they get the best care." (Stakeholder, Minimal)*

In general, it was felt that the planned vs urgent care (hot/cold site) split was also a positive move.

"Less likely to cancel planned ops if not hot/cold sites" [Staff, Greater, D1]

"An opportunity to improve regardless, as bringing the two sites together" [Staff, Minimal, D4]

Both staff and stakeholders felt that there would be fewer cancellations for surgery when elective and trauma is split, meaning better patient flow.

"Creating a Centre of Excellence in ST will give moral boost for staff and patients: attractive." (Stakeholder, Minimal)

"Attempting to do activities on both sites / continues to confirm in peoples' minds that there is a gold standard." (Stakeholder, Minimal)

"An extra Diagnostic and Imaging Centre - makes more sense to do it at ST as a bigger site." (Stakeholder, Minimal)

There was also view that this would be supported by the public and the previous Stroke services example being positively cited.

"E.g. Stroke = people are warming up to going to one location for their care realising the benefits." (Stakeholder, Minimal)

"The work from Phase One has already proved that the results are there (strokes)." (Stakeholder)

Stakeholders commented that it was positive if staff are working across both sites and in bigger teams – helping to improve quality, learn from each other to improve patient experience. However, there was some comment from stakeholders about a potential to increase stress on staff at Sunderland.

"Same team but in different places – distance isn't a problem." (Stakeholder, Minimal)

"A lot of stress on staff (potentially) at Sunderland dealing with high volume of emergencies." (Stakeholder)

Despite the support for this, concerns about the loss of provision in South Tyneside were raised, as well as potential disadvantages for those with a care plan for long term conditions.

"More palatable for councillors to see that things will be given to South Tyneside (Centre of Surgical Excellence / Diagnostic Centre)." (Stakeholder)

BUT

"No local beds in South Tyneside." (Stakeholder)

"Concern regarding admission to/from STDG of those with Long Term Conditions - may fragment care for patients with individual plans with consultant and specialist nurse/teams." (Stakeholder)

There were comments and queries relating to how will the new provision would be staffed and if there would be an additional cost for this. In particular, queries about whether there would be private partnerships involved were raised by staff and stakeholders.

"Diagnostics centre – who is going to pay?" (Stakeholder, Minimal)

"Concerns if diagnostics privately funded – what will be the impact for the workforce?" [Staff, Minimal, D1]

"Diagnostics centre, how will it be handled and run – will there be private funded?" (Stakeholder)

"Will any private organisations be involved in providing the new ideas, particularly diagnostics?" (Stakeholder campaign group)

There was conflicting comment on the potential flexibility of the model.

"Splitting idea of emergency and planned = better outcomes using flexibility of having both teams split." (Stakeholder)

VS

"Lack of flexibility due to referral pathways." (Stakeholder)

Some staff had queries relating to this for the Minimal change working idea.

"Diagnostics need to be 247 – Minimal change won't work for this" [Staff, Minimal, D1]

"Is there capacity to do diagnostics?" [Staff, Minimal, D4]

Whilst the potential for a hot/cold split was not specifically challenged by stakeholders, some alternative options were also asked for which see less of a split across the two sites.

"Option – we'd like to look at retaining trauma at STDH under Some change and Minimal change." (Stakeholder Campaign Group)

"Access to full ED under some change – look at option of this instead of only urgent care." (Stakeholder)

"Having an ED is better for STFT" (Stakeholder)

"Can hot and cold sites be done differently? All a mix of hot and cold on both sites – mix it up or rotate." (Stakeholder)

"Could a hot/cold split be achieved at each site i.e. within current service arrangements?" (Stakeholder)

"Both sites should be excellence – elective and emergency." (Stakeholder, Minimal)

One stakeholder comment asked for the option of 'no change' to be included, although this was balanced with a comment around sustainability.

"We would like to discuss a 'no change' option." (Stakeholder, Minimal)

"NHS are not sustainable for the future so something has to change." (Stakeholder, Minimal)

Other comments on alternative options were also made by stakeholders.

"Could the services at each site not be rotated so clinicians move around rather that the patients?" (Stakeholder, Greater)

"Could clinicians rotate around the sites/patients and telemedicine be used to enable this?" (Stakeholder, Greater)

An area of stakeholder comment alluded to the potential negative connotation of a 'Centre of Excellence' and superior services on one site, not the other, with a suggestion to change this.

"The descriptions of the services at the two hospitals - 'specialist' and 'minor/less serious' implies a superior/inferior level of care and this in itself could contribute to inequity and negatively affect health inequalities" (Stakeholder, Greater)

"Make it a Dual Centre of Excellence – better way to describe. Would help create centre of joined up South Tyneside/Sunderland." (Stakeholder)

5.9 Theme 8: Referral and joined up provision

This theme was added following stakeholder feedback

Stakeholders fed back concern over referrals within the proposed models, reflecting staff comments in the previous events. There was seen to be a need for sufficient input from social care services to enable patients to be discharged as soon as is possible, and that this would require more confirmation and work on community links.

"Social care; wrap around care, impact on staff/ services including community." (Stakeholder)

"Include social care in discussion – as well as NEAS, OOH services and public health." (Stakeholder)

"Will there be links with volunteer organisations if the patients place of care is different i.e. operation at Sunderland but lives in South Tyneside?" (Stakeholder)

Comment on discharge and social care was again highlighted.

"Need more evidence and info regarding social issues on discharge from hospital. But focusing on hot and cold should improve sorting out social issues sooner." (Stakeholder, Minimal, D3)

"Too much uncertainty – need all bodies and services linking together." (Stakeholder, Greater)

"Follow up care should be closer to home. Happy to go further for surgery but follow up shouldn't be." (Stakeholder, Minimal, D2)

The need for prevention was also highlighted by stakeholders.

"Need to firm up the prevention, self-care (lifestyle change education required) and out of hospital care agenda in line with this, to ensure deliverability." (Stakeholder, Minimal, D4)

"Prevention and OOH to align at the hospital = CCG and GPs linking for the required engagement work" (Stakeholder)

5.10 Theme 9: Efficiencies and duplication

This theme was inherent across several of the other themes. Staff felt that efficiencies needed to improve and could be improved, suggesting ideas about ways in which they felt this could happen. Staff felt that better use of available space – assuming adequate staffing and appropriate skills were in place – could lead to more efficiencies.

"Currently there are empty wards that could be used" [Staff, Minimal, D4]

"Some facilities are not currently used – for example ED Resus, due to staffing shortages" [Staff, Minimal, D4]

"There are ways to addressing efficiency, such as using the side wards effectively" [Staff, Minimal, D4]

One area which was supported and it was felt would impact on efficiencies was the merger of the Trusts - planned for 1st April 2019 – and the 'coming together' more generally of the two hospitals.

"Merger drives changes" [Staff, Greater, D1]

"Support merging – assuming systems, resources etc. work for both sites" [Staff, Minimal, D1]

"Good idea to merge but still need huge investment in staff training as Theatre equipment is different on both sites" [Staff, Minimal, D4]

"More funding opportunities available" (sub-criteria 4) [Staff, Minimal, D1]

"More opportunities for both hospitals coming together. More job security and progression." [Staff, Greater, D1]

Some had further questions about bringing the two hospitals together, in particular how this will work when liaising with two separate Local Authorities and CCGs.

"Need to consider working with others – e.g. Gateshead and Newcastle – not been factored in" [Staff, Some, D4]

"Local Authorities need to be on board – it's a challenge to work with two different Las, and two CCGs" [Staff, D4]

"Need patients/system enablers e.g. integrated care teams, also community links e.g. geriatrics, services in the community" [Staff, Some, D4]

"Need proper integration with social care - Is there a benchmark for NHS working with Social Services?" [Staff, D4]

"Needs to be one pharmacy across both sites" [G D1]

Efficiencies was at the heart of the discussions around RAG rating the working ideas. Though concerns about recruitment and retention were expressed, the need for more efficient ways of working and systems to support his was a clear ask of the change ideas going forward.

"This option (GREATER) will reduce duplication and improve efficiency as a combined stronger site-specific service." [Staff, Greater, D4]

There was little specifically commented on about improvements in efficiencies/reductions in duplication in the Stakeholder sessions - which is to be expected this subject may be primarily visible to staff.

5.11 Theme 10: Systems management

The integration of systems through merger and closer working in bigger teams across sites was well supported, with some positive feedback.

> *"Already moving towards having joint systems - let's continue" [Staff, Greater, D1]*

> *"Sharing aspects of care improves patients experience and we have fewer complaints" [Staff, D1]*

> *"Improved efficiency" [Staff, Greater, D1]*

In particular, there was support for more integrated IT systems and staff wanted more information about how this would work.

> *"IT needs to be on same system – patient records accessible at all sites" [Staff, Minimal, D1]*

> *"Get reports back the day after, so need to keep patient in overnight. This needs to change, integration could reduce this" [Staff, Minimal, D4]*

> *"Need sharing across system – IT, patient records, NEAS" [Staff, Some, D4]*

> *"IT systems need to be integrated – there is a plan but it has not been shared with the workforce in detail and it's unclear how it will work" [Staff, Minimal, D1]*

For some, there remained questions, as well as queries about IT equipment provision under any changes.

> *"Currently IT issues – machinery broken" [Staff, D1]*

> *"Is there enough IT equipment?" [Staff, Some, D1]*

Suggestions were offered on possible systems improvements which may assist practically.

> *"Community service is using EMIS – different system. Needs to be integrated" [Staff, Minimal, D1]*

> *"Handhelds would be beneficial" [Staff, Minimal, D1]*

> *"Staff will need training on new systems" [Staff, Minimal, D1]*

Systems management was not an area commented on by staff, though positive comments were given.

"This should be taking place now. It's not necessarily any different? It's happening now." (Stakeholder, Greater, D1)

"Yes, there is an existing risk management in place." (Stakeholder, Greater, D1)

Risk management was seen as an important issue and staff saw benefits to integrating and standardising the approach. Generally, staff felt that this was something they can do well across the two hospitals, taking the best from each site.

"System risk management shouldn't be problematic if both on same system" [Staff, Greater, D1]

"Better if standardised, to become uniform across sites" [Staff, Some, D1]

"E.g. R&D reduced infection risk. Should continue" [Staff, Greater, D1]

"Already working in South Tyneside" [Staff, Some, D1]

Patient safety was specifically cited in relation to risk management, with risks related to staffing levels and transfer – covered more fully in *Theme 2: Staffing, recruitment and retention* and *Theme 3: Travel and transport.*

"Need to ensure patient safety – currently not enough staff, sickness etc." [Staff, Greater, D1]

"What about a patient being discharged from one site then having a complication – where so they go back to?" [Staff, Greater, D1]

"Potential safe-guarding issues whilst transferring patient from site to site e.g. what happens when a vulnerable person (e.g. child) attends A&E after 10pm at night?" (Stakeholder, Minimal, D1)

There was sometimes disillusionment within the staff groups about not capturing positive patient feedback.

"We only hear complaints; no-on has time to record compliments" [Staff, D4]

5.12 Theme 11: Communication, definitions and planning for change

Communication was seen as a key element in both successful planning and successful delivery of all the working ideas. This applies to staff and systems as well as patients and the public.

Staff participants commented on the need for continuous dialogue with all staff on the issue well in advance of decisions being made and for staff engagement to be a key part of the process.

Some cited worry and illness resulting from the stress of the change process, which they saw could be improved with good communication.

> *"Needs more 'organisational openness', all staff informed" [Staff, Minimal, D4]*
>
> *"Management need to communicate with staff about the changes – currently there is sickness, stress and worry" [Staff, Minimal, D4]*
>
> *"Need to ask and listen to more staff opinion" [Staff, Minimal, D1]*

The need to get staff 'on board' with the proposed changes was also a key element of this theme.

> *"Having staff on board with the delivery is crucial" [Staff, Greater, D4]*
>
> *"Communicate more in advance – feeling that we get to know last minute" [Staff, Some, D4]*

There was a clear view from staff that good communication with the public will be critical to avoid confusion, which could lead to patients not finding the right service in the right place at the right time, putting them at risk. Patient safety was suggested as a rationale for the changes and important to feature in any communication with the public.

> *"Confusions for patients" [Staff, Greater, D1]*
>
> *"Needs to be sold positively to the public – and avoid mis-understanding" [Staff, Minimal, D1]*

The need for clear communication with the public about where to go for what services was also highlighted by stakeholders, reflecting earlier staff discussions.

> *"Worry that people might not be clear on where to go for what for emergencies (Grey areas)" (Stakeholder)*
>
> *"Patients may not understand which site they need to be at which could cause major incidents." (Stakeholder, Greater)*
>
> *"There needs to be an awareness campaign/ targeted communication campaign/pilot study with public as to what they perceive as an emergency." (Stakeholder, Greater)*
> *"Communication before any change is key. Need to think about how." (Stakeholder, Greater)*
>
> *"Let the public know it is for the safety of patients" [Staff, Some, D1]*

Significant comments on the need for robust communication with the public – both in terms of what the options for change are in simple terms as well as the process of engagement and consultation, were given by stakeholders – covered in the added *Theme 7: Additional information and framing*

There were some specific comments about the working ideas.

> *"Minimal change may impact on staff morale – need clear communication and listen to all staff feedback is essential" [Staff, Minimal, D4]*

"Provided the public know they have somewhere to go, Greater change will be easier for them to understand" [Staff, Greater, D1]

In general, there was a feeling that communication about change is something that can be acted on now, using effective communication and engagement methods. There was a sentiment from staff that the public will come on board with the changes once the changes lead to positive experiences for them and their friends/family.

"Need to know what's going to happen and get on with it!" [Staff, Some, D1]

"We will need good education and advertising on this" [Staff, Some, D1]

"Public need time to adjust, but will respond when others have positive experience and service" [Staff, Greater, D1]

There was some comment on communication between depts., in particular to have an integrated communications system across sites to work together.

"111 streaming – will it be right?" [Staff, Greater, D1]

Linked to communication, staff participants felt that the definition of key terms and pertinent issues should be explained. 'Workforce', 'elective vs emergency' and 'same day emergency care' were terms mentioned.

Stakeholders advised that definitions of the language around some terms – specialist, minor, less serious – was seen as a need. 'Ambulatory Care' was a term to avoid, in favour of 'same day care' which makes more sense.

Specifically, clarity was requested around the definitions and use of 'emergency' 'potentially', 'proportionally', 'accessibility' and 'appropriate' in the resource pack and materials produced.

"Needs to be more research into what patients perceive as an emergency." (Stakeholder, Greater)

Planning for the change, again linked to communication, was seen as key to improving staff morale and positivity about the process and getting systems ready. Receiving briefings in advance, being engaged for opinion and supported through the process were all needed.

A lack of clarity on timescales was also raised as an issue.

5.13 Theme 12: Impact and future-proofing

A longer term view was evident in some of the feedback and though there were obvious concerns, many of which have already been detailed in the preceding themes. Staff fed back under this theme; it was not specifically part of stakeholder comments.

In general there was great support for change and some positivity about the future. This was less true for the Minimal change idea and more applicable to the Greater change idea.

"We can't carry on as we are – if we don't work differently we are at risk of losing services anyway." [Staff, Some, D2]

"Aligns to national direction of specialist centres and e.g. Hartlepool/Northumberland" [Staff, Minimal, D4]

"Minimal change doesn't support the other services or Transformational plans because there isnt enough change" [Staff, Minimal, D4]

Main concerns about the potential to future-proof the plans were around the capacity to meet demand, the need for good planning and adequate funding. Sustainability and the need for an approach that has longevity was also flagged.

"Amount of work is going to increase – do we have capacity to accommodate?" [Staff, Minimal, D4]

There was an obvious concern about lack of investment to support the changes and the massive investment needed, although event organisers had asked participants to assume the funds for change were forthcoming for the purpose of the exercise.

There were requests for information on the regional Transformational plans as well as examples of good practice from elsewhere on predictive future health needs.

Specifically, the effects of integrating and merging on Research and Development was commented on positively by all as a future gain.

"More attractive and more time to do research" [Staff, Some, D1]

"Easier to build networks for R&D when bigger" [Staff, Minimal, D4]

Innovation as a technique to support change into the future was also commented on.

"Remote working and access – new models e.g. NHS digital, costing dependent" [Staff, Some, D1]

Comments about the role of prevention in future impacts were given and the need for early action to improve the population's health was recognised.

"Prevention action hasn't been implemented early enough" [Staff, Minimal, D1]

5.14 Additional Theme: Clarity of information and framing

This theme was added following stakeholder feedback

There was a clear call for more information and detail around the working ideas, especially from stakeholders. Information and data/evidence for, as well as projections compared to current provision.

It was generally felt that the full impact of a particular working idea could not be fully assessed because the information was not available to do so. Several tables fed back that they felt underequipped to make comment on, or to RAG rate in a few cases, the working ideas.

> *"More details on specific offering may be essential for public consultations." (Stakeholder)*
>
> *"Data pack / evidence pack to sit along services is needed" (Stakeholder)*
>
> *"We need more detail about how the idea [Greater] would work – maybe use examples of patients and how they would be affected." (Stakeholder, Greater)*
>
> *"Need more detail for services on each site – use examples that public can follow relate to." (Stakeholder, Greater, D1)*
>
> *"If we do not get any capital funding, what will happen?" (Stakeholder)*
>
> *"Unknown benefits and risks in all aspects" [Staff, Some, D4]*

Specifically, there was concern from stakeholders that fewer beds would be a problem – as has historically been true - and the need for more detail around any bed reduction in each of the ideas to inform decisions.

> *"Impact on both sites [Greater change] need details (CCU/ICCU beds)" (Stakeholder)*
>
> *"Need detail on beds, correct level of staffing and capital required" (Stakeholder, Greater, D3)*
>
> *"Will this (Minimal change) have any effect on ITU and medical wards? Is there any change in number of beds? Is there work being carried out on bed number detail?" (Stakeholder, Minimal)*

There were fears that even the Minimal change idea will result in bed reductions, which was believed to have historically resulted in many NHS problems. Stakeholders fed back that more patients at Sunderland could be an overcrowding risk and may exacerbate existing competition for beds, especially during periods of winter pressure.

There was an additional comment for more information on patient journeys and the role for staff continuity in handling this.

> *"View from complex patients – flows of patient journeys e.g. on admission to South Tyneside, on admission to Sunderland; staff handler continuity of care." (Stakeholder)*

One stakeholder discussion summed up an area for clarification.

> *"We would like to think this is a pre-consultation and not 'This is going to happen'. i.e. we would like to think this will influence what happens." (Stakeholder, Greater)*

There were strong requests for the wording in the document to be in layman's' terms – covered in *Theme 7: Communication, definitions and planning for change*

In addition, some fed back issues with the information and the format of it e.g. feedback about the criteria suggested that there was too much to consider.

> *"The booklet states change in 1-3 years but the emails and documents are saying 1-2 years, which is it?" (Stakeholder)*

> *"Domain1 has too many points to consider." (Stakeholder, Minimal, D1)*

> *"Some of this could be green, amber or red; this is too much info to look at [Domains]. It needs to be more specific on each domain as it's currently a mixture of many different things." (Stakeholder, Minimal)*

Several stakeholder discussions wanted more information about how the three working ideas in the future compare to the current situation and felt there was not enough information about this in the documentation. Suggestions were made.

> *"Presentation of working ideas needs to be clear/detail around the change on both sites - current vs future." (Stakeholder)*

> *"Could there be various case studies / health scenarios of patient pathways for each type of change so they can be compared side by side?" (Stakeholder, Minimal, D4)*

> *"Could we have an easy view/summary of the current state services in relation to the future states in the ideas so we can see the differences more easily?" (Stakeholder)*

> *"Have a clear list of current state services and how that would be against each working idea, so we understand what will go where." (Stakeholder)*

The way the Domain statements were phased was commented on – some questioned the working idea, others were noted as a 'command'.

> *"This (Domain1, sub-criteria6) is a command. All we can do is agree. Do we think that it will? That's a different Q." (Stakeholder, Greater, D1)*

> *"This (Domain1, sub-criteria8) is another command! Change the word 'must' to 'will'. Incorrect use of a verb!" (Stakeholder, Greater, D1)*

"The word 'maintain' not relevant (Domain1, sub-criteria1)" (Stakeholder, Greater, D1)

"Rather see 'reducing' than 'mitigating' (Domain 3, sub-criteria 2)." (Stakeholder, Greater, D3)

There were also more general comments on presentation of information about changes to keep these equally positive.

"Wording in document – need same level of care/quality of care on both sites." (Stakeholder, Greater)

6 Staff: Comments by working idea (RAG rating comments)

Below are the key comments relating to the three working ideas which participants fed back whilst RAG rating the ideas. The full RAG rating breakdown can be found in APPENDIX 5

Although the numbers of participants evaluating each working idea varied, with MINIMAL change being discussed by fewer participants than either SOME or GREATER change, in this qualitative assessment the collective comments are equally valid across all three.

6.1 MINIMAL change – Staff RAG rating comments

Overall RAG rating staff comments: MINIMAL change / Domain1:

"Overall rating RED, because Minimal change is only moving around rather than addressing the issues"

"Minimal change may not achieve the changes needed with regard to sustainability workforce"

"Is it likely that there would be a natural change from Minimal, to Some or Greater change, over the next 3 years anyway?"

"Need to be careful of language used – e.g. 'enhance', 'exceed' – under this model"

"Grave concern about staffing and beds. Minimal change does not provide enough change to address the current and ongoing issues"

"I think this change will make people move around more which makes this worse and I think more staff will leave"

Overall RAG rating staff comments: MINIMAL change / Domain4:

"AMBER because at best the plan meets requirement, but due to questions about workforce and how the community models fit/work with the plan"

"Deliverability depends more on capital – but with prevention services cut it means we can't provide capacity for demand"

"Overall rating RED – because we need to know more about numbers, projected metrics, service demand and predicted flow to be able to influence the deliverability, plus confirmed access to capital"

"Minimal change = more achievable but less effective"

"The services need more of a change to improve. There would need to be more financial investment for positive change"

"Don't feel like the Minimal change is big enough to positively impact the changes needed"

"Other areas such as social care has an effect on capacity – Minimal change doesn't address this"

"No confidence in the Minimal change – if we are merging, we should merge"

6.2 SOME change – Staff RAG rating comments

Overall RAG rating staff comments: SOME change / Domain1:

"Safer model in having some medical intake compared with Greater change"

"Do-able, can see benefits - it's how we deal with hurdles"

"Is there an example elsewhere in the country where this has worked – as a measure for getting this right?"

Overall RAG rating staff comments: SOME change / Domain4:

"Ideas are all brilliant – but can we deliver?"

"Any plans need to be doable – concern won't see changes in secondary care until 10/20 years"

"Add 'Manage patient flow safely across all sites' to the sub-category 2"

"Major problem with patient safety at weekends/OOH - any idea that meets 24/7 for acutely ill patients has to be better"

"We see very little evidence of cross boundary working to deliver the plan"

"In conclusion the group were positive that if this was done correctly and worked then it would be great – just massive reservations at present with the lack of info on how it will be delivered"

6.3 GREATER change – Staff RAG rating comments

Overall RAG rating staff comments: GREATER change / Domain1:

"Will increase access"

"More opportunities for both hospitals coming and working together"

"More elected orthopaedics/trauma etc. means more scope to develop and better staff retention"

"Won't meet waiting time targets"

"In terms of critical care this is definitely a beneficial idea"

"This option is clearer for patients on what is where"

Overall RAG rating staff comments: GREATER change / Domain4:

"If get Domain1 right, Domain4 future proofing can be achieved"

"In theory the plans seem doable" (table of AHPs)

"GREEN for medical/nursing staff. BLOOD ORANGE for admin staff"

"Short term instability, long terms sustainability"

7 Stakeholders: Comments by working idea

The stakeholder sessions were less forthcoming in terms of gaining a consensus RAG rating and several of the discussion groups did not RAG rate the working ideas overall. However, specific comments related to the ideas, beyond those more generally fed back and included in the Themes above, were noted. These are presented below.

The numbers of participants evaluating each working idea varied. The Stakeholder sessions were designed to be a 'balanced table' of invited participants and therefore were limited in number, though it should be noted that the Some change working idea was only discussed by one table of 4 people.

Stakeholder RAG ratings breakdown can be found in APPENDIX 6

7.1 MINIMAL change – Stakeholder key comments

Similar to staff, stakeholder comments included the view that Minimal change, though supported by some, would not go far enough.

> *"This doesn't have enough change; it may not enhance recruitment or solve any major issues going on currently."*
>
> *"Minimal change is always the easiest option. But this won't achieve the kind of impact that we are looking for"*
>
> *"This panders to the perceived need of the public – short term not long term. Its attractive to the public but doesn't solve problem."*
>
> *"If you're adapting for the future, it isn't enough."*
>
> *"it's not bold enough as a concept, won't give us a good return in the long term."*
>
> *"Minimal change would provide better recruitment, retention, quality of service, financial issues. However, there are much bigger issues to consider and address to ensure full successful deliverability e.g. considering new technology, remote consultations, Telemedicine."*

There were general comments in the summing up for this working idea.

> *"Need to make sure people are going to the right places and they know where to go."*
>
> *"Urgent care centres are big issues; they can't cope as is so how will they cope with extra STFT patients?"*

Sometimes differences between disciplines was alluded to amongst stakeholders e.g. Domain1 (sub-domain3 around enhancing recruitment and retention etc.) was given GREEN for Surgery and

AMBER for Medicine. Some stakeholders cited a lack of information for their RAG rating, whilst others refused to RAG rate without further information.

"AMBER – because a lot of detail is missing so it is hard to make decisions."

"None of this [D1] is GREEN as there are too many questions around each point that need to be clarified."

"Very hard to decide these points without more facts."

"We refuse to give any ratings due to lack of clarification and more information required."

7.2 SOME change – Stakeholder key comments

Some change was seen as a reasonable middle ground.

"This will be safer [than Minimal change] as complex will go straight to Sunderland"

"Capital investment is not as high but there are still benefits."

"A bit more scope [than the other working ideas] for keeping staff."

"You're being referred to the right place by triage - cuts down the number of people walking into A&E."

However, pressures on staffing were still foreseen by stakeholders in this change idea.

"Doesn't address the staffing issues, pressures on staff, motivations."

"Staffing pressure still remain in acute medical beds."

The working idea was primarily RED RAG rated overall though Domain1 was rated AMBER (Domain1 was discussed most thoroughly in the sessions). The issue of access and choice could move towards AMBER for some, based on the fact the idea involves far less service change than the greatest change idea and less travel for South Tyneside people.

For Some change, more information was again requested by stakeholders to make an assessment.

"Potentially some change could deliver but not enough info available regarding details - specifically risk management, and clinically safe distances and travel time"

7.3 GREATER change – Stakeholder key comments

Greater change attracted both positive and negative comments. Again there were lots of questions about the working idea and it was felt that more information was needed to assess this under Domains.

"Can't assume. We need more evidence and info."

"We need to see statistics."

"We can't say the idea is deliverable because it is reliant on capital funding."

Although a lack of information meant that the Domains couldn't not be fully assessed in the eyes of some stakeholders, they gave some positive comment on the change idea, especially around staffing.

"This has already been evidenced in 'stroke". I think this will happen with the greater change model."

"Greater change will help staffing issues, plus the opportunity for staff to learn new skills."

"Greater change gets the economies of scale for staffing in some areas."

There was some negativity about this working idea from some stakeholders.

"Not sustainable or deliverable due to capacity/services on site."

"Fear of what STDH will become."

"Greater change doesn't acknowledge follow up care."

"Patient access and choice (Domain2) has not been addressed in Greater change."

Deliverability was generally viewed positively for this working idea, with caveats that services are more integrated.

"If we've got the funding – yes (Domian4)!"

"Potential [for robust workforce development plans] – because you'd have the staff "it's your seed corn"

RAG ratings overall were primarily AMBER with some RED.

"Possible AMBER (D1) – Long future view."

"GREEN will need time for people to get used to so can't be green now."

"AMBER because of lack of detail and uncertainty. Need to know what support services and bodies are doing as they all link together. Are the other bodies buying into the changes? Need more communication!"

"D4 – positive: from a medical staffing perspective only, it would work"

Greater change was seen as the most ambitious, though this view was not as common amongst stakeholder as it was among staff.

"It the most aspirational - patient outcome, mortality, long term future of the Trust as a whole. Improving the health of the whole community."

8 Summary

The staff and stakeholder events were designed to test the draft desirable 'evaluation criteria' against the three working ideas proposed and this was done comprehensively by participants. However, the sessions also provided valuable staff and stakeholder engagement on the working ideas for change, facilitating the opportunity for those present to feed into the process and offer their insights into how the working ideas might fare in practice, from the point of view of a range of professions and settings. In this way, the themes which have emerged can support further development of the proposals by the Programme team.

The main feedback from each of the working ideas can be summarised in turn.

8.1 MINIMAL change

The overarching general feedback from participants was that there were lots of unknowns about this Minimal change idea, including how staff rotas will work, how the operational practices will integrate and the links to community services. There was a recognition that effective workforce planning and realistic management would be essential.

There were concerns about staffing issues in particular. There was concern about patient safety, safeguarding and competencies for staff moving around sites and departments – for example in the use of unfamiliar equipment and inability to access records. In terms of provision, non-247 diagnostics was viewed negatively.

In particular, concern about the need for training/re-training and the ability of this approach to get it right in terms of having the right staff competencies in the right place when they're needed. Issues around more travel between sites and the anticipated additional staff stress arising from this working idea were also raised.

Some efficiencies through rota changes were seen to be possible and working in bigger teams received support, to improve contact between staff and in terms of flexibility. The participants requested to see a more comprehensive workforce development plan, which may answer some of the questions posed about how this change idea might work in practice.

The working idea was seen as having potential for increasing staff recruitment, but not staff retention.

The RAG ratings given to this working idea overall were primarily Red with almost as many Amber ratings, alongside many operational questions linked to both. There were no Green RAG ratings overall for this working idea.

Aside from the operational concerns, Minimal change was seem by many to not go far enough to achieve the impact needed, coined well by one participant as 'Minimal change = more achievable but less effective'

8.2 SOME change

In Some change, the move towards hot/cold sites was seen as a positive, supporting increased efficiency. The proposals were generally well received, though there was some doubt as to whether they could be achieved in practice.

Participants saw a potential for Some change to provide more access to specialist opinion and could cite other successful models using this Triage approach successfully (Northumberland/Hartlepool). Despite this, a worry about de-skilling staff arose, especially at South Tyneside if there were reduced emergency admissions and staff moving between sites was not generally seen as positive.

There were several questions arising which revolve around how and where people will present and the case mix, for which the current information did not give answers to enable assessment of the working idea.

The vast majority of RAG ratings for this working idea overall were Amber, including several 'Amber-Green' and 'Amber-Red' variations. Only one table gave Some change a Red RAG rating and there were no Green RAG ratings for this working idea.

8.3 GREATER change

The Greater change working idea attracted a range of views, but of the three approaches participants offered the most positive support to this working idea. This was primarily because they felt this approach:

- offered the best approach in terms of improving staff recruitment and retention,
- provided an opportunity for bigger operational efficiencies, and
- was needed in order to have the impact on care longer term.

Words like 'exciting' and 'confidence' were used in relation to Greater change – which were not recorded in discussion of either of the other two working ideas. It was also felt that the clarity of this model would result in less patient confusion.

However, support for the expected staffing benefits in this model was caveated with concern for the lower grade and admin/clerical staff, whom it was thought would be disproportionally negatively affected – through staff cuts, work pattern changes, lack of opportunity and stress.

Capacity limitations was a bigger issue in this working idea, especially at Sunderland. Participants expressed concern about an increased demand when it was felt that the situation is already overwhelming in planned care and both sites currently deal with high volumes.

The concerns around clinically safe transfer times and the assumption about 'place of safety' were again raised for Greater change.

However, there was a feeling that this model offered the most opportunities, and as one participant suggested, 'short term instability for long term sustainability'. In terms of the evaluation criteria considered, it was felt that delivery of Domain1 remains key to success in Domain4.

Greater change was the only change idea which received a Green RAG rating overall (i.e. neither Minimal change nor Some change were rated Green by any of the tables of participants), with several Amber ratings. However, RAG ratings were split for this working idea and it should be noted that several tables did give this approach a Red rating.

The RAG ratings breakdown by domain and change idea fed back by staff can be found in APPENDIX 5

8.4 Collective summary

General findings which are relevant to all scenarios were the main feedback received from staff and stakeholders and therefore a general collective summary is useful.

Risks highlighted by the staff and stakeholders participating in the events focused on a number of areas. Patient safety and the need to ensure this in any new scenario was top priority. In particular, the issue of critically safe transfer times in an emergency was seen as a risk which requires more exploration to understand how this will be mitigated in any change approach. Linked to this, patient flow management was an area where participants felt that more and accurate modelling is required.

In terms of staff, risks around current and future recruitment, the impact of the different 'offers' of the two sites and the size of the training/re-training task were all highlighted. The drive to recruit necessitates attractive packages and the need for ongoing opportunities for staff skill development were both commented on – as well as the risk to recruitment and retention of not doing so in any model. In addition, limitations of the physical space for any expansion to accommodate services, patients and staff was of concern, for both clinical and surgical provision as well as other Estates issues such as car parking.

Linked to both patient flow and capacity is the commonly fed back need for more comprehensive workforce development plans and the view from participants that matching accurately predicted patient flow with staffing and competencies would reduce risks here. In particular, the need for all services to be engaged across the system to facilitate patient journeys was emphasized – especially links to social care and community provision.

A lack of clarity about who could be treated where was anticipated as an issue, requiring a big communications task to avoid potential public confusion about where to get help for different conditions or treatments - which could also impact on patient safety. The warning that clear and timely patient information and communication to reduce confusion and increase accurate self-presentation was given, as was a strong view that engaging staff in advance to get them 'on board' with the changes is essential. In addition, supporting staff through the transition was seen as important to all, with a focus on team building and consideration of part time staff, family commitments and any impact on home life.

Travel and transport for both staff and patients were highlighted. Though the need for better transport links was a common theme, including for staff, there was no consensus that this would be a significant issue for patients – especially those with additional needs – though some suggested that patients already expect travel and would be happy to travel to a Centre of Surgical Excellence at South Tyneside (STDH). This was caveated with the need to make provision for more vulnerable patients and their families or visitors – for example the elderly, those with long term conditions or single parents. The issue of access and support for those with specific needs e.g. hearing difficulties, cultural needs, was also raised.

The issue of reduced capacity was translated into potential risk - for example if all emergencies were not treated in South Tyneside, this would present a risk to the patient. The issue of what constitutes a 'clinically safe transfer time' was debated - for example for the scenario where there are unexpected complications during a routine or non-urgent procedure in South Tyneside, requiring the facilities at Sunderland. There was a common concern that critically safe transfer times need to be defined and used in ongoing development of the change options. This was seen a key issue for the hot/cold models proposed and one which needs attention in developing the next stages to be reassured that patients are not at risk through the split site provision.

In addition, staff were concerned that any request for an Ambulance from South Tyneside would not be prioritised because the patient was at a 'place of safety' – even though the staff on site deemed the patient in need of urgent transfer, without the skills or equipment to support an emergency. This is an area for which The impact on NEAS; ensuring that the Ambulance Service has the capacity to meet this additional need was raised and more liaison with NEAS was requested.

Areas that were well supported irrespective of the level of change being proposed were the establishment of a Centre of Surgical Excellence at South Tyneside and the new Diagnostics facility. Despite the uncertainty around staffing and flow, these were a cause for excitement and positivity. The Centre of Surgical Excellence was seen as a real opportunity for personal development as well as a tool for recruitment and retention of much needed specialists.

The development of hot/cold sites was viewed positively, in terms of the increased efficiencies of split sites and associated benefits for waiting times, including reducing the current wastage of

elective procedures being cancelled. In addition, the efficiencies gained from working differently, across bigger and more integrated teams and systems, was welcomed by the majority.

In general, there was a view that the changes affected South Tyneside more negatively in terms of staff recruitment and retention and that this may lead to fewer opportunities for staff, lower morale and the hospital becoming a less attractive site to work.

There was a call to start preparing now, to give a longer lead time for developing the plans, including staff engagement in advance.

Although not all comments were attributed or related to specific staff groups, there appears to be more support for change amongst surgical staff, with mixed support from clinical staff, many operational questions from therapies staff and concern about the impacts on admin/clerical or less senior staff.

In terms of RAG rating the working ideas overall – which are an indicator only, not a scientific assessment - the majority of ratings were Amber, reflecting the stage of development of the working ideas and that further information to make fully informed decisions was requested, such as the workforce development plans, patient flow modelling and critically safe transfer times already mentioned. Some did not feel equipped to make assessment of the working ideas without this. It is also worth noting that within the Domains, a range of views and RAG ratings on the sub-criteria - across Red, Amber and Green - were expressed, suggesting that the Domains as they currently stand cannot be easily assessed as a whole and that the aspects contained within them are viewed differently by staff and stakeholders.

However, there was a general recognition amongst most that to counter the current NHS staffing crisis and provide the level of service in the appropriate way for the population served by the Trusts, small changes won't have the impact needed. Participants highlighted the need for more radical action which can take effect quickly and a desire to create a model that is future proofed.

9 APPENDICES

9.1 APPENDIX 1 – Hurdle criteria

Hurdle criteria applied to long list of ideas:

Hurdle criteria		
Does it support sustainability?		
Does the scenario support service sustainability from a clinical workforce perspective?	Does the scenario support service sustainability from a clinical activity perspective?	Does the scenario support appropriate activity being moved from acute to primary and community care settings?
Does it deliver high quality, safe care?		
Does the scenario improve or at least maintain quality than that delivered in current service configuration?	Does this scenario deliver relevant quality/safety , experience standards and regulatory requirements for the service areas?	
Is it affordable?		
Does the scenario improve financial sustainability across the health care group and make a positive contribution to closing the STP forecast financial gap for 20/21?	Can the scenario be delivered within available capital resource?	Is the scenario deliverable without any additional significant cost impact to commissioners and the wider healthcare system?
Is it deliverable?		
Does an assessment of clinical co-dependencies suggest any delivery challenges can be addressed?	Is this option deliverable within the next 1-2 years	

9.2 APPENDIX 2 – Staff event timetable

Applying the Evaluation Critera - Staff event timetable example:

Staff workshop agenda – applying evaluation criteria

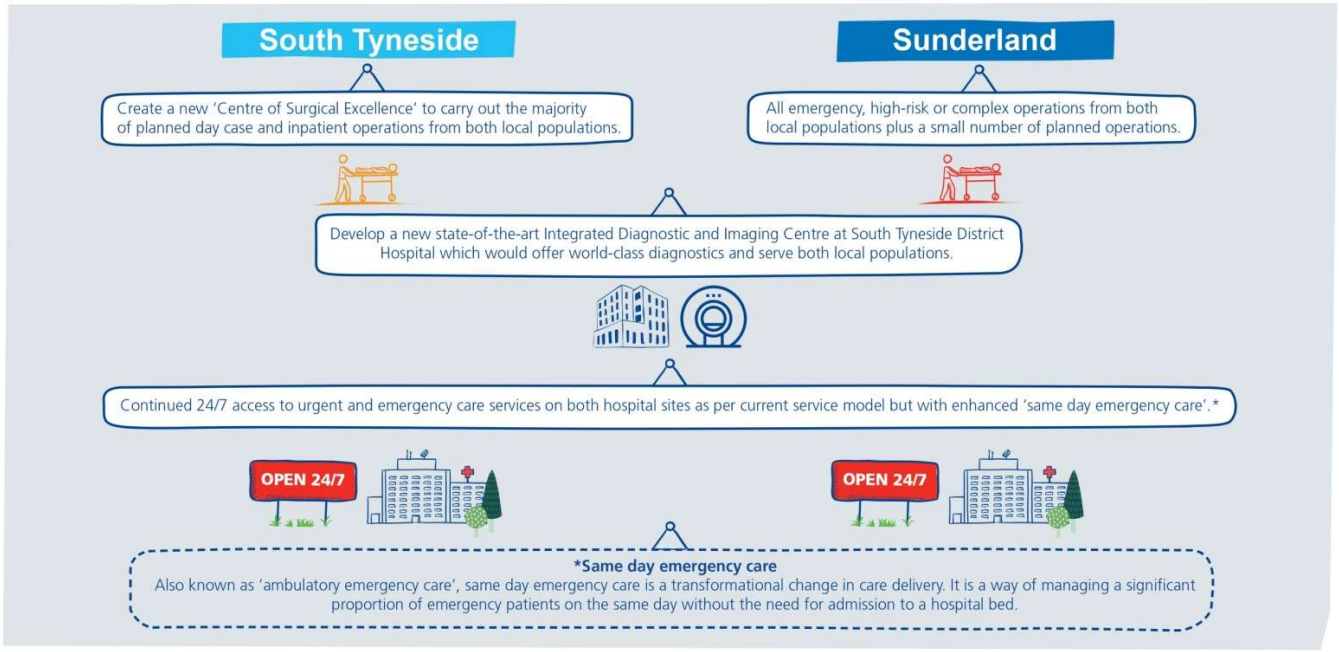
Thursday 28 March 2019, Clarion Hotel, Boldon

Item	Lead	Time	Duration
Welcome and introductions	Room MC – Caroline Latta	8.30am	5 mins
Background	Clinical Director – Dr Shaz Wahid	8.35am	20 mins
How the event is going to work	Caroline Latta	8.55am	10 mins
Table introductions and agreeing your table rules	Table facilitators and scribes	9.05am	10 mins
Emergency and acute medicine – Minimal change Present the working idea	Jill Simpson – programme team	9.15am	20 mins
Emergency and acute medicine – Some change Present the working idea	Jill Simpson – programme team	9.35am	20 mins
Emergency and acute medicine – Greater change Present the working idea	Jill Simpson – programme team	9.55am	20mins
Table work assessing the ideas: - Minimal - Some - Greater	Room MC and tables	10.15am	1hr 20mins
Tea and coffee available from 10.30			
Review of overarching RAG rating	Room MC and ALL	11.35am	20 mins
Coping with change	Clare Simpson – Wellbeing Team	11.55am	40 mins
Wrap up and next steps		12.35pm	5 mins
LUNCH and Networking			

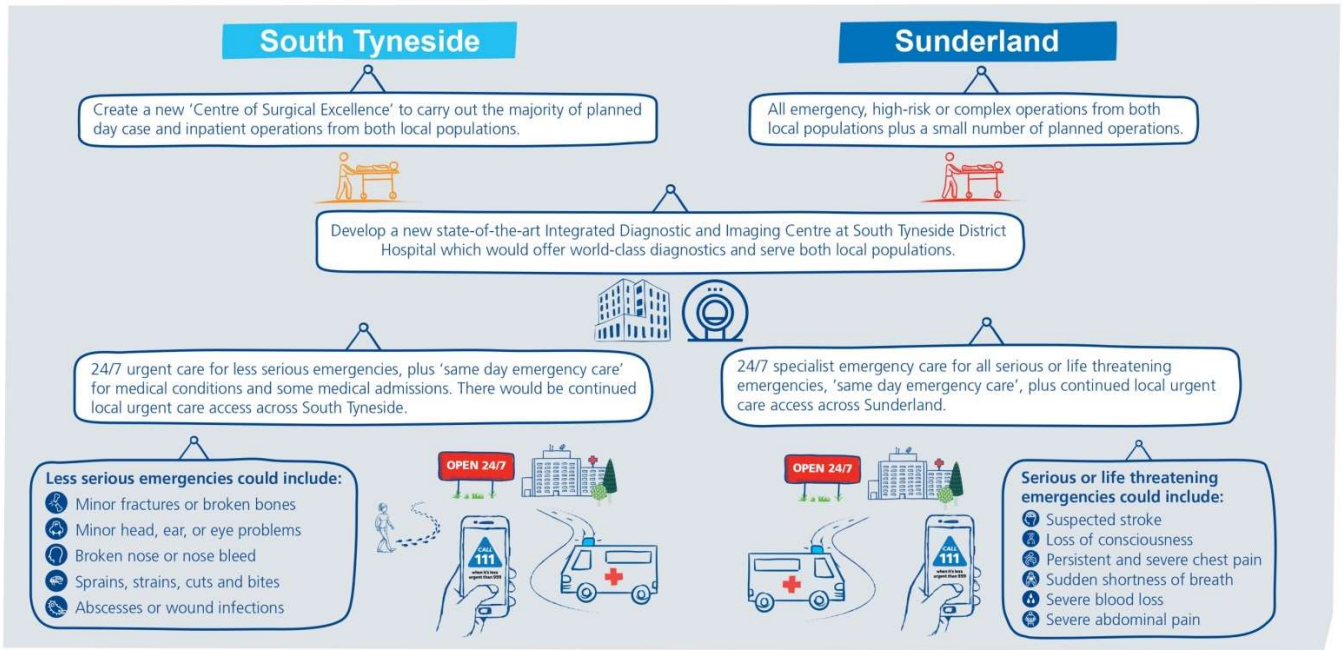
9.3 APPENDIX 3 – Working ideas

The three delivery model options, referred to as 'working ideas' - detailed infographics:

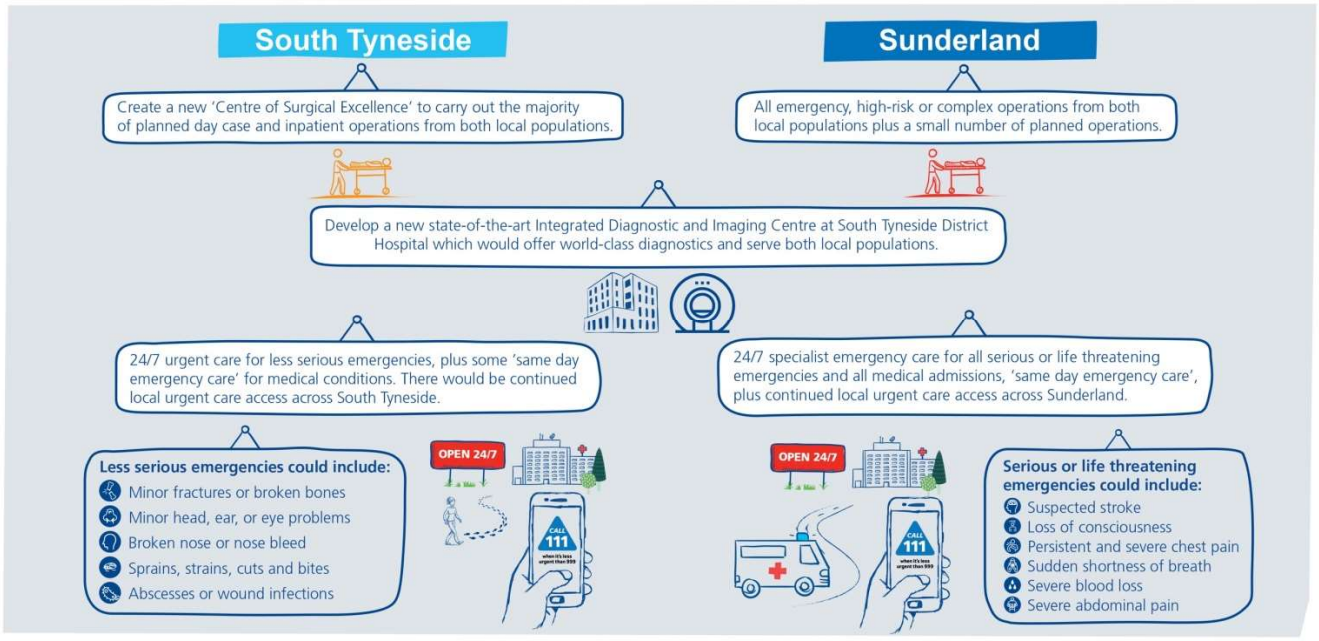
MINIMAL change



SOME change



GREATER change



9.4 APPENDIX 4 – Evaluation criteria

Evaluation criteria domains – full sub-criteria detail:

Domain 1: Quality, safety and clinical sustainability
1. Exceeds and maintains all core workforce standards 2. Delivers the correct number of staff with right competencies 3. Enhances recruitment and retention through the delivery of good working patterns and development opportunities 4. Creates capacity to increase opportunities for clinical research and innovation 5. System risk management processes can be safely put in place and monitored, for example safeguarding, complaints, complements, patient experience and reflect multi-agency approach where needed 6. Must deliver clinically safe distances and travel times to access services (including transfer between services) in line with national time access targets and guidance 7. Ensure appropriate access to specialist clinical opinions and diagnostic tests in line with national guidance 8. Must deliver access to planned care and follow up services in line with waiting time guidance and patient choice
Domain 2: Access and Choice
1. Ensure any accessibility challenges for patients, visitors and staff are proportionately addressed 2. Deliver joined up care close to home when this is safe to do so 3. Minimise any travel impact for patients, families, staff and visitors.
Domain 3: Equality, health and health inequalities
1. Make a positive impact on improving people's health, equality and reducing health inequalities and mitigating inequality risks where they occur. 2. Must improve and maintain health outcomes for all people that use hospital services.
Domain 4: Deliverability
1. Ensure there is capacity to accommodate predicted future health needs and projected increase in demand 2. Enough capacity to manage patient flow across all local hospitals 3. Robust workforce development plans to be able to implement and sustain new way of working 4. Complements or is supported by other relevant services and transformational plans across the region.
Domain 5: Financial sustainability
1. Can be implemented and funded in the long term within available resources

NB: Domain 5 was not considered in the workshops

9.5 APPENDIX 5 – Staff RAG ratings breakdown

NOTE: Gaining consensus on RAG Ratings was intended as a discussion tool. They provide useful indicators only and are not intended for comparison or as scientific absolutes.

Twenty-three tables fed back on both Domains1 for one allocated working idea (MINIMAL, SOME or GREATER), though one table covered two working ideas, therefore 24 table RAG ratings were analysed. Of these, 32 ratings were AMBER with only three GREEN and 13 RED.

MINIMAL change	**Green**	Amber-Green	**Amber**	Amber-Red	**Red**
Domain 1	0	0	2	0	4
TOTAL	**0**		**2**		**4**
Domain 4	0	0	3	0	3
TOTAL*	**0**		**3**		**3**
MINIMAL change total	**0**		**5**		**7**

SOME change	**Green**	Amber-Green	**Amber**	Amber-Red	**Red**
Domain 1	0	1	7	1	0
TOTAL	**0**		**9**		**0**
Domain 4	0	1	4	3	1
TOTAL*	**0**		**8**		**1**
SOME change total	**0**		**17**		**1**

GREATER change	**Green**	Amber-Green	**Amber**	Amber-Red	**Red**
Domain 1	1	1	6	0	1
TOTAL	**1**		**7**		**1**
Domain 4	2	0	2	1	4
TOTAL*	**2**		**3**		**4**
GREATER change total	**3**		**10**		**5**

**TOTAL numbers for each working idea amalgamate Amber-Red and Amber-Green into the Amber category for a top level clean RAG rating.*

9.6 APPENDIX 6 - Stakeholder RAG ratings breakdown

NOTE: Gaining consensus on RAG Ratings was intended as a discussion tool. They provide useful indicators only and are not intended for comparison or as scientific absolutes.

	Working idea - MINIMAL change				
Domain					
1	RED	AMBER-GREEN	Not given	AMBER	AMBER-GREEN
2	AMBER	AMBER	Not given	RED	AMBER-RED
3	GREEN	AMBER-RED	Not given	RED	AMBER-GREEN
4	AMBER	AMBER	Not given	AMBER	Not given
OVERALL RAG	**AMBER**	AMBER	**Refused**	**Not given**	Not given

	Working idea - SOME change
Domain	
1	AMBER
2	RED
3	Not Given
4	Not Given
OVERALL RAG	Not Given

	Working idea - GREATER change			
Domain				
1	AMBER-GREEN	RED	RED	AMBER
2	AMBER	Not given	AMBER-RED	RED
3	AMBER	Not given	RED	AMBER
4	AMBER	RED-GREEN	RED	AMBER
OVERALL RAG	**Not given**	**RED**	**Refused**	AMBER

The Path to Excellence

Phase Two

Applying the Evaluation Criteria

Feedback from Staff and Stakeholder events in April/May 2019

FINAL DRAFT report 22nd June 2019

Independent analysis by Social Marketing Partners

Social Marketing Partners (SMP) is an independent marketing, communications, engagement, and social research agency, commissioned to provide guidance, independent analysis and reporting for this engagement activity.

SMP's approach combines robust understanding of the principles and practice of qualitative and quantitative research, and formal consultation, with solid experience of market and social research, as well as expertise in communicating and engaging to improve health.

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