SOUTH TYNESIDE AND SUNDERLAND JOINT HEALTH SCRUTINY COMMITTEE

AGENDA

Meeting to be held in the Civic Centre Sunderland (Committee Room No. 1) on Thursday 21st June, 2018 at 2.00 pm

Contact: **David Noon Principal Governance Services Officer** **Tel: 561 1008**
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Information contained in this agenda can be made available in other languages and formats on request

E. WAUGH,
Head of Law and Governance,
Civic Centre,
SUNDERLAND.

13th June 2018

Item 2

South Tyneside Council

South Tyneside and Sunderland Joint Health Scrutiny Committee

South Tyneside and Sunderland Joint Health Scrutiny Committee

30 April 2018

Present:	South Tyneside: Councillors Dix (Chairman), Brady, Flynn, Hay, Hetherington, Peacock and Purvis Sunderland: Councillor Wright, Davison, Heron, McClennan, DE Snowdon and Walker
In attendance:	Matt Brown (South Tyneside CCG), Scott Watson (Sunderland CCG), Patrick Garner (South Tyneside and Sunderland Healthcare Group), Caroline Latta (NHS England), Andrea Hetherington (NHS England), Deborah Cornell (Sunderland CCG), Liz Davies (South Tyneside and Sunderland Healthcare Group), Nigel Cummings (Sunderland Council), Paul Baldasera (South Tyneside Council) and Brian Springthorpe (South Tyneside Council) 13 members of the public were in attendance

1. **Chairman's Welcome**

   The Chairman welcomed everyone to the meeting.

2. **Declarations of Interest**

   There were no declarations of interest.

Contact Officer: Brian Springthorpe, Strategy and Democracy Support Officer – Telephone 0191 424 7261

3. Minutes of 10 April 2018

Agreed: That the Minutes of the meeting held on 10 April 2018 be approved.

4. Chairman's Urgent Items

There were no urgent items.

5. Clinical Commissioning Groups' response to the draft referral to the Secretary of State

Matt Brown, South Tyneside CCG, presented the response to the Committee's proposed referral to the Secretary of State. It was acknowledged that the Committee was within its rights to make the referral. The services under consideration were very fragile and it was hoped that as rapid process as possible would be found should the referral be confirmed.

The NHS had provided a detailed written response to the 69 paragraphs of the Committee's referral statement which was focussed on the inadequacy of consultation and that the proposed changes were not in the best interest of the local health service.

A number of points were highlighted:

Paediatrics – It was acknowledged that staff had different views. Many staff had indicated that they just want to get on and implement any changes required. Two options had been considered safe and a third option, proposed by staff, had been investigated and deemed unsafe. In many parts of the country overnight paediatric care was not separate from adult care and staff were fully trained to deal with all cases.

Maternity – Assurance had been received from the North East Ambulance Service (NEAS) Trust Board that it would be able to provide the required ambulance service to maintain patient safety should the proposed changes be implemented. Freestanding Midwife Led Units operated successfully in many other parts of the country. Staff were fully competent to undertake this role and it would allow staff to help with related issues such as support for breastfeeding mothers.

Stroke – Aftercare was not part of the consultation process, however, the Committee was able to undertake scrutiny if it wished. Reference had been made by the Committee to conflicting medical advice received at a previous meeting. Dr Sen had provided written clarification of his views which was contained in the NHS response document. Regarding stroke services there was a

consensus on the proposals for change. During the temporary arrangements put in place in December 2017/January 2018 there had been a significant improvement in outcomes for patients, particularly those resident in South Tyneside.

There followed a question and answer session.

Councillor Hay advised that Committee members had been contacted by many staff who had expressed concerns over the proposals. Matt Brown acknowledged that conflicting views had been expressed and it was rare to have 100% agreement.

Councillor Hetherington highlighted issues over the consultation process and expressed concerns that the NHS had not provided evidence to show that consultation had included all stakeholders, particularly residents, and that no consideration had been given to the views expressed during the consultation. Matt Brown confirmed that it was the aim to provide the best services possible, as locally as possible; however it was the outcomes that were the critical concern. Pre and post pathways of care were largely unchanged.

Councillor Wright advised that Committee members had received a number of messages of concern from staff and expressed concerns over claims that there had been breaches of the working times directive to which no response had been received from the NHS. Councillor Wright added that she did not accept the CCG views and statement on the Gunning Principles, that serious concerns remained over NEAS's ability to cope and issues such as parking problems continued. Matt Brown confirmed that the Gunning Principles were crucial and that extra monies had been invested in NEAS which was already the best performing Trust in the country. Scott Watson confirmed that it was planned to provide additional parking spaces at the Sunderland site.

Councillor Dix highlighted the contradiction that NEAS had provided a letter supporting the change despite having a short-fall of 100 paramedics.

Councillor Peacock indicated that the CCGs/NHS did not fully understand or appreciate the role of scrutiny. It was suggested that officers consider any training or briefing requirements that may be necessary. Matt Brown confirmed that he was keen to ensure that the best ways of working together were developed.

Councillor Walker confirmed that the consultants appointed had carried out rigorous analysis of the information provided.

The Chairman asked the Strategy and Democracy Officer to outline the process to be followed by the Committee. The Committee was

advised that it was required to decide whether or not to confirm the referral to the Secretary of State, and if so, whether any amendments were required to the draft referral letter.

The Chairman advised that the Committee had held a series of meetings to consider the proposed changes and throughout the process it had followed the laid out procedure and legal advice which stated that the referral could only be made at the end of the process.

Agreed: That referral to the Secretary of State be confirmed based on the draft letter.

JOINT HEALTH SCRUTINY COMMITTEE **21 JUNE 2018**

THE PATH TO EXCELLENCE PHASE TWO – PROGRAMME OVERVIEW

REPORT OF SOUTH TYNESIDE AND SUNDERLAND NHS PARTNERSHIP

1. PURPOSE OF THE REPORT

1.1 The attached presentation provides, for information and comment, an overview of phase two of the Path to Excellence programme.

2. BACKGROUND

2.1 The Path to Excellence is a five-year programme to improve healthcare across South Tyneside and Sunderland and is part of the region's sustainability and transformation plans.

3. CURRENT POSITION

3.1 The presentation on phase two of the Path to Excellence, attached at appendix one of this report, sets out in greater detail the current position in relation to phase two of the programme including learning from phase one and alignment to the Health and Wellbeing Strategies of the two local authorities.

4. RECOMMENDATION

4.1 The Joint Health Scrutiny Coordinating Committee is recommended to consider and comment on the presentation on the phase two programme overview.

Contact Officer: Caroline Latta
Senior Communications and Engagement Locality Manager

The path to excellence

South Tyneside and Sunderland NHS partnership

The Path to Excellence

Phase 2

How we create the best possible improvements for healthcare in South Tyneside and Sunderland

21st June 2018

Joint Overview and Scrutiny Committee

Items to cover

- Phase 2 programme structure
- Why change is needed for the phase 2 services - Case for Change document
- Pre-consultation engagement strategy document

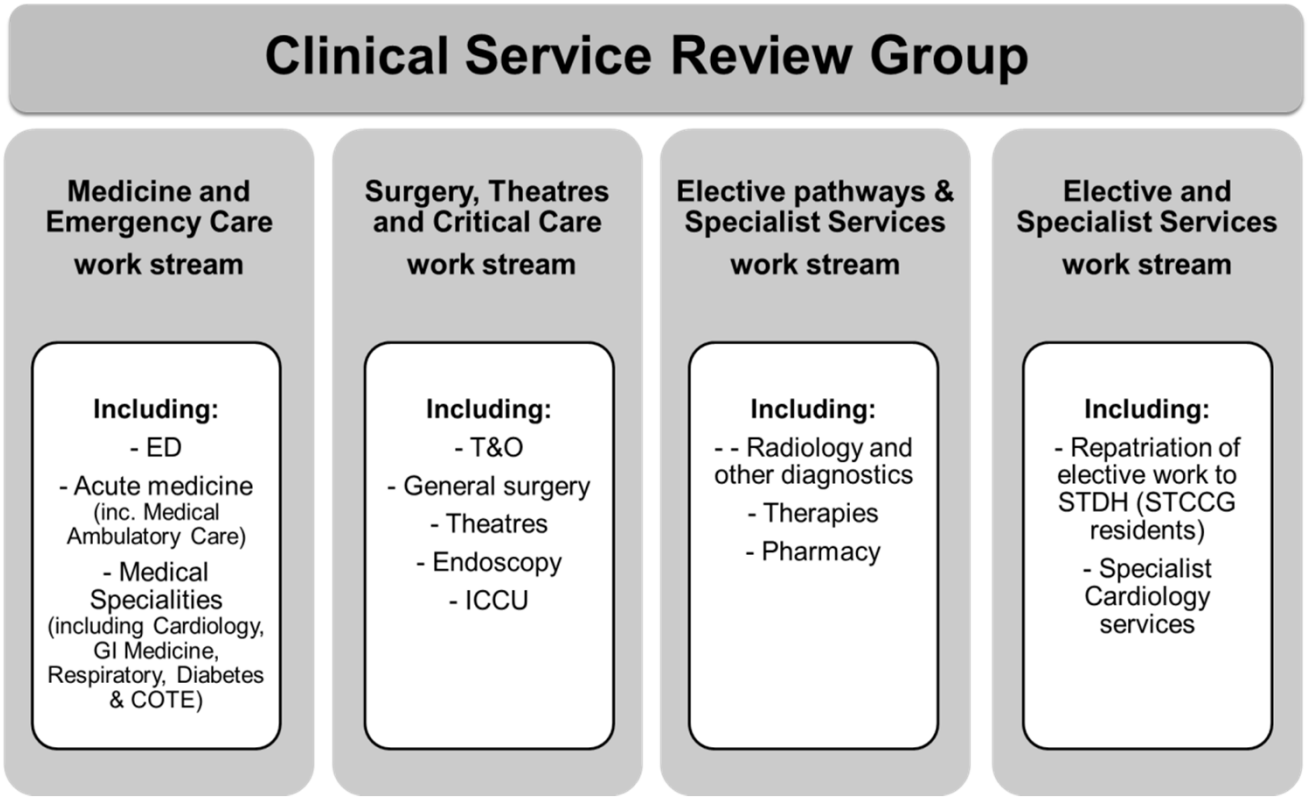
Phase 2 programme structure (i)

The PtE programme was originally planned to have three separate phases, now consolidated into two phases to mitigate the following risks:

- Potential in restricting the options development process for the two trusts/sites in the previous approach.
- Potential to discredit the service change process if service changes in earlier phases are used to substantiate proposals in later stages.
- Gives greater ability to recognise the critical clinical interdependencies across the services being reviewed.
- Reduces the number of public consultations and therefore reduces the potential for consultation fatigue amongst the public.
- Allows time for greater staff and patient/public engagement to help influence the design of the possible options.

Phase 2 programme structure (ii)

The revised programme structure to deliver only one further phase of clinical reviews is summarised in the diagram below.



ED: Emergency Department
GI Medicine: Gastrointestinal Medicine
COTE: Care of the Elderly/ Geriatric Medicine

T&O: Trauma and Orthopaedics
ICCU: Intensive care and High Dependency unit

Phase 2 programme structure (iii)

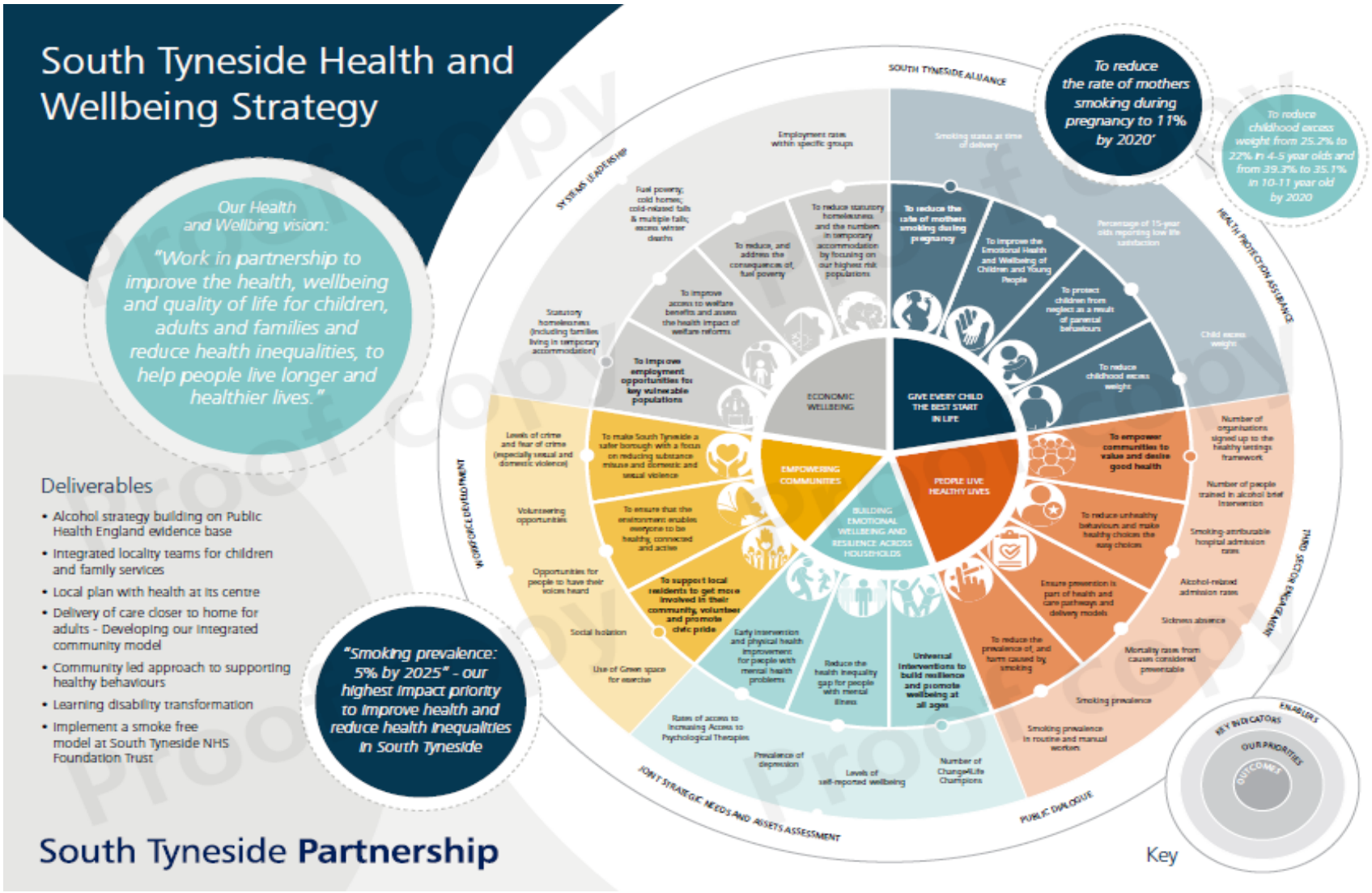
Learning from Phase 1

Despite phase 1 of the programme being awarded best practice status by the Consultation Institute, we are still looking to further improve the clinical design process by:

Area of focus	Response
Potential for earlier and greater engagement on the case for change with the public and the need for more co-design of possible options.	The case for change will be published within the next month, a full year before the public consultation and will be the key reference document used in the pre-consultation public and stakeholder engagement work.
Wider staff involvement in understanding the issues but also being involved more in the design work of possible options.	Significant work has already been carried out in this area with 700 staff already contributing to staff survey work, a further 200 staff have attended staff engagement workshops, with more workshops planned. This is over and above existing communication channels such as team brief, staff briefings from the Executive team and relaunch of the PtE internal staff website. In addition to this we have significantly increased the size of the clinical design teams with around 100 staff now sitting on these, who are in turn briefing their colleagues on this work.
To publish more information on the options development process including all the potential options that were discounted and the reasons why.	The rationale for why options were discounted (once complete) will be published as part of the consultation documentation for Phase 2 of the programme.
To explain more clearly the link between the out of hospital service transformation and prevention work and the Path to Excellence programme.	This will be articulated during the pre-consultation engagement phase of the programme and will also form part of the eventual public consultation material.

Phase 2 programme structure (iv)

Alignment with HWB strategy – South Tyneside



Phase 2 programme structure (v)
Alignment with HWB strategy – South Tyneside

- The vision of the HWB strategy in South Tyneside is to: *work in partnership to improve the health, wellbeing and quality of life for our children, adults and families and reduce health inequalities, to help people live longer and healthier lives.*
- The positive role that hospital services in achieving this vision can only be maintained if we have sustainable and therefore safe and quality hospital services, this is the core aim of the PtE programme.
- More specifically the programme links to a and trying to address a number of the challenges set out in the HWB strategy:

Challenged outlined in the strategy	Link to PtE programme
Continued pressure on the “South Tyneside Pound”	More so than Phase 1 of the programme financial sustainability is significant drive for the changes needed and this will need to be carefully assessed as options are developed.
Increasing emphasis on creating sustainable NHS provision	As stated above, the PtE programme is trying to ensure sustainability of health care services through redesigning our acute services and this has to be for the longer term.
Policy changes resulting in greater integration between health and social care	Social care colleagues are part of the PtE Programme Board (the Clinical Service Review Group) and are key partners in helping developing and ultimately implementing the models of care that will be decided on at the end of the programme.

Phase 2 programme structure (vi)

Alignment with HWB strategy - Sunderland

- As recognised in the joint Health and Well-being strategy we are collectively faced with reducing public resources and increasing demand meaning that the current ways of delivering services are recognised as no longer sustainable.
- The PtE programme is the response across Sunderland and South Tyneside looking at how we make our hospital services more sustainable in recognising that not changing the way our current services are configured is simply not an option.

In relation to the details of the joint Health and Well-being strategy the PtE programme links most closely (although not exclusively) to the following design principle:

HWB strategy design principle	Link to PtE programme
Equity – providing access to excellent services dependent on need and preferences that are also based on evaluated models and quality standards.	The clinical design workstreams are looking at models of care that provide excellent healthcare services in terms improving the quality and safety of the services under review.

Phase 2 programme structure (vii)

Alignment with HWB strategy - Sunderland

The programme also aligns to the following strategic objectives set out in the Sunderland Health and Well-being strategy as can be seen below:

HWB strategy strategic objective	Link to PtE programme
1.2 Services are responsive to community needs and assets, becoming co-produced where possible.	As will be outlined later, the programme is looking to engage both sooner and further with patients and the public to provide some opportunities for co-production of the models that will ultimately be consulted on.
5.2 Providing excellent integrated services to support those with long-term conditions and their carers	A number of the services being reviewed have cohorts of patients who suffer from long-term conditions. As highlighted earlier, we are ensuring greater alignment and integration with other programmes, therefore both the Clinical Service Review Group (which members of the LA attend) and the CCG Governing Body will be challenging the clinical teams to demonstrate this before any options progress to public consultation.
6.2 Providing excellent integrated services to support people to recover from ill health and crisis	

Phase 2 programme structure (viii)

Key milestones

Milestone	Timeframe
Completed Clinical case for Change, public and staff engagement and the parallel clinical design process.	Until the end of 2018
External clinical assurance (external clinical senate review)	Winter 2018
Pre-consultation Business Case completed and signed off by CCG Governing Bodies	Spring 2019
NHS England service change assurance process completed	Spring/summer 2019
Start of public consultation (provisional and subject to change)	Summer 2019

Item 5

JOINT HEALTH SCRUTINY COMMITTEE 21 JUNE 2018

THE PATH TO EXCELLENCE PHASE TWO – DRAFT CASE FOR CHANGE

REPORT OF SOUTH TYNESIDE AND SUNDERLAND NHS PARTNERSHIP

1. PURPOSE OF THE REPORT

1.1 The attached presentation provides, for information and comment, an overview of the main content of the draft Case for Change.

2. BACKGROUND

2.1 The Path to Excellence is a five-year programme to improve healthcare across South Tyneside and Sunderland and is part of the region's sustainability and transformation plans.

3. CURRENT POSITION

3.1 The presentation on phase two of the Path to Excellence, attached at appendix one of this report, sets out the main points in relation to the draft case for change.

4. RECOMMENDATION

4.1 The Joint Health Scrutiny Coordinating Committee is recommended to consider and comment on the presentation for the draft case for change.

Contact Officer: Caroline Latta
Senior Communications and Engagement Locality Manager

The path to excellence

NHS
South Tyneside and Sunderland
NHS partnership

The Path to Excellence

Phase 2

How we create the best possible improvements for healthcare in South Tyneside and Sunderland

21st June 2018

Joint Overview and Scrutiny Committee

Draft case for change

Draft Case for change

- Draft case for change – sharing with stakeholder advisory panel and clinical services review groups for feedback
- Objective is to set out clearly the issues and challenges we are facing
- Content drawn from staff engagement & feedback, patient experience, clinical review programme
- Summary of issues covered in slides - will share updated written draft with elected members shortly for comments
- We are seeking feedback, views, questions and comments – update draft will remain open to change as we share widely over summer, autumn and winter 2018

Health and wellbeing of our population

Despite having good NHS services, our population is in very poor health

- More emergency hospital admissions
- More alcohol-related hospital admissions
- More cases of cancer
- More people living with long-term conditions like diabetes, heart disease or breathing problems
- More deaths due to wholly preventable illnesses
- Lower life expectancy compared to the England average
- Significant gaps in the life expectancy between the least and most deprived areas of South Tyneside and Sunderland

Demands on hospital care

If we do not improve the general health and wellbeing we anticipate much further demand on our hospitals in the future.

Majority of patients admitted to hospitals are over 80 years old often with multiple long-term conditions, very poorly and need complex care and support from our staff.

This demand to grow even further in the years ahead.

Demands on hospital care

By 2025, in South Tyneside there will be:

- 35% more hospital activity for those aged 90 or over
- 23% more hospital activity for the over 75s
- 19% more hospital activity for those aged 65-74

By 2025 in Sunderland there will be:

- 47% more hospital activity for those aged 90 or over
- 30% more hospital activity for the over 75s
- 15% more hospital activity for those aged 65-74

Quality of care

Gap in workforce are the biggest challenge to consistently deliver the highest standards and quality of care

Daily challenges to staff wards and departments to a consistently safe level, relying on good will of staff working longer hours or extra shifts

Poses risk to health and wellbeing of staff and staff regularly report risks and concerns to staffing levels which must be addressed as part of long term plan

Quality of care

Organising services differently will attract people to come and work with us

Especially for a better healthy work / life balance

For NHS services which demonstrate improved quality of care and outcomes for patients

Shortfalls in the quality of care across our hospitals

- Too much unacceptable variation between hospitals on performance against many clinical standards that are the markers of high quality care
- Unable to consistently ensure that all emergency patients are reviewed by a consultant in a timely manner
- Some planned care, for example, going into hospital for an operation or x-ray, is not as efficient as it could be - differences in how often people are referred to specialists and the tests and treatments they receive
- We do not have consistent availability of senior clinical decision makers seven days a week or wrap around support services available
- Individually populations are smaller, but together creates vital critical mass of patients

Our financial position and efficiency of local NHS services

Local NHS faces arguably the most challenging we have ever encountered

Staff have made tremendous efforts to continually deliver millions of pounds in efficiency savings but there is still more to do

Local NHS organisations are collectively agreed a shared long-term financial recovery plan to help us get back into financial balance in the years ahead

Our financial position and efficiency of local NHS services

Emergency care and acute medicine in both hospitals cost more than funding - annual loss of £15million

Temporary staff amounts to over £11milion each year - over-reliance costs more and limits ability to make long-term quality improvements to patient care

- 5% of consultant posts and 12% of junior doctor posts are vacant at Sunderland Royal Hospital
- 16% of consultant roles and 15% of junior doctor posts at South Tyneside District Hospital
- 9% of band 5 nursing posts on medical wards are vacant at South Tyneside District Hospital and 10% at Sunderland Royal Hospital

Our financial position and efficiency of local NHS services

Some people who live in South Tyneside and Sunderland choose to other hospitals for their care, means that less funding comes into local health services

Number of people attending ED with minor ailments and injuries continues to grow and places unnecessary financial strain on the NHS when patients could seek advice elsewhere or look after themselves.

Working together across South Tyneside and Sunderland hospitals

Strong and proud history of partnership working - provide the very best clinical care for patients - staff fully committed to delivering the highest quality of services

Trusts working together since 2016 strategic alliance ‘South Tyneside and Sunderland Healthcare Group – already many positive benefits

Both Trusts working towards becoming one organisation over 8,500 highly committed and skilled NHS staff coming together as one Trust - further improve resilience within the workforce

Working together across South Tyneside and Sunderland hospitals

Both local hospitals in South Tyneside and Sunderland will continue to play vital roles in providing care for local people in the future

There will need to be changes to the way some hospital-based services are delivered so that we can address the challenges outlined

Trusts working together puts South Tyneside and Sunderland in the best possible position to address the difficult challenges and create a prosperous and exciting future for local healthcare services.

Path to Excellence Phase Two – our ambitions for the future

Emergency care and acute medicine – care we provide when patients arrive at our Emergency Departments or need emergency admission to hospital

Emergency surgery – care we provide for patients who are admitted as an emergency and require immediate surgery

Planned care including surgery and outpatients – care we provide after you have been referred by your GP for a test, scan, treatment or operation

Improve and develop various clinical support services across both hospitals such as therapy services, clinical pharmacy and radiology.

Emergency care and acute medicine

Both hospitals have 24/7 Emergency Department saw a combined total of over 156,000 attendances last year:

- 75% were classed as Type 1 – serious emergencies which are potentially life threatening
- 25% were classed as Type 3 attendances – minor injury or illness, such as stomach aches, cuts and bruises, small fractures, infections or rashes.

People arrive:

- by emergency ambulance after calling 999
- after being referred directly by their GP
- after being advised by NHS 111
- by choosing to attend and walk-in themselves

Performance

- Both perform well, above the national average for 95% of patients attending the Emergency Department to be seen with four hours of arrival
- Significant pressures during the busy winter period have seen performance dip, however both hospitals remain among the top 25% of Trusts nationally 2017/18
- South Tyneside recording a performance of 94.35% and Sunderland 91.25%
- Ambulance hand over challenges in winter period – 3% patients waited 30 mins or more, less than 1% faced handover waits in excess of 1 hour

Challenges

Capacity and demand – staff have highlighted increasing demand – hospitals operate close to full capacity, increased number of older people with complex needs

Aging population means pressures increasing in both numbers of people using services and complexity of patient conditions

Last winter most common emergencies were people suffering from breathing or heart problems:

- Sunderland, over 60% of all emergency patients were aged over 60, with 25% aged over 80
- South Tyneside, 67% of all emergency patients were aged over 60, with 30% aged over 80

Challenges 2

Patient flow – timely ‘flow’ through system, medical assessment and treatment

Delays in discharge for medically fit patients – requires system working together, care packages and assessments

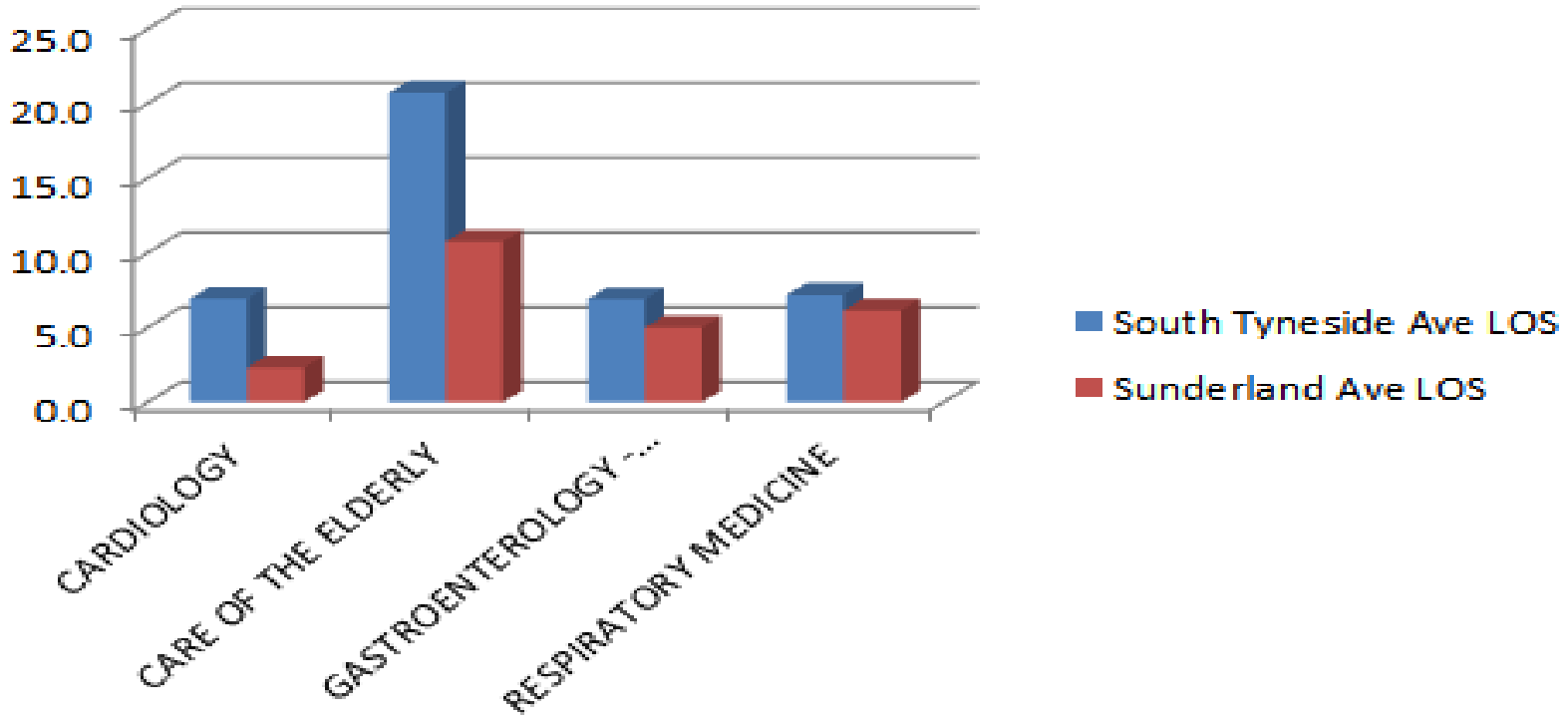
Senior clinical decision making – widespread agreement sooner emergency patients see a senior clinical decision maker or specialist – more likely to survive and have better outcomes

Not able to consistently deliver senior care = decisions made by those with less experience therefore higher unplanned re-attendances (5% national average)

- 7.4% Sunderland
- 8.6% South Tyneside

Challenges 3

Length of hospital stay – more time in hospital, longer recovery – variation between hospitals



Clinical reasons for change

Despite strong performance, there are gaps:

- Not having enough staff for timely consultant review and senior clinical decision making = consistently provide safe levels of nursing care
- Limited availability of specialist cardiology tests and specialist assessment at South Tyneside in particular
- Variation in the availability of advice for GPs and alternatives to hospital admission
- Variation in the level of mental health service support available including absence of space to observe patients with mental health needs in the Emergency Department at South Tyneside

Emergency surgery

Both hospitals provide:

- **Emergency Trauma and Orthopaedics** – this is the emergency surgery undertaken for major fractures or broken bones
- **Emergency General Surgery** – this concerns the treatment of patients presenting with acute abdominal pain, infections, bleeding and trauma.

During 2017/18 across both hospitals 8,452 emergency surgical admissions – 6622 at Sunderland Royal Hospital and 2230 at South Tyneside District Hospital

Emergency surgery

Most common emergency surgery:

- Surgery to fix badly broken bones
- Broken / fractured hips
- Appendicitis
- Gastrointestinal (stomach bleed)
- Emergency bowel surgery
- Gall bladder removal
- Amputation

Trauma and orthopaedics

General surgery

Performance

Both trusts perform well – but need to do better – many clinical standards not being met where care needs to further improve

Example: National Hip Fracture Database (NHFD)

(Green= best performance White=improvement needed)

	Sunderland Royal Hospital	South Tyneside District Hospital
Admitted to orthopaedic ward within 4 hours	63%	59.5%
Surgery on day of, or day after, admission	84.4%	85.1%
Surgery supervised by consultant surgeon and anaesthetist	92.7%	46.9%
Physiotherapy assessment by the day after surgery	98.5%	94.8%
Mobilised out of bed by the day after surgery	92.7%	73.7%
Nutritional risk assessment	98.3%	94.9%

Challenges

‘Getting it right first time’ (GIRFT) recommends:

- Reshaping emergency surgical services to ensure consultant-delivered care and rapid senior surgical opinion
- Separating emergency and planned surgical patients to reduce unnecessary cancellations or delays
- Ensuring that ‘on-call’ surgical teams, including the consultant, are not listed to deliver any routine planned operations or clinics whilst they are on call

Clinical drivers for change

Need for consultant-led, speciality driven care is now widely agreed with clear evidence if surgeons regularly carry out their chosen areas of expertise, patients are more like

Working better together and functioning as a single clinical team across two sites will:

- provide better access to 24/7 consultant delivered care and relevant support services
- move from a generalist surgical opinion to specialist surgical advice
- improve our ability to consistently deliver high quality training for surgical trainees
- improve the efficiency of service delivery and reduce unnecessary cost
- eliminate variations which exist in care and improve clinical outcomes for patients

Planned care including surgery and outpatients

Vast range of short and long-term medical complaints. over 420,000 outpatient appointments in two hospitals and community venues

Table 2017/18 planned care activity

	South Tyneside	Sunderland
Outpatients – first appointments	41,214	96,610
Outpatients – follow up appointments	89,077	197,512
Planned day case procedures	13,228	60,330
Planned operations with an overnight stay	1,152	11,448
Planned endoscopy procedures	4,031	13,195
Total inpatients with an overnight stay (including ambulatory care)	15,158	54,402

Out patients

Phase two medical specialities account for 200,000 out patient appointments per year:

- Cardiology
- Respiratory
- Gastrointestinal medicine (including endoscopy)
- Diabetes
- Care of the Elderly
- Surgical

Majority of planned procedures are day cases – people go home sooner and recover more quickly

Both hospitals have Endoscopy Depts seeing 18,000 patients a year

Performance

Both hospital perform well against national waiting time standards

	National standard	South Tyneside	Sunderland
Number of patients receiving treatment within 18 weeks of referral by their GP	92%	95.87%	94.21%
Number of patients seen within 2 weeks of an urgent cancer referral by their GP	93%	96.53%	94.99%
Number of patients starting treatment for cancer within 62 days of urgent referral by their GP	85%	89.11%	83.62%
Number of patients waiting more than 6 weeks for their d***iagnostic test***	Less than 1%	0.01%	1.32%

Challenges and clinical reasons for change

Care closer to home: estimate 44,000 out patient appointments in Sunderland for patients who live in South Tyneside – many of these could take place in South Tyneside

Have more specialist services (currently only in Sunderland) from South Tyneside hospital eg: ophthalmology (eyes), ear, nose and throat (ENT), urology, oral and maxillofacial, rheumatology and vascular services

More specialist services (currently only available outside Sunderland and South Tyneside) in the two areas Eg planned specialist cardiac MRI scan

Challenges and clinical reasons for change

Working together as larger clinical, nursing and therapy teams, our ambition is to deliver:

- much more care closer to home when is safe, sustainable and appropriate to do so
- improved patient experience by separating planned care from emergency care
- more consultant led ward rounds and senior speciality review to enable patients to get on the road to recovery sooner
- better access to vital therapy and support services seven days a week to reduce unnecessary delays in recovery

Clinical support services

Number of vital clinical support services with a large number of staff playing a crucial role to help make sure patients get the timely and effective care they need:

- **Hospital pharmacy services**
- **Radiology services**
- **Therapy services**

All will need consideration and review to support the clinical specialities

What do patients say?

Recently published national Adult Inpatient Survey (2017) has demonstrated a number of quality improvements for both hospitals over the past year with the following areas rated ‘better’ than 2016:

South Tyneside	Sunderland
privacy when being examined or treated in ED	privacy when being examined or treated in ED
members of staff working well together	length of time on the waiting list
involving patients in decisions about their discharge from hospital	being advised what to expect to feel after an operation or procedure
patients receiving sufficient support after leaving hospital	discharge from hospital
hospital staff discussing any further health or social care services required	getting understandable answers to questions from doctors

- Additional research took place in February 2018 gathered real time views of 120 patients in ED, planned care or treatment - face to face
- Further field work underway with 4000 surveys
- Will further inform clinical teams thinking (full reports available)

What do patients say?

Three most important things for patients when accessing emergency care:

- getting the right treatment as quickly as possible
- access to an expert or specialist for their condition
- quick access to the necessary diagnostic tests

Being able to access care close to home said to be more important when needing ‘urgent care’, rather than emergency care

Some patients reported encountering waits for blood tests, X-rays or scans and some were unsure as to whether they had seen a senior doctor daily

Patients reported mixed experiences of discharge planning

Patients recognised the staffing and workload challenges of the doctors, nurses and other health professionals working across the services and wards

Four most important things for patients receiving planned care:

- quick access to an expert or specialist for their condition
- getting the right treatment as quickly as possible
- quick access to the necessary diagnostic tests
- services which are close to home

What do staff say?

Survey of 700 staff highlighted many recurring themes (Dec 2017-February 2018)

Echoed by 200 staff attending engagement workshops March 2018

(Full reports available)

Workload and staffing – daily challenge around nursing vacancies, recruitment and retention, reliance on temporary staff, good will and negatively impacting on resilience

"Staffing pressures can compromise quality standards"

What do staff say?

Capacity and demand – widespread acknowledgement of growing and relentless demand on services all year round, challenges of caring for more older people with complex conditions and rising levels of dementia –experiences of barriers to accessing social care often delaying discharge and impacting on overall capacity

"It's not just winter surge anymore, it's all year round"

What do staff say?

Staff training and development – pressures impact on time for training and one-to-ones supervisory discussions, supporting new staff and lack of permanent consultants pressured junior doctor training. Use of temporary staff could result in different skill mix, having to ensure they know systems and ways of working. Need consistent consultants instead of locums to support teams and ease pressures

“Support for staff must be paramount”

What do staff say?

Differences between the two Trusts - current inequity of service provision between sites, with the limited amount of specialty cover at South Tyneside at weekends given as an example, medical staffing shortages impact senior doctor cover, cultural differences, policies, protocols, skill mix in teams. Major theme of IT infrastructure, need for unity and will be a key enabler to integrate cross site working

"In some specialities there are huge discrepancies between the two sites / services"

"Changes and improvements need to happen faster"

What do staff say?

Communications and engagement – emphasised importance of empowering staff at all levels, timely, open and honest. Keep providing updates (even when there was not one) to provide reassurance, dispel rumours. Very important to speak positively about the future, and clear communications to public who were recognised to be very sceptical about the future of South Tyneside hospital

"Staff want to know what's happening and are happy to work together for the good of the people"

What do staff say?

Several reoccurring themes identified from staff feedback:

- Have a clear, shared vision for each clinical service across both Trusts
- Have stable, integrated teams which are sustainable
- Deliver standardised care and treatment across both Trusts which offers the safest, most effective care for patients – ‘excellence’
- Provide a smooth journey for patients and ensure they are seen by the right specialist, at the right time, in the right place seven days a week
- Become an employer of choice offering greater flexibility for staff, a better work / life balance and attractive working conditions
- Have fully integrated IT systems
- Deliver improved outcomes for patients through continuous learning, innovation and improvement

Workforce sustainability

- The underlying issue of workforce sustainability is a common thread throughout
- We cannot ignore this and need to think differently about how we work together as larger clinical, nursing and therapy teams across both hospitals.
- Having a stable, fully staffed workforce is critical to making improvements and by making improvements will attract more staff
- 8,500 staff loyal employees who enjoy long and fruitful careers - turnover rates are broadly in line with the national NHS average of 0.87% - 0.96% at South Tyneside and 0.71% in Sunderland.
- Age profile – 20% workforce in ST and 16% S'land are of retirement age
- Both hospitals have higher staff turnover in highly pressurised 'emergency care and acute medicine'

Table shows workforce pressures in emergency care and acute medicine (end of 2017/18)

South Tyneside	**Sunderland**
20% of all permanent roles vacant	8% of all permanent roles vacant
16% of consultant roles vacant	5% of consultant roles vacant
15% turnover rate among nurses in emergency care	11% turnover rate among nurses in emergency care
12% in medicine and care of the elderly.	13% in care of the elderly.

Impact of workforce pressures

**Staff wellbeing and morale - ** daily pressures, impacts continuity of services, pressure on staff to keep things running smoothly, many going above and beyond – impacts health and well-being

Quality and safety – costly over reliance on locum staff compromises ability to consistently deliver best quality care, leads to delays in assessment, treatment and discharge. Many wards rely on temporary nurses to achieve ‘nurse to patient ratios’, and incidents and risks arise from low staffing levels and staff not familiar with local policies

Impact of workforce pressures

Training and supervision – working hard to recruit newly qualified staff – however they need support. Need a mix of experienced and new staff.

Work underway locally, regionally and nationally but need to think beyond organisational boundaries about how we use precious staff skills and expertise

Will not be resolved by money as there is not enough qualified staff available who want:

- opportunity to regularly practice their chosen areas of specialism or clinical expertise
- see a high volume of patients and deliver the best outcomes
- offer a good work / life balance
- provide strong opportunities for learning, research and development.

The local, regional and national picture

- Phase two programme in line with national and regional ambitions to evolve the NHS to meet growing needs, rising demand and costs of new treatments and technologies
- South Tyneside and Sunderland no different to other parts of England
- Workforce issues across the NHS but more acutely in NE
- Move away from thinking as individual organisations to more collaborative joined up healthcare systems – better experiences and care for patients

The local, regional and national picture

Path to excellence has helped forge even stronger relationships across the local NHS – one part of a wider conversation to join up primary care, community services and hospital based care:

All NHS organisations locally wish to:

- deliver a single system wide way of working and more joined up services
- improve health outcomes and patient experience
- drive out unnecessary duplication and waste
- deliver the services patients need within our affordability envelope
- use the capacity and capability we have across our system wisely and to best effect.

Continuation of travel and transport reviews and development

What happens next?

Clinical design teams continue to work with frontline hospital staff to think about how to solve the challenges and better organise services

Further staff events in June and public engagement programme summer 2018

Later in 2018 share this thinking with wider stakeholders and gain feedback to influence final options the CCGs will consider for consultation – expected Summer 2019

Item 6

JOINT HEALTH SCRUTINY COMMITTEE 21 JUNE 2018

THE PATH TO EXCELLENCE PHASE TWO – COMMUNICATIONS AND ENGAGEMENT STRATEGY

REPORT OF SOUTH TYNESIDE AND SUNDERLAND NHS PARTNERSHIP

1. PURPOSE OF THE REPORT

1.1 The report provides, for information and comment, the latest Communications and Engagement Strategy for phase two of the Path to Excellence Phase.

2. BACKGROUND

2.1 The Path to Excellence Phase Two Communication and Engagement Strategy is attached at **Appendix 1** of this report and builds on the previous strategy developed in 2017.

2.2 The Path to Excellence is a five-year programme to improve healthcare across South Tyneside and Sunderland and is part of the region's sustainability and transformation plans.

3. CURRENT POSITION

3.1 The communication and engagement strategy sets out in detail a number of key issues as follows:

- Programme for Public Engagement
- Compliance with legal and policy context for NHS Service Change
- Learning from Phase One
- Patient experience and public/staff engagement will influence the development of credible options for service change
- Updated programme governance
- Measurement and testing of communication and engagement mechanisms.

3.2 A presentation, **Appendix 2** of this report, will be provide an overview of the strategy for members information.

4. RECOMMENDATION

4.1 The Joint Health Scrutiny Coordinating Committee is recommended to consider and comment on the information provided in the communications and engagement strategy and the presentation.

Contact Officer: Caroline Latta
Senior Communications and Engagement Locality Manager

NHS
South Tyneside and Sunderland
NHS partnership

The path to excellence

Communications and engagement strategy

Phase two – Path to Excellence programme

DRAFT ONLY SUBJECT TO COMMENTS AND CHANGES

May 2018

Project title:	The Path to Excellence Phase 2 public engagement and consultation communications strategy
Authors:	Caroline Latta - NECS Emma Taylor - NECS Liz Davies – ST&S FT's
Owner:	Caroline Latta
NHS organisations	South Tyneside and Sunderland NHS Partnership (two CCGs and two FTs)
Date:	March 2018
Version:	4
Comments:	This document is an updated strategy based upon an outline strategy developed and shared in November 2017 **Communications and engagement action plans under pins this strategy and is referenced**

Change record

Date	Author	Version	Summary of Changes
04/05/2018	L Davies	3	Updates to staff feedback sections
14/05/18	P Garner / E Taylor	4	Updates p7 clinical areas, added to aims, benchmarking patient experience section – moved to appendix 4
21/05/18	E Taylor	4	Updates to action plan Updates to section 10 Key milestones timeline Updates to appendices

P2E communications and engagement strategy has been distributed to:

Name	Title	Date of issue	Version

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P2E Governance Group	Outline P2E phase 2 communications and engagement strategy	December 2017	1
P2E clinical services group	Outline P2E phase 2 communications and engagement strategy	December 2017	1
P2E stakeholder advisory panel	Outline P2E phase 2 communications and engagement strategy	January 2018	1
P2E Governance Group	P2E phase 2 communications and engagement strategy	April 2018	2
P2E clinical services group	P2E phase 2 communications and engagement strategy	April 2018	2

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Contents

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Executive Summary

This paper builds upon the outline public engagement and communications strategy developed in winter 2017 for the next phase of the Path to Excellence Programme (PtE) – which focuses on the programme of acute care collaboration between South Tyneside NHS Foundation Trust and City Hospitals Sunderland NHS Foundation Trust. The services delivered by South Tyneside District Hospital and Sunderland Royal Hospital which are under review are:

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

The strategy has been developed further after engagement discussions and input from PtE NHS South Tyneside and Sunderland partners from trusts and clinical commissioning groups, stakeholder advisory panel and HealthWatch organisations.

This strategy paper sets out:

- key information on clear tactical action plans, tracking key deliverables and activity for the programme of public engagement for the main service areas noted above
- how we will ensure compliance with legal and policy context for NHS service change, best practice communications and engagement advice to support staff, public and stakeholder understanding, gain support to develop the best solutions for change to ensure NHS service sustainability, and minimise opposition
- how learning and identified adaptions from phase one of the Path to Excellence pre-engagement and consultation programme as reported to both NHS South Tyneside Clinical Commissioning Group (CCG) and NHS Sunderland CCG at their joint decision making meeting in February 2018 have been incorporated along with recommendations for phase two
- how insights gained from patient experience and public and staff engagement will influence the development of credible options for service change during the formative stage and prior to formal public consultation
- updated programme governance which includes establishment of PtE consultation stakeholder reference group (provide advice, views, suggestions or opinions on communications and engagement activity)
- enhanced staff engagement and involvement that is already underway for all staff and specific targeted activity with staff working across the three key clinical service areas under review

- how we will explain how the problems are being identified, how ideas for change will be assessed using transparent assessment criteria, how 'clinical due diligence' will take place in order to ensure feasible options for the future are developed
- measurement and testing of improved communications and engagement mechanisms to ensure they are robust and support continuous dynamic dialogue required for best practice consultation.

To date, the Path to Excellence programme has drawn upon robust methods of social research as consultation and engagement methodologies where appropriate to provide best practice approaches.

The challenge

This work aims to make what are very complex issues as simple as possible for the public to understand, to enable people to make an informed view. This in turn allows decision makers to understand public feedback in a systematic way, incorporate the feedback into planning and options development, and ensure compliance in regard to legal duties around major service changes and NHS future public consultation.

This strategy provides the framework for:

- clear rationales for activities to be undertaken
- how specialised communications and engagement expertise will be deployed
- how that expertise will support clinical leaders and other NHS staff to lead public and stakeholder engagement
- how the governance and partnership arrangements provide oversight on the end to end programme of pre-engagement and subsequent public consultation.

The strategy outlines that two distinct phases of pre-engagement and subsequent formal public consultation will be developed and mobilised during this service review.

Pre-engagement phase (December 2017– Autumn-Winter 2018)
The main aims of this pre-engagement phase are for the programme to:

- Ensure public and stakeholders are aware of the reasons and issues of why change is needed, prior to any future consultation
- Understand what is important to patients, staff and the public
- Share early thinking on emerging ideas for the future.

In line with best practice it demonstrates how benchmarking patient experience and patient and public engagement is being conducted and again in line with best practice how this insight will be used to continue to build a robust knowledge base.

It highlights how the staff survey work and staff workshops show there was a re-occurring theme of the desire for more opportunities for engagement and enhanced staff communications and how this work will be developed.

It provides further detail on how expertise will be used to develop a case for change and supporting narrative and how resources will be deployed to ensure equality analysis work will be conducted as well as continued stakeholder mapping and further work to ensure democratic and partner engagement.

It outlines proposals on how any future options will be presented and will also be open to influence during a public consultation planned for spring/summer 2019. It also identifies further opportunities for influence (with decision making likely to be early 2020) as following further clinical due diligence in winter 2018/19 how this can be used to inform direction of travel, timeline and next steps for engagement and consultation in a continuous dynamic process.

Finally it highlights the strategic direction of how healthcare services will likely be delivered. It has been recognised that in order to solve the issues being faced by acute hospital services, a considerable element of ways to help solve these problems sits outside of hospital settings within primary care, community services, public health prevention, social care and services provided by the community and voluntary sector.

The strategy paper supports the tactical delivery action plan and the key programme milestones (see appendix 1) which are the outputs of this strategy document. The communications and engagement tactical action plan tracks the operational delivery for all activity which is overseen by the communications task and finish group.

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1. Background to strategy development

This strategy builds upon the outline public engagement and communications strategy developed in winter 2017 for the next phase of the Path to Excellence Programme (P2E) – which focuses on the programme of acute care collaboration between South Tyneside NHS Foundation Trust and City Hospitals Sunderland NHS Foundation Trust.

It has been developed further after endorsement and input from P2E NHS South Tyneside and Sunderland partners from both trusts and clinical commissioning groups, stakeholder advisory panel and Health Watch organisations

Clear tactical action plans underpin key elements of this strategy which is a live working document, tracking key deliverables for the programme of public engagement.

It takes into account the legal and policy context for NHS service change, best practice communications and engagement advice to support staff, public and stakeholder understanding, gain support to develop the best solutions for change to ensure NHS service sustainability, and minimise opposition.

For the purposes of this strategy the term ‘public’ incorporates all stakeholders, public, patients, staff, elected members, other NHS bodies, the community and voluntary sector, and other individuals and groups as identified by the stakeholder analysis. (See section 8)

This strategy incorporates learning from phase one of the Path to Excellence pre-engagement and consultation programme as reported to both NHS South Tyneside Clinical Commissioning Group (CCG) and NHS Sunderland CCG at their joint decision making meeting in February 2018. Clear adaptations in the phase one strategy were identified along with recommendations for phase two strategy which are included in this updated paper.

Read the P2E phase 1 consultation process assurance paper here

It also takes account of the North of England Commissioning Support communications and engagement staffing resource available via the P2E programme which will deliver best practice strategic advice and guidance, and deliver agreed operational activity working closely with the trust’s head of communications, P2E programme manager and associated in-house NHS teams.

It demonstrates how enhanced staff engagement and broader participation in the pre-engagement phase will take place in response to feedback from key partners and stakeholders around their desire to be involved.

In particular, it incorporates equality delivery as integrated to this strategy and not as a standalone.

To date, the Path to Excellence programme has drawn upon robust methods of social research as consultation and engagement methodologies where appropriate to provide a best practice approaches.

However, engagement and consultation around significant NHS service change is not an academic research project but more a targeted continuous dialogue with staff and communities who are most affected by potential changes. The process aims to ensure that they have the information, time for consideration and clear ways to give their views, with a particular focus on collecting depth qualitative feedback to give the richness of insight to inform robust solutions to the problems the NHS is facing and to support decision makers in performing their statutory duties and inform their final decisions.

The Path to Excellence partners recognise that a programme of pre-engagement and subsequent formal public consultation for significant NHS service change is a continuous (on-going) dynamic (adaptable/open to change) dialogue (a two way conversation) and as a result this strategy will adapt as work progresses.

In the light of this, this strategy sets out a sound basis to progress work, with clear rationales for activities within NHS policy (Including the NHS Five Year Forward View), best practice communications and where relevant statutory duties and case law.

It should be noted that this version (March 2018) sets out the pre-engagement strategy, this paper will be updated to incorporate the formal public consultation phase, to take place in spring/summer 2019.

It should also be noted that while this strategy makes reference to the need for a wider communications and engagement strategy about creating a vision for health and care across South Tyneside and Sunderland (see section 16),this strategy specifically focuses on the acute / hospital services aspects. This in line with the NHS Five Year Forward View vision and, in particular, to help close the gaps in quality and the variations in patient outcomes and experience which currently exist by reshaping how acute hospital care is delivered.

As work progresses on a wider vision for health and care across South Tyneside and Sunderland, this will focus on other important aspects of the NHS Five Year Forward View. For example how we support people to take responsibility for their own health and wellbeing so that they do not become unwell with wholly avoidable illnesses, and how we can continue to improve efficiency across our health and care system.

2. Introduction

This strategy sets out the NHS legal and policy context for significant service change in relation to public consultation and engagement, and the strategies, governance and subsequent activities that will need to be undertaken in order to ensure a robust process for the Path to Excellence phase two pre-engagement and consultation in line with this context.

The NHS legal and policy context is set out in appendix 2.

The main services being reviewed are those delivered by South Tyneside General Hospital and Sunderland Royal Hospital. These are:

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

The challenge is to make what are very complex, interdependent issues as simple as possible for the public to understand, while ensuring underpinning good communications and engagement processes providing the right information for people to make an informed view. This in turn allows decision makers to understand public feedback in a systematic way, incorporate the feedback into planning and options development, and ensure compliance in regard to legal duties around major service changes and NHS future public consultation.

This strategy provides the framework for:

- clear rationales for activities to be undertaken
- how specialised communications and engagement expertise will be deployed
- how that expertise will support clinical leaders and other NHS staff to lead public and stakeholder engagement
- how the governance and partnership arrangements provide oversight on the end to end programme of pre-engagement and subsequent public consultation.

The strategy outlines that two distinct phases of pre-engagement and subsequent formal public consultation will be developed and mobilised.

It sets out how insights gained from patient experience and public/staff engagement will influence the development of credible options for service change during the formative stage and prior to formal public consultation.

These future options will be presented and open to influence during a public consultation planned for spring/summer 2019 with decision making likely to be early 2020.

There is a clear stakeholder, staff and public expectation to be involved earlier in phase two and as a result pre-engagement phase involvement with key groups will be enhanced.

Updated programme governance includes establishment of P2E consultation stakeholder reference group (provide advice, views, suggestions or opinions on communications and engagement activity).

The terms of reference for this group is included as appendix 3.

At an early stage in phase one travel and transport was identified as a key issue. A travel and transport working group was established to take these issues forward and two key task and finish groups have been agreed as part this work.

3. Pre-engagement phase (December 2017– Autumn-Winter 2018)

3.1 Pre-engagement aims

The main aims of this pre-engagement phase are for the programme to:

- Ensure public and stakeholders are aware of the reasons and issues of why change is needed, prior to any future consultation
- Understand what is important to patients, staff and the public
- Share early thinking on emerging ideas for the future.

3.2 Communications and engagement strategic objectives

During the pre-engagement phase, the key objective is to ensure all activity is to ensure the successful preparation of full pre-consultation business case and relevant assurance assessments for formal consultation in 2019.

The objectives are:

- Ensure compliance with key NHS legal and policy requirements for significant service change in relation to public engagement and future consultation
- Benchmark patient experience across the pathways to inform clinical service review case for change and option development
- Ensure staff engagement and involvement in order to provide opportunities for input, feedback, influence and sense checking on emerging future options
- Development of updated issues document /case for change to include the draft working list of future potential options be shared initially in draft form to allow for staff, public and stakeholder feedback in order to influence option development at the formative stage
- Carry out detailed stakeholder mapping and data analysis in order to identify civic society groups and organisations with interest

- Provide wider opportunities for participation by key groups with interest and experience in the specific issues as identified by the stakeholder mapping
- Deliver a highly visible public engagement programme throughout summer 2018 to socialise the issues, explain the current gaps in quality, share the early thinking from staff on potential solutions and allow an opportunity for the public to influence potential solutions at the formative stage.
- To explain how the problems are being identified, how ideas for change will be assessed using transparent assessment criteria, how 'clinical due diligence' will take place in order to ensure feasible options for the future are developed
- To test improved communications and engagement mechanisms to ensure they are robust and support continuous dynamic dialogue required for best practice consultation utilising digital and social media as required

4 Ensure compliance with key NHS legal and policy requirements

As highlighted, appendix 2 contains information on the NHS legal and policy context for service change – and it is summarised below.

NHS policy requires two distinct phases to deliver significant service change:

- Pre-engagement phase – socialising issues and case for change, staff and stakeholder involvement in option development (the focus of this strategy as of March 2018)
- Formal consultation phase – formal consultation on options devised in the pre-engagement phase (this strategy will be updated later in 2018 to plan for formal public consultation)

Compliance required with statutory legal duties for consultation, including consultation with Joint Overview and Scrutiny Committees (JHOSC), plus case law such as the Gunning Principles and the Equality Act.

Compliance required with five NHS assurance test for service change:

- Clinical engagement and support from clinical commissioners
- Strong patient, public and stakeholder engagement
- Clear clinical evidence base
- Consistent with current and prospective need for patient choice
- Bed test (added in April 2017)

Other key NHS policy areas to ensure alignment:

- Empowering community model for patient centred care

- NHS constitution standards around patient involvement and patient choice
- Clinical standards
- Five Year Forward View

In order to gain third party independent quality assurance of the process, the programme will work with the Consultation Institute.

This strategy and associated action plans acts as assurance on meeting NHS legal and policy obligations in relations to the public engagement and communications elements of significant service changes for the NHS.

5 Benchmarking patient experience

Ensuring robust insight around current experiences of services is critical intelligence required to help the clinical design teams understand what is important to patients, what is working well and what areas there are for improvement.

This will be conducted in a three phase approach, with each phase feeding into the next:

5.1 Desk review

In line with best practice, and to assist discussions taking place amongst staff from both South Tyneside and City Hospitals Sunderland NHS Foundation Trusts, a desk review was undertaken of any national benchmarking patient experience surveys to allow comparison of the performance of both Trusts against national standards.

The review also reviewed existing local, regional and nationally available insight and patient experience work for each clinical speciality.

Again in line with best practice, this is carried out in order to frame the local engagement research methodology and ensure previous work is not reinvented to continue to build a robust insight knowledge base.

5.2 Qualitative patient interviews and surveys

In addition, targeted engagement was also undertaken with patients from both Trusts to further understand patient experience and perception in relation to the above clinical review service areas.

Patients and carers is hospital settings were targeted to share their recent experience of using these three clinical service areas and how they feel they could be improved.

Further detail on benchmarking patient experience can be found in appendix 4 together with a draft analytics benchmarking patient experience report which is included at Appendix 5 and will be updated with wider field work findings when completed.

5.3 Wider patient experience field work and quantitative research

The qualitative face to face survey work described above will be supplemented by broader quantitative field research over Spring 2018 which again will be shared with the teams involved in the clinical services review work streams to inform discussions.

The two main methods for this engagement research phase includes quantitative surveys, either by direct mailing with a free post return or online targeted via digital advertising and social media, and as noted above by face to face qualitative surveys carried out on hospital wards and out-patient clinics in the hospitals by trust patient experience staff and volunteers.

6. Staff engagement and involvement

As key improvements from phase 1, enhanced staff engagement and involvement has been supported and as highlighted in the outline strategy, is underway.

Across both Trusts there has been improved staff communications for all staff – and specific targeted with staff working across the three key clinical service areas under review. This has included very clear visibility on who is involved in each of the work streams and regular proactive briefings across both Trusts in relation to Phase Two.

Targeted staff communications and involvement was identified as needed with teams in the three service areas:

- Acute medicine and emergency care
- Emergency surgery (including theatres and critical care)
- Planned and ongoing care and specialist services

The objective was to capture views from frontline staff on the challenges and difficulties they currently face in service delivery, what ideas they had for improvements for service delivery and also their feedback on how staff should be involved.

6.1 Staff survey

A survey was designed to capture views from frontline staff in South Tyneside and Sunderland on the challenges and difficulties they currently face in everyday service delivery and to seek their ideas on how to further improve the quality of patient care.

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The survey included quantitative and qualitative methods, the findings reported back to staff and used to inform the development of phase 2 case for change as well as improved staff communications and involvement.

In total, 710 people members of staff responded to the questionnaire from a total of 4246 staff who were invited to take part who work in the areas impacted by Phase two. This represents an overall response rate of 16.7%. Of these 710 responses 580 members of staff responded to most of the questionnaire.

Almost a fifth (17.8%) of staff invited to complete the survey at South Tyneside NHS Foundation Trust did so (n = 215 from a sample size of 1207). This equalled six per cent of the total Trust workforce. For City Hospitals Sunderland NHS Foundation Trust, sixteen per cent (16.3%) of staff invited to complete the survey did so (n = 494 from a sample size of 3039). This equalled ten percent of the total Trust workforce.

Summary quantitative feedback from staff survey

- A third of staff told us that their ward or department often saw patients who should be admitted or seen by another speciality. Nearly all (93%) of respondents felt they had the right skills to deal with patients in their ward or department.
- Almost four out of ten staff felt there was enough staff and capacity on their ward or department to treat patients safely and effectively most of the time (38%) or some of the time (37%).
- Only 24% of staff reported having easy and quick access to specialist advice about their patients care and treatment all of the time, with 53% stating this was available most of the time.
- Only 17% of staff reported having easy and quick access to diagnostic tests, scans, and results all of the time, with 52% stating this was available most of the time

Summary qualitative feedback from staff survey

The top five qualitative themes from the staff survey are detailed below, with most people commenting on issues to do with workload, staffing, working conditions, physical capacity and equipment and facilities:

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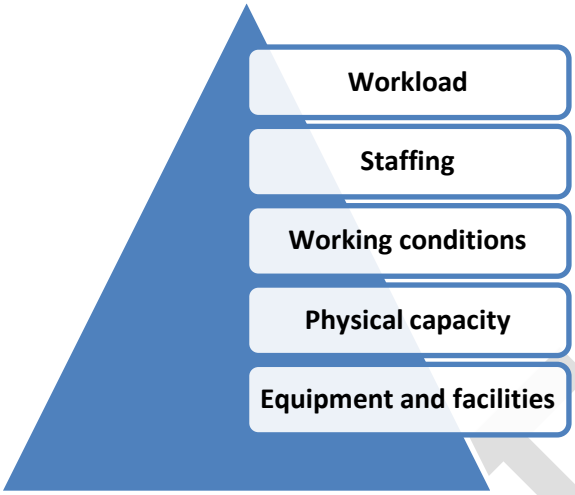

Workload

This theme includes comments made about an increased or large workload for staff. This includes staff having to work across multiple sites. Staff mentioned having a lack of capacity to carry out their role, with competing timescales. Staff commented on high-dependency patients and balancing complex case-loads.

Staffing

A number of comments were made in relation to a shortage of staff, and a shortage of appropriately trained staff or specialist staff. Some staff commented that there was inadequate staff employed. Training was identified as an issue – either through people having training needs which are not being addressed, or not being able to find the time to attend training. Some staff were asked to work-up beyond their skills or role, and some staff felt they were asked to do jobs below their current role. There was also comments made about the use of agency staff and locums, particularly in the final question (any other thoughts or comments). For example, one member of staff commented how they needed a consistent consultant instead of locums to help support the team and ease pressure. Another member of staff commented on the expenditure of outsourcing staff (locums) in Radiology.

Working conditions

This theme identified issues such as overtime, flexi-time, sickness, low pay, and lone-worker policy. Some people identified bullying and harassment, unfair dismissal, or working with obstructive staff. This theme also covers comments made about management, decision making and financial issues. A number of staff mentioned low morale, and feeling undervalued. This includes low job satisfaction and people looking for other jobs. People commented how they are unable to find a work-life balance, and were asked to work beyond their hours without pay. Staff commented on feeling mentally exhausted. Alongside job insecurity, staff felt there was no career pathway or progression for them. They also felt their roles had too many admin tasks associated with them. A lack of communication was also

mentioned, both internally with staff, perhaps through bulletins, and externally to the public.

Physical capacity

Staff frequently mentioned a shortage or limitation of bed space for patients. Comments were received in relation to not having capacity to accommodate referrals from other services. Staff felt pressured to discharge patients to free up bed space and capacity. Comments about waiting lists also fell into this theme. In addition, comments about a lack of storage space fell into this theme.

Equipment and facilities

A number of comments were made in relation to out of date equipment. This included IT equipment, but also medical facilities. Staff identified a high demand for certain rooms and facilities (such as theatre space and x-ray equipment) as a challenge. They also identified improved IT systems and electronic access to medical records as an area for improvement. Staff also commented on inappropriate facilities for patients (for example – a ward not being suitable for neuro or stroke rehabilitation). Finally, this theme covered a lack of stock (staff predominantly did not elaborate further than 'not enough equipment' or 'low stock', however one member of staff identified low film for x-ray rooms).

The full staff survey report is included as appendix 6.

6.2 Staff engagement events

Three half-day discussion workshops were held in March 2018 for each of the clinical review service areas:

- Emergency care and acute medicine
- Emergency surgery
- Planned and ongoing care and specialist services

As well as the core design team, key representation from the wider workforce was invited **from both Trusts** and included:

- Ward managers and senior nursing staff
- Junior doctors and middle grades
- Clinical support (radiology, pathology, therapies, pharmacy as appropriate)
- Therapy teams

In order to allow some clear thinking space and signal unity between the two FTs, these sessions were held off site at a venue in between South Shields and Sunderland (Boldon) and bring together staff from both Trusts.

The format included an introductory presentation from the core design team, feedback from the staff survey work (see section 6.1) and feedback from the patient experience benchmarking to date (see section 5).

The purpose was to explain the issues each core design team had identified to date, asking staff about what issues they identify and what ideas and potential solutions for these challenges they had. Their comments and feedback would be captured in-order to feed into case for change development.

In order to provide the best conditions for open and honest conversations, the workshops required facilitated round table discussions, allowing people to input their views. Independent facilitation of these events supported by NECS ensured smooth running and that no-one side of the alliance were perceived to dominate the conversation.

A draft feedback report from the staff events covering issues and ideas is contained as appendix 7.

A further round of similar staff engagement events is being planned for June 2018 and will include a discussion on:

- Brief feedback from March events (You said, we did)
- Progress update from work stream
- The draft case for change and working list of potential future scenarios
- Risks and opportunities / links to other work streams
- Organisational support for staff during change.

Feedback from these June staff engagement events will be fed into the first clinical due diligence event in July 2018 (see section 6.5).

6.3 Key insights gained from staff in relation to communications and engagement up until April 2018

During the staff survey work and staff workshops, there was a re-occurring theme of the desire for more opportunities for engagement and enhanced staff communications.

Staff emphasised the importance of being engaged and empowered at an earlier stage. They wished to have further advanced notice of staff engagement events and more opportunities to get involved as well as references to staff needing time to respond to engagement opportunities – either face to face or survey work.

Feedback also contained references to how staff on the ground wanted to influence the shape of how services might change. There was also mention of the culture of the organisations making sure people felt able to contribute ideas without concerns of criticism for doing so.

One particular area of interest surrounded the use and importance of patient feedback and how this could be used much more practically and visually across both organisations as well as with patients and the public.

It was requested that after each clinical services review session, sub groups of the clinical service review group should feedback progress. There was emphasis about wishing to have open and honest communication, with ‘clarity’ and being ‘consistent’ the key words used by staff in feedback.

Feedback from the event evaluation forms showed that there were some very positive responses to the three events. Staff felt that the events were a good opportunity to discuss their opinions, concerns or themes, especially away from their departments and interruptions. They enjoyed being in a different atmosphere and being able to speak their minds among staff from both Trusts. In particular, staff at all three workshops mentioned that the events made them feel valued and being able to give their opinions made them feel appreciated, it also provided staff with the opportunity to begin creating personal links with colleagues from both sites.

There was some concern about the lack of representation from other organisations and services, therefore more work needs to be done to understand how staff are invited to events. There was very much an appetite for more sessions to take place - which is a good starting point - and they liked the way the events were structured and organised.

The table discussions stood out as a positive along with the opportunity to hear the opinions and views of other people. Facilitators were mentioned specifically and were seen as very supportive, with staff praising the idea of having a facilitator at each table and they liked having their comments recorded by a scribe.

Some even indicated that they liked the table facilitation process the most, therefore consideration needs to be given in regards to how facilitation training could be broadened to staff across the Trusts and wider health economy in order to support staff engagement, recording their feedback in order to influence plans and respond to issues raised.

In regards to improvements while it was commented that the events were well organised, there were some suggestions for improvements to timing and length, however as mentioned earlier, as much notice as possible should be given to ensure a wider representation of staff groups. Concerns about how people who cannot attend events in person could be part of the process were also raised, this could be resolved through video, apps such as sli.doand post event communications allowing people to contribute in different virtual ways.

In terms of what happens next, staff wanted to see action plan which includes the impact of their contribution and how the information that they have provided will be useful in the case for change.

Some early themed questions have emerged around jobs and organisational culture, these included:

- There were many questions surrounding the future of South Tyneside District Hospital, will it change into a “cottage hospital”?
- There were many questions about what any changes might mean to people’s individual jobs, for example:
    - If there will be job losses
    - In relation to seven day working, would people be moved from shift work (especially those who don’t current work shifts)
    - Will people need to move and work on different sites
- Have the larger decisions already been made?
- Will there be equal influence and voice across both trusts? (perceptions of bias)

These questions were addressed during the events and will continue tobe incorporated into wider staff communications.

6.4 Staff communications from clinical design teams

It is recognised that there is a strong appetite for more communications and engagement activity as set out above to ensure the workforce across both Trusts is kept up-to-date as work progresses and make sure staff have an opportunity to become involved at appropriate times.

- A revised programme of regular internal communications and engagement activity for both Trusts is significantly helping this process as follows: Regular proactive updates for all staff are shared across both organisations about Phase Two via a number of mechanisms
- Updated intranet pages across both Trusts now include:
    - Details of work stream leaders and membership
    - Overarching timeline for Phase Two
    - Monthly e-bulletin updates from each work stream meeting which have been held since December 2017 are now available to all staff
    - Facility to ‘Ask a question’ / get involved and give views
    - Copies of all materials shared at March 2018 staff engagement events
    - Staff survey report
    - Staff engagement events report

In addition to the above, there is a need to support the clinical leaders involved in the core design teams for each area undergo some strategic leadership / core interpersonal communications skills training in preparation for helping to deliver staff, stakeholder and public engagement activities in front of large audiences. Work is also underway with organisational development and HR colleagues in both Trusts to develop a suite of support to be made available to help staff cope and deal with what is going to be a challenging agenda at the same time as managing business as usual.

More information is highlighted in the tactical action plan which tracks the operational delivery for staff communications and engagement on phase 2 P2E and also support

for staff development - this activity is summarised in key programme milestones (see appendix 1).

6.5 Clinical 'sense check' due diligence workshops

Two clinical 'sense check' due diligence workshops are recommended for summer 2018 and winter 2018 / early 2019. These will be day-long events and will bring together the core designs teams only, across the three service areas from both Trusts. These events will allow for strategic discussion and sense checking on the working list of potential future scenarios which have been put forward by each work stream.

Again, it is recommended that these are held off site and independently facilitated. The purpose will be to look at the working list of emerging models from each work stream and sense check on the clinical interdependencies and any other areas for consideration as part of option development. These events will also play a key role in building upon the work started in the March staff engagement workshops by bringing together working cultures from both organisations.

Elements of these events will be captured on video, with vox pops from clinical leaders which can be shared with the wider workforce and demonstrates transparency – linking back to staff requests for more information to be shared (see section 4.4.3)

There should also be simultaneous updates for stakeholders and the public on the work underway as part of the clinical service reviews.

To coincide with these clinical due diligence events, simultaneous staff and stakeholder updates will be shared widely to ensure there is a consistent message about:

- Context / case for change / current situation
- Why change is needed and will be better for patient care
- Feedback gained from discussion workshops with staff / staff involvement
- The emerging direction of travel / potential future options
- What needs to be considered as part of option development
- Timeline, process and next steps for public engagement and consultation

7. Updated issues document – the narrative for the case for change

In order to articulate to the public the issues the local NHS is facing, an updated issues document will be developed which will act as the underpinning narrative and key messages for phase two.

This will take into account the feedback to date from staff, patient experience benchmarking and the work carried out to date by the clinical design teams.

It should be shared initially in draft form for staff, public and stakeholder feedback and updated as necessary as work moves towards formal public consultation in summer 2019.

The updates 'case for change' should include:

- Reminder about why phase one vulnerable services were chosen
- Learning lessons from phase one to improve wider staff and stakeholder involvement at earlier stages
- The strong and vibrant future for South Tyneside hospital
- Changes are clinically led to make best use of staff resource, expertise and to improve clinical care and therefore outcomes for local people
- Feedback to date from staff engagement regarding the challenges they observe
- Feedback to date from patient experience

In addition to this, a high level clinical narrative is developed which clearly articulates the clinical vision and the areas being discussed and likely to be consulted upon:

- Emergency care and acute medicine
- Emergency surgery
- Planned and ongoing care and specialist services

This will underpin all communications and engagement activity during the pre-engagement and formal consultation phases and ensure there is a consistent message from the outset of phase two.

For each of the clinical service review areas, a specific narrative will need to be developed and approved which covers the following points:

- What is the current situation? (Data, facts and figures)
- Why is change needed?
- Why would change be better for patients and what is important to them?
- What do we need to consider?

Further detail can be found in our tactical action plan which tracks the operational delivery for the issues document development, clinical narratives, how and where it is shared in draft and finalised, this is summarised in our key milestones document in appendix 1.

8. Stakeholder mapping

In order to ensure the programme effectively targets patients, key groups and organisations, detailed stakeholder mapping and data analysis of demographics is

being carried out in order to inform who has influence and/or interest in the issues within the Path to Excellence programme.

It must be emphasised that this is best public relations practice, and it is carried out in order to make the best use of programme resources to target key interest groups, in order to ensure they have the opportunity to hear about the issues, get involved as they wish, ask questions and feedback views.

We are currently mapping key stakeholder groups within each of the clinical work streams and will use this detail to inform future planning of targeted engagement activity.

9. Democratic engagement

9.1 South Tyneside and Sunderland joint health overview and scrutiny (JHOSC)

NHS partners are mindful of their statutory duties to engage with health overview and scrutiny committees and elected members and respect this is how NHS organisations are locally democratically accountable. Section 244 sets out the duty to consult with local scrutiny committees on matters of NHS significant variation of services and NHS consultation (see appendix 1).

From April 2016, South Tyneside and Sunderland hospital trusts began a formal discussion with the two separate health overview and scrutiny committees around the formation of the partnership and subsequent Path to Excellence phase one programme.

The partnership made a formal request to the local authorities that the formation of a joint overview committee should be considered under section 30 of the local authority health scrutiny guidance.

NHS leaders subsequently attended 11 JHOSC meetings since April 2016 to January 2018, in addition to a large commitment of the programme management resource to support requests for information, involvement of elected members in procurement etc.

This also included:

- Programme support to fund The Consultation Institute for members training
- Support provided for lead specialist and senior clinicians from NHS clinical networks to attend JHOSC to provide independent clinical views on the options
- Dedicated briefing session for members on the safety of freestanding midwife led units by the regional maternity system lead consultant took place and a visit to a successful FMLU is being organised. This was in

direct response to a request from JHOSC members to obtain better information about the safety of midwifery-led care

The JHOSC interim response to the P2E phase 1 consultation praised the NHS involvement with the committee, however its final response criticised the NHS for use of jargon and not understanding the scrutiny process.

In March 2018, the JHOSC and subsequent the two single local authority health overview committees decided on a unanimous basis to refer the Path to Excellence phase 1 consultation to the Secretary for State for Health and Social Care, citing inadequacy of consultation with them (JHOSC), and that decisions were not in the best interest of local health services.

In the light of this, consideration should be given to how programme management resources should be aligned on a proportionate basis in order to make best use of the limited resources (people and time) and also ensure statutory duties to consult with the committee are met.

9.2 Co Durham Health overview and scrutiny

The programme will continue to engage with County Durham Health Overview and Scrutiny committee to assess their requirements for consultation with them as a single HOSC.

9.3 Members of Parliament

Each of the NHS organisations continues to engage with local members of parliament, usually via chief officers. NHS Chief Officers will continue to co-ordinate this via their regular CEO meetings.

9.4 Attendance at local area ward committees

As part of developing the updated issues document, attendance at local area committees is recommended to reach local communities and civic society.

A section of the programme tactical action plan tracks the operational delivery around democratic engagement, a high level timeline can be found in our key milestones document – see appendix 1.

10. Engagement with NHS partners

10.1 Health Watch organisations

Both South Tyneside and Sunderland Health Watch organisations are members of the communications and engagement task and finish group and stakeholder advisory panel. They continue to provide robust positive challenge, suggestions and ideas to contribute to the development of the overall engagement and consultation processes. This is in line with their statutory role as a consumer voice for health and social care.

The Path to Excellence partners welcome and value the ongoing involvement of the Health Watch organisations. They recognise that as small organisations, their contribution of time and knowledge is extremely precious – therefore even more valuable as a result.

10.2 Primary care – GP community

The CCGs are membership organisation of GP practices, and therefore are ideally placed to support enhanced GP engagement for phase 2.

A programme of engagement with the GP community will be developed in parallel with the public and trust staff engagement. This is likely to take the form of updates at training events, council of practices, via GP federations and via The British Medical Association and Local Medical Committees.

10.3 North East Ambulance Service (NEAS)

During phase one, there was a public perception that NEAS were not involved in P2E discussions, despite the organisation being involved at appropriate times.

In order to allay public fears, work will take place with NEAS to provide joint updates and specific references to their involvement in work as it progresses.

This also accounts for NEAS being a regional organisation and will assist in helping make best use of resources.

10.4 Neighbouring provider trusts

As we understand the options in more detail and the potential impact on patient flows we would start to have conversations with other providers i.e. Gateshead Health Foundation Trust and Newcastle Upon Tyne Foundation Trust.

10.5 Clinical senate and clinical networks

As a continuation of phase 1, work will continue with the Northern region clinical senate and networks.

They provide targeted system support to improve health outcomes and reduce unwarranted variation, and support the development of lasting local solutions to address national priorities.

Combining the experience of clinicians, the input of patients, and the organisational vision of NHS staff, the Northern England Clinical Networks work in partnership with those who use, provide and commission health services to make improvements in outcomes and reduce variation across the region.

11. Public participation and involvement

There is a clear mandate from NHS England, for the enhancement of participation and ‘co-production’ with stakeholders and communities in order to deliver the NHS

Five Year Forward View, and the development of integrated care partnerships (formally known as sustainability and transformation partnerships).

Participation means giving people the meaningful opportunity to shape and take part in activities that will have a clear influence in the end results.

A key element of the pre-engagement strategy is to provide wider opportunities for participation by key groups with interest and experience in the specific issues under review as identified by the stakeholder mapping (see section 8).

Given the complex nature of the interrelated service reviews, consideration should be given to how participatory techniques can be deployed in a realistic and meaningful manner.

There are different participatory techniques that can be deployed, and there is no one size fits all, so different approaches will need to be adopted depending in the emerging issues. Approaches may include face to face events or digital participation.

Wider participation will be deployed to support options development and/or options appraisal as well as participation in setting the evaluation criteria (which is used to assess options as being robust for consideration) and testing via formal public consultation period in 2019, including harder to reach groups.

In the pre-engagement phase, each area of clinical service review requires close consideration between the clinical design teams and communications and engagement staff in order to ascertain the most meaningful participation techniques relevant to develop and deploy.

12. Wider communications plans to explain the case for change and clinical assurance (pre-engagement phase)

Whilst the pre-engagement phase should not feel like it is a public consultation, it is important that public engagement activity is highly visible in order to socialise the issues, explain the current gaps in quality, share the early thinking from staff on potential solutions and allow an opportunity for the public to influence potential solutions at the ‘formative’ stage.

In addition to this wider public engagement, activity will also be carefully targeted in order to support engagement with key groups as identified via the stakeholder analysis (See section 8).

It is important to note that this does not exclude anyone who wishes to take part, stakeholder analysis is a tool to assess those with interest and influence in issues in order target their involvement and make best use of programme resources in order to gain meaningful and informed feedback on the issues.

The main purpose of communications and publicity in the pre-engagement phase is to explain how the problems are being identified, how ideas for change will be assessed, how 'clinical due diligence' will take place in order to ensure feasible options for the future are developed and how people can be involved.

All public materials will use plain language, be honest and transparent for example – instead of saying clinical risks – say the harm that can happen to patients that could result in their condition becoming worse, or in some cases long term disability or even death.

This is recognition that in phase 1, despite best efforts, it was clear in public events and other public feedback received that some people did not make the connection between quality of services meaning that having qualified and trained staff to work in those services with access to the right support/supervision and diagnostics had a direct link to the care delivered to patients – and the subsequent effect this had on the patient's health outcomes.

Wider communications plans include:

- Promotion of wider patient experience field work (see section 5) defined by data analysis for most relevant tach
- Updated and refreshed Path to Excellence website (Phase 1 archived so will available)
- Publication of key documents, print and digital – including updated issued document (see section 7)
- Stakeholder bulletin updates
- Enhanced social media presence, with video, graphics as required
- Use of existing communications channels, NHS websites, staff communications
- Regular media releases and special features in the Echo and Gazette – in particular pre and post key milestones (eg staff or stakeholder participation events)
- Continuation of promotion and use of My NHS (CCG membership scheme with c1500 members)
- Public engagement roadshows across South Tyneside and Sunderland during summer 2018 and quantitative feedback via an online survey

13. Monitoring improved communications and engagement plans

As previously stated, this strategy is about developing a continuous dynamic dialogue, with every aspect of strategy delivery open for review and continuous improvement and therefore adaptation as phase 2 progresses into formal public consultation.

Consideration should be given to evaluation measures that can be tracked and reported to give insight into the strategy's effectiveness. This is a continuation of phase one metrics and examples are included below and more should be developed as time progresses.

13.1 Evaluation and measures

In order to assess what communications and engagement mechanisms are working and what could be improved it is important to build in continuous review in order to ensure tactics are robust and support continuous dynamic dialogue required for best practice consultation.

It is recommended that:

- Every event to have post event evaluation forms, analysed and reviewed for lessons and improvements, shared with relevant groups and published.
- Every event to have pre-meet and post event debrief with event staff in order to bring lessons or improvements into the next event.
- For every key tactic being planned, active evaluation measures are considered and should be a key part of each specific plan.

Outputs

- Feedback forms from staff and public at events (including demographic analysis and sentiment)
- Numbers of staff attendance at events
- Number of stakeholder/public at events
- Attendance at public engagement roadshows
- Online survey responses
- Number of questions asked by staff via intranet page
- Social media engagement, sentiment and tracking
- Media coverage sentiment and tracking

Outcomes

- Improvement in 2017 NHS staff survey for Trust staff
- Best practice met in line with Consultation Institute independent quality assurance
- Improvement in CCG stakeholder 360 survey results in relation to key stakeholders

14. Equality delivery

The Path to Excellence plans are subject to a rigorous NHS assurance process which aims to eliminate discrimination, promote equality of opportunity and ensure that, wherever possible, services are provided in ways which might reduce health inequalities.

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The general and specific equality duties (detailed in appendix 1) and set out in section 149 of the Equality Act at:
http://www.legislation.gov.uk/ukpga/2010/15/contents.

In exercising its functions, the NHS must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act, and actively promote equality
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

As part of the pre-consultation business case, a fully integrated equality, quality and health impact assessment will carried out.

In addition to this, a health equalities analysis will be conducted on the pre-engagement and consultation processes. The health inequalities impact assessment (HIIA) is a tool used during NHS service reform planning to assess the potential of any policy, plan, proposal or decision to reduce or increase health inequalities. Many policies have the potential to impact on health inequalities and this is critical information that the NHS will need to consider in making their final decision.

It is very important that key data monitoring information is requested at all opportunities consistently across all engagement methods. However whilst it is a public sector equality duty to ask for data monitoring information, it is an individuals' choice whether to decide to provide it.

The assurance process requires appropriate engagement with the identified groups who work with people who may face barriers to taking part in engagement activity providing a meaningful opportunity for people who may be more impacted by any potential change to consider and feedback on the various issues.

The programme will build upon the robust work carried out in phase one, which took as asset based approach to work with local third sector voluntary and community groups or organisations to hold focus groups or an event in South Tyneside and Sunderland to support phase 1 consultation with different vulnerable groups in relation to specific or different issues.

14.1 Standards and formats of information

As a result of learning from phase 1 – the following aspects have been incorporated into phase 2 planning.

- Support from Sunderland People First (learning disability) to develop a protocol for easy read documentation

    - This includes ensuring key programme public documents have sufficient lead in time so that easy read versions can be developed and published alongside other public document in order to ensure equity of access
- Inclusion of HealthNet (CVS umbrella organisations) in a new Stakeholder Advisory Panel – earlier engagement with CVS organisations to support equality delivery

All public information produced as part of the programme will be written in language that can be understood by members of the public. Technical phrases and acronyms will be avoided, and information will be produced in other formats as required, to reflect the needs of the population.

This may include, but is not limited to:

- Easy read
- Large print
- Audio
- Braille
- Different languages
- Video
- Interpreters at public events

All tactical delivery plans will include equality delivery as standing items to ensure active consideration of equality as part of each key planning document.

15. Travel and transport

In phase 1 pre-engagement period, from November 2016 to March 2017, a number of activities were carried out to develop how the issues relating to travel and transport could be understood.

At an early stage travel and transport was identified as a key issue. As a result, dedicated travel and transport events were planned – one for the public that allowed the feedback to be considered at a second event for stakeholders. The feedback helped to identify the risks in relation to travel and transport and what might be needed to mitigate some of these.

The stakeholder event was attended by travel and transport organisations, bus providers, councils and third sector organisations. All issues and concerns, as well as comments and ideas for solutions, were collected and were extremely helpful in enabling wider discussion with those organisations directly involved in travel and transport.

A working group has been established to take these issues forward – and will continue to work together and two key task and finish groups have been agreed as part of this.

As part of the North East and North Cumbria strategic work around developing integrated care systems, a regional transport group has been identified as being required. The P2E programme will make links with this group as it is established.

16. Developing a wider vision for health and care for South Tyneside and Sunderland

It has been recognised that in order to solve the issues being faced by acute hospital services, a considerable element of ways to help solve these problems sits outside of hospital settings within primary care, community services, public health prevention, social care and services provided by the community and voluntary sector.

The strategy for the overarching health and wellbeing of the residents of Sunderland and South Tyneside sits with each local authority Health and Wellbeing Board.

The current policy direction of the NHS in England (NHS England, NHS Improvement and Public Health England) is developing on from Sustainability and Transformation Partnerships (bringing all local plans together into one overarching plan) to the development of integrated care partnerships in order to secure the future of local NHS services and maintain and improve the quality of services.

The two clinical commissioning groups have indicated that they wish to explore how a joint vision and joint working may be developed across the health and care system, drawing upon existing health and wellbeing strategies.

This section will be developed as this work progresses, and can be incorporated into the work programme as it develops.

17. Timeline for engagement and communications

A detailed timeline is required and has been developed in order to plan key activities – since April 2018 this has been underway, however at a high level the timings are:

May to July 2018

May 2018 - Wider qualitative patient experience research starts (see section 5.3)

June 2018 – Staff engagement events

July 2018 – First clinical due diligence ‘sense check’

Public and stakeholder briefings will take place to update on workshops taking place with staff and ensure consistent messaging about the case for chance, areas under discussion with staff and robust process being followed.

Wider communications and publicity takes place (see section 12)

Summer 2018

July 2018 – publication of the case for change document and emerging ideas for the future (widespread staff, public and stakeholder engagement activity to capture views and opinions at the formative stage)

Two targeted stakeholder events (one in each area) following the first clinical 'sense check' due diligence workshop to share feedback gained from staff, emerging models/direction of travel, sense check hurdle criterial and process for option development.

September 2018

Update for staff, public and stakeholders following second clinical due diligence event and and direction of travel, timeline and next steps for engagement and consultation.

October to December 2018

Further public engagement events as required to test aspects of the process for example hurdle criteria.

January 20 March 2019

Further round of staff, public and targeted stakeholder engagement activity to provide final opportunity to influence prior to formal public consultation in summer 2019.

Appendix 1 – Key programme milestones

P2E key milestones 140518.docx

Appendix 2 – NHS legal duties and requirements

There are several areas of statue, case law and national policy in relation to NHS reconfiguration and consultation. This section shows where this work would need to be compliant and planning audit trails would need to demonstrate the activity

undertaken. This would also ensure best practice engagement and consultation as part of a quality assurance process with the Consultation Institute.

NHS Act 2006 (As Amended by Health and Social Care Act 2012)

The NHS Act 2006 (including as amended by the Health and Social Care Act 2012) sets out the range of general duties on clinical commissioning groups and NHS England.

Commissioners' general duties are largely set out at s13C to s13Q and s14P to s14Z2 of the NHS Act 2006, and also s116B of the Local Government and Public Involvement in Health Act 2007:

- Duty to promote the NHS Constitution (13C and 14P)
- Quality (13E and 14R)
- Inequality (13G and 14T)
- Promotion of patient choice (13I and 14V)
- Promotion of integration ((13K and 14Z1)
- Public involvement (13Q and 14Z2):
    a. Under S14Z2 NHS Act 2006 (as amended by the Health and Social Care Act 2012) the CCG has a duty, for health services that it commissions, to make arrangements to ensure that users of these health services are involved at the different stages of the commissioning process including:
        i. In planning commissioning arrangements;
        ii. In the development and consideration of proposals for changes to services;
        iii. In decisions which would have an impact on the way in which services are delivered or the range of services available; and
        iv. In decisions affecting the operation of commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

S.244 NHS Act 2006 (as amended)

The Act also updates s244 of the consolidated NHS Act 2006, which requires NHS organisations to consult relevant local authority overview and scrutiny committees on any proposals for a substantial development of the health service in the area of the local authority or a substantial variation in the provision of services.

S.3a NHS Constitution

The NHS Constitution sets out a number of rights and pledges to patients. In the context of this project, the following are particularly relevant:

Right**:** You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

Pledge: The NHS commits to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services.
(Section 3a of the NHS Constitution)

S.82 NHS Act 2006 - Co-operation between NHS bodies and local authorities
In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

The Gunning Principles
R v London Borough of Brent ex parte Gunning [1985] proposed a set of consultation principles that were later confirmed by the Court of Appeal in 2001.

The Gunning principles are now applicable to all public consultations that take place in the UK. Failure to adhere to the Gunning principles may underpin a challenge relating to consultation process that may be considered through judicial review.

The principles are as follows:

1. When proposals are still at a formative stage
   Public bodies need to have an open mind during a consultation and not already made the decision, but have some ideas about the proposals.

2. Sufficient reasons for proposals to permit 'intelligent consideration'
   People involved in the consultation need to have enough information to make an intelligent choice and input into the process. Equality assessments should take place at the beginning of the consultation and be published alongside the document.

3. Adequate time for consideration and response
   Timing is crucial – is it an appropriate time and environment, was enough time given for people to make an informed decision and then provide that feedback, and is there enough time to analyse those results and make the final decision?

4. Must be conscientiously taken into account

Decision-makers must take consultation responses into account to inform decision-making. The way in which this is done should also be recorded to evidence that conscientious consideration has taken place.

'The Four Tests' – NHS Mandate 2013-15 (carried forward through NHS Mandate 2015-16)

NHS England expects ALL service change proposals to comply with the Department of Health's four tests for service change (referenced in the NHS Mandate Para 3.4 and 'Putting Patients First') throughout the pre-consultation, consultation and post-consultation phases of a service change programme.

The four tests are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners.

As a proposal is developed and refined commissioners should ensure it undergoes a rigorous self-assessment against the four tests

Planning, Assuring and Delivering Service Change for Patients – NHS England Guidance

Guidance from NHS England sets out the required assurance process that commissioners should follow when conducting service configuration.

Section 4.4 of the guidance refers to involvement of patients and the public, stating that "it is critical that patients and the public are involved throughout the development, planning and decision making of proposals for service reconfiguration. Early involvement with the diverse communities, local Healthwatch organisations, and the local voluntary sector is essential. Early involvement will give early warning of issues likely to raise concerns in local communities and give commissioners time to work on the best solutions to meet those needs."

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Appendix 3 – Stakeholder Advisory Panel terms of reference

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The Path to Excellence
Public Consultation Stakeholder Advisory Group

TERMS OF REFERENCE

1. Introduction

1.1 The Path to Excellence Public Consultation Stakeholder Advisory Group (the group) is established as a sub group of the Programme Management Group, accordance with the governance arrangements for the path to excellence programme and the South Tyneside and Sunderland NHS Partnership.

1.2 Work being undertaken by the NHS South Tyneside and Sunderland Partnership in the Path to Excellence Programme will cover a sustained perio of reform for hospital services over the next few years.

The partnership comprises of:

- NHS Sunderland Clinical Commissioning Group
- NHS South Tyneside Clinical Commissioning Group
- City Hospitals Sunderland NHS Foundation Trust
- South Tyneside NHS Foundation Trust

1.3 These terms of reference set out the membership, role, scope and reporting arrangements of the group.

2. Principle function

2.1 The principle role of the advisory group is to offer advice, views, suggestions opinions on matters related to the way in which the programme of public consultation and reform for the Path to Excellence should be conducted. The term public is in reference to all stakeholders.

Appendix 4 – Further detail on Benchmarking patient experience

Desk review

In line with best practice, and to assist discussions taking place amongst staff from both South Tyneside and City Hospitals Sunderland NHS Foundation Trusts, a desk review was undertaken of any national benchmarking patient experience surveys to allow comparison of the performance of both Trusts against national standards.

The review also reviewed existing local, regional and nationally available insight and patient experience work for each clinical speciality.

Again in line with best practice, this is carried out in order to frame the local engagement research methodology and ensure previous work is not reinvented to continue to build a robust insight knowledge base.

Qualitative patient interviews and surveys

In addition, targeted engagement was also undertaken with patients from both Trusts to further understand patient experience and perception in relation to the above clinical review service areas.

Planning started with the communications and engagement task and finish group in November 2017 to develop surveys and discussion guides.

Patients and carers is hospital settings were targeted to share their recent experience of using these three clinical service areas and how they feel they could be improved.

A small segment of the patient population with an overall sample size of 126 people responded by taking part in a facilitated one to one surveys in Trust sites.

These face to face surveys were carried out in order to give a flavour of the real-time views and opinions of patients who have recently used services at both Trusts (during February 2018) in order to inform staff engagement workshops planned for March 2018 and clinical service review discussions at the earliest possible stage.

Field work in the Trusts took place during the month of February 2018 at a time of heightened demand for NHS services.

A draft analytics benchmarking patient experience report is included at Appendix 4 and will be updated with wider field work findings when completed.

Wider patient experience field work and quantitative research

The qualitative face to face survey work described above will be supplemented by broader quantitative field research over Spring 2018 which again will be shared with the teams involved in the clinical services review work streams to inform discussions.

The tactical engagement delivery of the qualitative research will be decided after the key demographic data for the target groups of patients is analysed in order to ascertain the most appropriate engagement method.

This will be used to inform the further development of the engagement and communications plan for each specialty included in Phase 2 and will include publicity and promotional activity relevant to each target group (in line with the MOSAIC segmentation tool) to raise awareness of the opportunity for those with experiences of the local services to give their views.

For example, targeting of people who've recently used Emergency Departments via social media for an online survey (younger groups more likely to use smart phones and social media); and the direct mailing of a paper survey to acute medical patients with long-term conditions and their carers (older groups with a preference for paper formats).

The two main methods for this engagement research phase includes quantitative surveys, either by direct mailing with a free post return or online targeted via digital advertising and social media, and as noted above by face to face qualitative surveys carried out on hospital wards and out-patient clinics in the hospitals by trust patient experience staff and volunteers.

In order to ensure quality assurance, surveys and questions will be benchmarked against national NHS or special interest group surveys, in order to ensure relevancy and good practice. All final versions are to be agreed by the communications and engagement task and finish group and signed off by the lead medical director for the programme.

During this engagement activity, a dedicated event with local community and voluntary sector organisations to brief them on the issues, explain the engagement process and gain support and involvement to engage with service users to provide the opportunity to give their views. In summary, with the focus particularly in relation to equality impact and ensuring the process can capture the views of people with protected characteristics.

Appendix 5 - Benchmarking patient experience – report as of March 2018

FINAL A review of patient insight Sunder

DRAFT

Appendix 6 – Staff feedback report – staff survey

FINAL Path to excellence staff survey

Appendix 7 – Staff feedback report - staff workshops

Path to Excellence phase 2 - Seeking stat

DRAFT

South Tyneside and Sunderland
NHS partnership

The path to **excellence**

Transforming services in South Tyneside and Sunderland

South Tyneside and Sunderland Clinical Commissioning Groups
South Tyneside and City Hospitals Sunderland NHS Foundation Trusts

South Tyneside and Sunderland
NHS partnership

Phase 2 public engagement and communications strategy

Pre-engagement (listening) phase

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Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

During the pre-engagement phase

Key objective is to ensure all activity supports the successful preparation of full pre-consultation business case and relevant assurance assessments for formal consultation in 2019.

Eight underpinning objectives – all supported by tactical delivery plans

Builds upon and incorporates learning from phase 1 – reviewed by stakeholder advisory panel

Enhanced staff engagement and broader participation in the pre-engagement phase in response to feedback from key partners and stakeholders around their desire to be involved.

Incorporates equality delivery as integrated

Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

1. Ensure compliance with key NHS legal and policy requirements for significant service change in relation to public engagement and future consultation

Compliance required with statutory legal duties for consultation

- Consultation with Joint Overview and Scrutiny Committees (JHOSC)
- Case law such as the Gunning Principles
- Equality Act

Compliance required with five NHS assurance test for service change:

1. Clinical engagement and support from clinical commissioners
2. Strong patient, public and stakeholder engagement
3. Clear clinical evidence base
4. Consistent with current and prospective need for patient choice
5. Bed test (added in April 2017)

Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

1. Ensure compliance with key NHS legal and policy requirements for significant service change in relation to public engagement and future consultation

Other key NHS policy areas to ensure alignment:

- Empowering community model for patient centred care
- NHS constitution standards around patient involvement and patient choice
- Clinical standards
- Five Year Forward View

More emphasis on co-production and participation elements

Need to ensure clear audit trail of how options are developed and assessed prior to consultation – this is as important as final decision making

Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

2. Benchmark patient experience across the pathways to inform clinical service review case for change and option development

Robust insight around current experiences of services is critical intelligence required to help the clinical design teams understand what is important to patients, what is working well and what areas there are for improvement.
Three phase approach – one and two complete with wider field work starting May 2018

Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

3. Ensure staff engagement and involvement in order to provide opportunities for input, feedback, influence and sense checking

Key improvement from phase 1, enhanced staff engagement and involvement

Alignment with the trusts' ambitions to explore a merger between the two organisations

Targeted staff communications and involvement was identified with teams in the three pathway areas

Capture views from frontline staff on the challenges and difficulties they currently face in service delivery, what ideas they had for improvements for service delivery and also their feedback on how staff should be involved in the future

Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

3. Ensure staff engagement and involvement in order to provide opportunities for input, feedback, influence and sense checking

Targeted staff survey carried out (findings shared at staff engagement events)
Three half day discussion workshops and gained:

- Feedback on the issues to inform the cases for change
- Feedback in relation to communications and engagement

Staff survey work and staff workshops strong re-occurring theme of the desire for more opportunities for engagement and enhanced staff communications

More information about CSRG leaders – who is who, ways to ask questions, regular outputs

Support for CSRG colleagues some strategic leadership / core interpersonal communications skills training in preparation for helping to deliver staff, stakeholder and public engagement activities in front of large audiences.

Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

3 Ensure staff engagement and involvement in order to provide opportunities for input, feedback, influence and sense checking

Clinical sense check due diligence workshops Summer 2018 and autumn 2018.

Day-long events and for core designs teams, across the three service areas from both Trusts, to allow for strategic discussion and long list option development.

Video and social media coverage of events to share with wide workforce
Updates to wider stakeholders

Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

4 Development of updated issues document to be shared in draft form for public feedback and influence and wider once finalised

Act as the underpinning narrative and key messages for phase two.
Shared initially in draft form for public feedback and comments, then used more widely once finalised.
This update should include:

- Reminder about why phase one vulnerable services were chosen
- Learning lessons from phase one to improve wider staff and stakeholder involvement at earlier stages
- The strong and vibrant future for South Tyneside hospital
- Changes are clinically led to make best use of staff resource, expertise and to improve clinical care and therefore outcomes for local people
- Feedback to date from staff engagement regarding the challenges they observe
- Feedback to date from patient experience

Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

5 Carry out detailed stakeholder mapping and data analysis in order to identify civic society groups and organisations with interest

Work with each CSRG to consider each pathway:

- Stakeholder mapping – clinical groups, CVS organisations, other NHS organisations
- Data analysis – demographical analysis of patient flow, heat maps, postcode analysis or mosaic segmentation tool

    - Continuation of Joint overview and scrutiny committee – involvement of Co Durham
    - MPs
    - Clinical networks and senates
    - Other NHS Partners including NEAS

Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

6. Provide wider opportunities for participation by key groups with interest and experience in the specific issues as identified by the stakeholder mapping

Enhancement of participation and ‘co-production’ with stakeholders and communities in order to deliver the NHS Five Year Forward View

Work with each clinical pathway to understand what opportunities there are to develop participatory opportunities to involve staff and wider stakeholders (from mapping)

Options development, options appraisal, participation in setting evaluation criterion

Different techniques can be used – face to face, digital

Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

7. To explain how the problems are being identified, how ideas for change will be assessed using transparent assessment criteria, how 'clinical due diligence' will take place in order to ensure feasible options for the future are developed

Integrated communications and marketing incorporating:

- Enhanced staff communications and engagement
- Promotion of wider patient experience field work
- Updated and refreshed Path to Excellence website
- Publication of key documents, print and digital
- Stakeholder bulletin updates
- Enhanced social media presence, with video, graphics as required
- Use of existing communications channels, NHS websites, staff communications
- Regular media releases and special features in the Echo and Gazette – in particular pre and post key milestones (eg staff or stakeholder participation events)
- Continuation of promotion and use of My NHS (CCG membership scheme with c1500 members)

Communications and engagement strategic objectives

South Tyneside and Sunderland NHS partnership

8. To test improved communications and engagement mechanisms to ensure they are robust and support continuous dynamic dialogue required for best practice consultation utilising digital and social media as required

Consistent collection of data monitoring information inc protected characteristics
Monitoring and evaluation - eg event evaluation forms, post event debriefs,
Digital engagement metrics and media sentiment
For every communication activity – active evaluation measures are included for each plan

Continuation of travel and transport group and delivery of proactive communications to support phase 1 implementation

Equality delivery

South Tyneside and Sunderland NHS partnership

Support from Sunderland People First (learning disability) to develop a protocol for easy read documentation - key programme public documents ensure equity of access

Inclusion of HealthNet (CVS umbrella organisations) in a new Stakeholder Advisory Panel – earlier engagement with CVS organisations to support equality delivery

All public information produced as part of the programme will be written in language that can be understood by members of the public.

Technical phrases and acronyms will be avoided, and information will be produced in other formats as required, to reflect the needs of the population.

All tactical delivery plans will include equality delivery as standing items to ensure active consideration of equality as part of each key planning document.

Developing a wider vision for health and care for South Tyneside and Sunderland

The two clinical commissioning groups have indicated that they wish to explore how a joint vision and joint working may be developed across the health and care system, drawing upon existing health and wellbeing strategies.

Timeline

May to July 2018

Wider qualitative patient experience research starts

Public / stakeholder briefings to update on workshops taking place with staff and ensure consistent messaging about the case for change, areas under discussion with staff and robust process being followed.

Wider communications and publicity takes place

Summer 2018

Two targeted stakeholder events (one in each area) following the first clinical 'sense check' due diligence workshop to share feedback gained from staff, emerging models/direction of travel, sense check hurdle criterial and process for option development.

Timeline

September 2018
Staff, public and stakeholder update on long list of options and direction of travel, timeline and next steps for engagement and consultation.

October to December 2018
Further public engagement events as required to test aspects of the process for example decision making criteria.
To add: detailed timeline after discussions with relevant teams and co-ordination with strategic programme timeline

Detailed timeline after discussions with relevant teams and co-ordination with strategic programme timeline