27th April 2018

Dear Cllr Wright and Cllr Dix,

NHS response to South Tyneside and Sunderland Joint Health Overview and Scrutiny Committee's proposed referral letter to the Secretary of State for Health and Social Care

Thank you for sending a copy of the proposed referral letter dated 12th April 2018 (rec: 13th April 2018) and providing the NHS partners with the opportunity to respond in writing to the issues the committee is raising.

In this response, we have attempted to provide information and evidence relevant to each issue or point raised, and in order to be helpful we have used the reference paragraph number from the Joint Health Overview and Scrutiny (JHOSC) letter. We append your letter for ease of reference.

Grounds for referral

The JHOSC has set out the intention to refer to the Secretary of State on two circumstances: (ref: para 1.2)

Firstly, that it considers several aspects of these proposed changes will not be in the interests of the Health Service in South Tyneside and Sunderland and secondly, that the committee are not satisfied with the content of the consultation and that it has not complied with the Gunning Principles.

The first point is grounds for referral as set out within the regulations, however whilst we understand, but respectfully do not agree with the first of the two issues, the second basis of referral we believe to be incorrect and not in accordance with the guidance issued to health scrutiny committees by the Department of Health in 2014 (Link to guidance). We will attempt to explain our position on this matter later in this letter.

Circumstance 1: Not in the interest of local health services

To address the JHOSC's first concern that 'the changes would not be in the best interest of local health service', members will recall the very compelling reasons why these three clinical services were prioritised in order to reduce the safety, quality, sustainability risks which current exist. Throughout the whole engagement and formal consultation process, highly experienced clinical leaders and chief officers at all four partner organisations (NHS South Tyneside CCG, NHS Sunderland CCG, South Tyneside NHS Foundation Trust and City Hospitals NHS Foundation Trust) have consistently described how no change is simply not an option in these vulnerable service areas.

Stroke, obstetrics (maternity) and gynaecology and paediatrics (children's) emergency services are amongst those hospital-based services, particularly in South Tyneside, which are facing the most severe workforce sustainability issues, resulting

in service continuity challenges, risk around patient safety and quality, as well as financial pressures. These issues were set out and shared with the JHOSC at their meeting on 8th November 2017 as a draft issues document which sets out the key drivers for change as a direct result of these service vulnerabilities. Members were asked for their comments on this draft document prior to it being finalised, published and a programme of pre-engagement undertaken. The final version is available at the link below:
Path to Excellence issues document November 2016

Circumstance 2: Adequacy of consultation
In your proposed referral letter, members also express their dissatisfaction on the 'content of the consultation'.

Around adequacy of consultation, we respectfully note that according to the regulations[1] the basis for referral is that a JHOSC is not satisfied with the adequacy of content or time allowed for consultation with the scrutinising body rather than wider consultation with patients, the public and stakeholders.

Members have acknowledged the significant amount of time and energy invested by both scrutiny members and NHS officers as part of this process. In addition to 11 formal JHOSC meetings, we have also offered support and training, via access to The Consultation Institute, around the NHS legal and policy context for service change and consultation. We have also facilitated attendance at JHOSC by national and regional independent clinical experts, provided additional sessions on maternity and offered field visits.

Adherence to the Gunning Principles

Also, we would note that the Gunning Principles are legal case law considerations rather than issues for the scrutiny referral regulations, however, we are very happy to respond to points raised in relation to our compliance of the Gunning Principles in our consultation with the JHOSC, and this is set out below. It is also worth noting the CCGs formal consultation process has best practice certification pending from The Consultation Institute which recognises strong compliance in line with the Gunning Principles.

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 have not already made the decision, but have some ideas about the proposals.

In relation to phase one of the Path to Excellence programme, a range of different credible potential options were developed by the clinical design teams made up of key clinical staff in both Trusts. These potential future options were assed via key

1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf, page 26, ref 18

criteria, before being published. These potential future options were assed via agreed key 'hurdle' criteria before being published in order to ensure any potential future scenarios were both credible and deliverable in the expert and considered views of key clinical leaders.

This process was discussed with JHOSC 19th September 2016, 8th November 2016, 30th January 2017 and 17th July 2017.

We have been consistent throughout this process, that all potential future options were open to influence, and the consultation process was an important opportunity to test these options and seek other ideas and suggestions from all stakeholders for any other possible solutions.

Both the Pre Consultation Business Case (PCBC) and consultation document explicitly sets out the link between the main findings from the pre-consultation patient insight work and how those informed the option development. The pre-consultation patient insight report was presented to JHOSC on 30th January 2017.

In the public consultation document itself (pgs 30-35), pre-engagement feedback is summarised for each service area. Pre-engagement featured some feedback which rated the ability to see a specialist over locally accessible services; this was considered pre-options development and therefore at a formative stage.

In addition, in the consultation assurance report considered at the CCGs joint governing body meeting on 21 February 2018, there is a section that sets out how phased feedback gathered through engagement activity influenced options development (page 16). There were also many examples of 'options' development being discussed and responded to as part of the consultation process with formal Q&A documents developed during the consultation process and shared with the JHOSC.

An example of one such Q&A document and response is included below and highlights a question about stroke option development and why there was not a South Tyneside option.

The Q&A document stated: *"A range of potential options for future stroke service provision were considered, including provision at South Tyneside. This was not possible for a number of reasons including limited available space for beds and diagnostic test capacity together with the existence of other interdependent specialist services at Sunderland Royal Hospital such as vascular surgery.*

Furthermore, such an option would require capital funding to build the space to accommodate a unit large enough for all South Tyneside and Sunderland patients. This would have taken some time. The stroke service would remain significantly vulnerable during this time and both South Tyneside and Sunderland patients would continue to not receive the best stroke care and have worse outcomes."

Throughout the consultation it was made consistently clear that the proposed future options put forward by the clinical design teams for consultation were absolutely open to influence. Staff and the public were encouraged to provide alternative

proposals, and offered programme management assistance to develop them and asses them against the agreed hurdle criteria.

During the consultation period, the senior nursing staff from the special care baby unit (SCBU) at South Tyneside District Hospital (STDH) proposed an alternative model for a transitional care unit at STDH regardless of which option was chosen to be implemented for obstetrics.

Their proposal was to have four SCBU cots to provide the ongoing level 1 or transitional care, to point of discharge, for the local population of South Tyneside, thus freeing up cot space in the unit at Sunderland Royal Hospital. Day to day management of SCBU infants would be by advanced paediatric nurse practitioners supported by the team of experienced SCBU nurses at South Tyneside District Hospital.

The view of the nursing staff was as SCBU will be providing care for lower risk babies, medical support could be provided by an on call consultant with one session on site per week to undertake a ward round, supported by telemedicine.

In order to assess whether this option should be considered in the final decision making process the option needed to be assessed against the hurdle criteria by which all other options that progressed to public consultation had been subject to.

To help with this assessment comments from the Neonatal Network (NN), NHS England specialised commissioners (NHSE) and the National Quality Surveillance Visit Programme (NQSP) have been taken into consideration. The hurdle criteria assessment is summarised in the table below:

Table 1: Hurdle criteria assessment for the proposed alternative SCBU model.

Hurdle criteria	Sub-criteria	Assessment of alternative model
Will deliver high quality, safe care	• Does this option deliver improved quality than that delivered in the current service configuration? • Does this option deliver applicable quality/safety/experience standards and regulatory requirements for service?	X Peer review (NQSP) identified serious concerns about medical and nursing staffing support in current unit and the alternative model would not address these √ Would continue to provide local access to transitional care for the local population X Risk of increased transfers of care, should baby deteriorate (NN) X Limited medical support available locally (on call from CHS) should baby

		deteriorate (NN) X Concerns about ability of staff to maintain clinical skills working in alternative model described (NN) X Limited facilities for parents and carers (NQSP) X Single site SCBU and NICU co-located associated with better clinical outcomes
Supports sustainability/ resilience	• Does this option support service sustainability from a clinical workforce perspective? • Does this option support service sustainability from a population and activity perspective?	X Model will not to be commissioned by specialist commissioners as does not meet SCBU criteria (NHSE) X Neonatal Network advised there is capacity across the network to absorb STDH activity (NN) – additional level 1 capacity not required X Concern about the ability to recruit and retain suitably trained staff in a model – national shortage of Qualified in Speciality trained nurses (NN)
Is affordable	Is this option deliverable without any significant additional cost impact to commissioners and the wider healthcare system?	X Model will not be commissioned by specialist commissioners as does not meet SCBU criteria – would need additional investment from CCG (NHSE) X Additional investment in nurse staffing required to support the current and alternative model
Is deliverable	Is this option deliverable within the next 1-2 years?	√ Model is deliverable in short term, but question long-term sustainability due to concerns about recruitment and retention
Supported by Neonatal Network		X Based on comments above
Supported by Specialist Commissioning		X Based on comments above

Following the publication of the decision making report from which the above table is

taken, and prior to the decision making meeting, the CCGs received formal confirmation from NHS England specialised commissioners that, *"Following discussions with the Northern Neonatal Network we cannot support the progression of this model as an alternative to a SCBU at South Tyneside Hospitals. The proposed model does not meet the key requirements of the NHSE National Service Specification for a SCBU and therefore could not be considered a SCBU service. We would have concerns around the lack of medical cover for such a service as well as other concerns around the viability of the service given the small activity levels.*

Taking this into account along with further advice from the Neonatal Network Clinical lead and network manager we would not be willing to commission such a model and would not expect this model of service to be considered as an 'alternative' to SCBU level care."

In relation to paediatrics, an additional option was put forward prior to public consultation by the paediatric consultant team at STDH. However, due to a number of shortcomings in the proposal, it failed to clear the hurdle criteria. This option was reviewed by the Northern England Clinical Senate, which supported the pre-consultation decision that this was not a viable model.

We have been consistent is saying that no decision had been taken to remove acute hospital services from South Tyneside District Hospital in advance of the public consultation. However, the basis of the clinical service review was that services had to change, and indeed some services have already been changed on a temporary basis - the temporary relocation of stroke prior to the commencement of consultation (this was discussed with JHOSC on the 19th September 2016) and the temporary closure of Special Care Baby Unit (discussed with JHOSC on the 7th December 2017) after the consultation, both due to service vulnerability directly arising from staffing pressures resulting in patient safety issues.

At the JHOSC meeting 12th December 2017 the chairman asked if the proposals were if the decisions were a done deal (in relation to Gunning 1) and received a response from the Sunderland CCG accountable officer Dave Gallagher that no decision had been made, while the status quo could not continue there was no predetermination about what would be the final decision.

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.

To satisfy this, an integrated communications and engagement strategy was developed and implemented throughout Phase One of the Path to Excellence programme. This was shared as it developed on a number of occasions to JOHSC on 8th November 2016, 30th January 2017, 7th March 2017, 17th July 2017 and 10th October 2017.

This included the use of deliberative events, allowing people time to consider the

issues and give feedback. Verbatim feedback was published on the programme website and this, along with the other data collection activities, was thematically analysed by an independent research company (Social Marketing Partners)

Integrated equality impact assessments were carried out and published at the start of the consultation, and were referenced in the consultation documentation. Dr Jackie Grey presented her independent analysis to the JHOSC on 21st September 2017.

Also a document publication scheme was published on the website which was added to as further information was gained and included:

- The full pre-consultation business case for change and all appendices (technical NHS business document)
- The public facing consultation document: a summary of the above
- The summary consultation document: a summary of the public facing consultation document
- The slide pack of the consultation issues
- Full baseline travel and transport impact reports
- Service specific travel and transport impact reports
- The public facing summary of the baseline impact report
- Integrated health, quality and inequality impact assessments

During the consultation process itself, a number of key questions came to light from members of the public attending events. As such, the programme developed a set of question and answer documents that were published on the programme website and shared with the JHOSC – these are on the links below.

- Questions about children and young people's urgent and emergency (paediatrics) services proposals

- Questions about maternity services proposals

- Questions about stroke service proposals

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.

For Phase One of the Path to Excellence programme the time frame for the formal public consultation period was agreed to be 14.5 weeks in order to take account of the snap general election in 2017 which caused a delay to the start, and would run over the August holiday period.

The overall time frame from consultation to decision making was included in the consultation documentation and highlighted at public consultation events. The

Consultation Institute provided assurance on the suggested time frame and extra allowances built into the overall schedule for public consultation. JHOSC was appraised of the timeframe on a number of occasions. Timescales were discussed at different meetings 30th January 2017, 7th March 2017, 17th July 2017 and 10th October 2017.

The overall time frame from consultation to decision making was included in the consultation documentation and highlighted at public consultation events.

4. Feedback 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.

CCG governing body members spent two full days in decision making workshops to consider all the feedback and evidence gathered throughout the consultation process. This involved significant reading, reports and presentations by experts to help with in their deliberations.

We understand that if a legal challenge is to be successful on 'consultation' grounds (use of Gunning Principles), there must be a clear and material error in the process, we believe that there have been no such errors in this case.

Assurance against all aspects of NHS statutory, legal and policy context for the Path to Excellence was published as part of the clinical commissioning group's decision making meeting and is available at the following link.

Consultation assurance paper February 2018

Specific points raised by the proposed JHOSC referral letter

The remainder of this letter will now go on to address the points raised in sections five, six and seven of the proposed JHOSC referral letter

Section 5 – Summary of reasons for referral

In response to paragraph (5.3.1) in relation to paediatric emergency services and professional differences of opinion, it is important to note that the proposals also benefitted from clinical input from external experts (both clinical senate and child health network) and they were satisfied that the options put forward would improve the quality of paediatric services available in Sunderland and South Tyneside.

For example, the Child Health Network noted that:

"We have identified no reasons that question the safety and clinical efficacy of the proposals and believe they will provide a safer, more sustainable alternative to what is delivered at present, given the current service configuration's reliance on a succession of locum medical staff. We cannot suggest any other service configuration option that might potentially achieve as good an outcome as those likely to be delivered from the change proposals outlined, without further, more

radical service reconfiguration."

This was in line with the presentation by Dr Mark Anderson to the JHOSC on 21st September 2017.

Paediatric staff were invited to attend clinical design meetings which had been arranged around clinical rotas to allow people to attend. It was unfortunate that there was limited attendance in these sessions, despite encouragement by programme staff.

The involvement of clinical staff in the clinical design teams was discussed at length during a meeting with the JHOSC chairs on 25th August 2017, when programme management staff were able to demonstrate a contemporaneous audit trail of evidence. This included evidence of emails, invitations, minutes of meetings and other records as well as follow up requests for further information and evidence that was provided via scrutiny officers to the chairs.

This was followed up by a meeting of elected members, the clinical staff and programme staff on 11th October 2017.

Clinical staff from both trusts participated in the clinical senate review on the 28th November 2017 which supported the clinical safety and effectiveness of options under consultation - a third paediatric option was explicitly reviewed and not considered to be viable after assessment through the hurdle criteria and external clinical experts. This senate report was considered in the decision making process and an appendix to the decision making report.

The CCG governing bodies took a range of information into consideration and different professional perspectives were taken into account. This included; feedback from the independent analysts who wrote the consultation feedback report, presentation from different clinical design groups on adjustments that could be made to the options in the light of the consultation feedback.

In terms of concerns raised about the safety of paediatric services overnight (5.3.2) JHOSC concerns were noted about the ability of the adult emergency department team at STDH to deal with paediatric issues out of hours.

It is understood that we will a need to ensure sufficient paediatric life support skills to manage this under both options. This was discussed previously with JHOSC (with Dr Mark Anderson on 21st September 2017 and with programme management representatives on 10th October 2017) and the NHS partners have agreed that as part of the implementation planning we would ensure that adult A&E staff would have refresher training in resuscitation training for children (such as Advanced Paediatric Life Support Training) which is already a core component of medical training for adult A&E medical staff.

At the CCG's decision making meeting on 21st February 2018, a question was asked as to what assurance could be given to parents presenting at STDH with a sick child requiring required urgent attention after hours.

The minutes recorded the following:

"Chair invited Dr Wahid, Medical Director from STDH and SRH to provide expert advice in relation to the questions raised. Dr Wahid advised that a communication strategy was being developed to advise local residents of the new paediatric arrangements. He clarified that in the event that a child attended STDH out of hours, the child would be assessed and stabilised as all A&E consultants were trained in paediatric advanced life support. If necessary, the child would then be transferred to the PED at SRH or the Great North Children's Hospital if required. The last admittance would be at 10pm where the patient would either be discharged or transferred to SRH."

It is also worth noting that there are a large number of units nationally where the paediatric emergency department is staffed from adult A&E and there is no separate senior medical rota in providing care overnight. This is a well-accepted and safe model of care.

(5.3.3) We understand the concerns members have, and we believe we've explained on a number of occasions that there are significant issues in recruiting and maintaining sufficient senior doctors to provide an emergency paediatric care service at STDH, at middle grade level. This was included as one of the main drivers for change at the JHOSC in 19th September 2016, in the draft issues document presented to JHOSC 8th November 2016. It subsequently was included in the consultation case for change and the public consultation document.

There are currently only two middle grade doctors working on the emergency rota and there is a reliance on covering the medical rota with agency doctors out of hours.

Whereas variability caused through the use of agency doctors has been minimised through attempting, where possible, to make repeated use of the same doctors familiar with the service, this cannot be guaranteed and does raise safety concerns, as the middle grade is the most senior doctor within the department at night. When the rota cannot be covered by locum doctors, then consultants are expected to provide resident out of hours cover. If this happens, then there is a likelihood that planned work for the following day, such as outpatient clinics would need to be cancelled. The issue of using locum doctors was a key theme discussed with JHOSC members and through-out the public consultation documents and events.

It is therefore with reference to the above why 'no change' is not an option. We would wish to remind members that we are dealing with a very small number of patients who would need to attend SRH overnight in option 1 with on average only five patients per night attending the paediatric emergency department at STFT under the revised opening times (9 patients per night in the public facing consultation document, which reflected the options prior to the revision of opening hours).

In option 2 around 80% of patients could be seen by a nurse practitioner service and therefore the majority of children will still be seen in the borough.

(5.4.1) We agree with JHOSC members that ambulance services are a key

consideration and this was a high priority in particular for CCG governing body members. The CCG's have had substantial assurance on this from the Medical Director of North East Ambulance Service (NEAS) as a board member on behalf of Ambulance Trust Board. Yvonne Ormston, chief officer of NEAS attended the JHOSC (1st August 2017) to give information.

During the JHOSC meeting on August 1st elected members acknowledged that the CCG's would not commission services that were unsafe, and expressed concerns around public sector budget constraints.

At the JHOSC meeting on 12th December 2017, members were given verbal confirmation by CCG chief officers that there would be a collective agreement to ensure NEAS had the appropriate support in order to assist the partnership in whatever the future changes (at that point in time they were not know because no decisions had been made) would be.

Yvonne Ormston, chief officer of NEAS attended the JHOSC for the second time on 8th January 2018 to give information and assurances around capacity and performance. It would be helpful to discuss what further assurance the JHOSC would wish to see. More information about NEAS is contained in (6.3.1)

(5.4.2) In reference to the continued viability of a free standing midwife led unit (FMLU), this question was also a key consideration for CCG governing body members. As a result of considerations by governing body members at the pre-decision making workshops they asked for further work to be carried out in order to provide more information to them to help them in their decision making.

This issue was also debated at length by elected members and covered in detail in the CCG decision making report. In addition, a CCG governing body member as secondary care representative and board member is an obstetrics and gynaecology consultant who was involved in setting up the Friarage free standing midwife led unit, and he had detailed questions as part of the decision making process which were considered and responded to as part of the CCG's decision making process.

The long term sustainability of the proposed FMLU in option 1 has been raised during the public consultation and, as such, the clinical teams and programme board have given this further consideration in accordance with Gunning 4.

FMLUs continue to feature in national maternity policy and, while it is true that they have not been successful in other parts of the north east, they have proved more successful nationally with a rise in the number of MLUs over the last 10 years.

Additionally, the key NHS policy around improving maternity outcomes 'Better Births' illustrates that FMLUs should be more than just a place to give birth and be a community hub offering a range of additional activities such as antenatal classes, smoking cessation support, breast-feeding support etc.

The clinical teams within the trusts have confirmed a commitment to developing the proposed FMLU in option 1 into a vibrant, thriving birthing centre, in line with the national model, and providing a new choice to women not previously available.

In England the majority of FMLUs have between 200-300 births a year. According to the original postcode based analysis it has been assumed that approximately 320 births from South Tyneside and Sunderland would be delivered at the FMLU in option 1.

As outlined in the CCG decision making report, further analysis to look at the potential catchment population for the FMLU has been carried out to inform the final decision-making assessment. Previous retrospective case mix analysis has shown that the annual number of eligible low risk births at STDH is 19% or 250 births. This is lower than the Birthplace cohort study which estimated that about 50-60% of women meet the NICE 'low risk' criteria.

However using this same proportion for SRH would give another 610 eligible births. It is also known that 140 women from South Tyneside and 40-50 from Sunderland choose to have their baby at the Birthing Centre at the Royal Victoria Infirmary (RVI) in Newcastle upon Tyne for non-medical reasons.

It is assumed that those women opting for care at RVI for non-medical reasons are exercising their choice to give birth in an alongside midwifery led unit (AMLU), and that these women would also be eligible to give birth in the FMLU at STDH. With these potential births factored in we can see that there are a total of around 1000 eligible low risk women across South Tyneside and Sunderland who could potentially give birth at the FMLU under option 1.

An alternative way of investigating the sustainability issue is by looking at what women hypothetically would choose if they were given the full range of birthing choices. Recent patient engagement work done across Teesside, Darlington and Durham as part of the Better Health Programme has looked at this. During this engagement work 889 mothers (with children aged 5 or under) and women planning to have children were interviewed with their birthing preferences ranked as follows:

1. Alongside midwife-led unit (52%)
2. Consultant-led unit (27%)
3. Freestanding midwife-led unit (FMLU) (11%)
4. Home birth (10%)

Using the 11% of women expressing their preference to give birth in a FMLU from this regional work and applying it to the total number of births across South Tyneside and Sunderland (4,500) we would have potentially 495 births.

Whilst it is difficult to predict the number of women across South Tyneside and Sunderland who would choose to give birth in a FMLU, we can see by looking at the clinical eligibility and some local comparable engagement work, that both produce a higher estimate of the potential number of women who could give birth in the FMLU than was contained in the previous analysis when developing the options for consultation.

There is no doubt that it will be essential for local health and care system leaders, staff, key interest groups, members of the public and elected members to come

together to help support the sustainability of such a unit, and to help develop a vibrant, exciting choice for expectant mothers to make.

Key to fully informing women on the benefits and risks of an FMLU would be a communications strategy to ensure women had facts and evidence, rather than anecdote to inform their choice – again this is a direct consequence of the feedback received during the consultation.

The CCGs and trust have committed to the establishment of a stakeholder group to oversee these issues and to ensure a FMLU would be successful.

In addition, there is enough staff commitment to run a new FMLU with midwifery staff running antenatal clinics, education classes etc. out of the FMLU as well, this is all part of the concept of developing a community hub – a Birthing centre - as referenced in Better Births.

Dr Steve Sturgiss at the JHOSC on 21st September 2017 and the dedicated workshop organised for elected members 6th November 2017 addressed the issue of FMLU viability, and emphasised it was not just about number of births but a range of factors such as skill sets, support by local stakeholders, and other services ante and post-natal – each unit would need to be considered on its own merits. At the workshop Dr Sturgiss said it is what that type of unit can do in terms of the whole maternity pathway that needs to be taken into consideration.

We would welcome elected member input into helping ensure the sustainability through the external stakeholder group we wish to establish.

(5.5.1) Stroke aftercare was not part of the consultation, which focused only on stroke services with the in-hospital aspects. This was highlighted in the consultation documentation on 17th July 2017 when the programme presented to the JHOSC on the stroke options. However, we can confirm to the committee that both areas have community stroke teams in place, and robust discharge arrangements are embedded within the current [temporary] pathway. As part of the mobilisation planning (subject to the outcome of the referral to the secretary of state) these arrangements can be further developed, with the trusts and CCGs happy to work with the individual health overview and scrutiny committees (HOSC) around assurance and scrutiny on these services. Also there was suggestion by the chair and agreement at the JHOSC on 21st September 2017 that stroke aftercare should be assessed by the individual HOSCs.

As the letter to the JHOSC dated 28 February 2018 sets out, the Trusts have not implemented the full stroke option therefore cannot further develop to improve the acute rehab and community rehab elements of care until the secretary of state referral process has been completed

The temporary change has however dramatically improved the rate of thrombolysis taking place within an hour, from 0 to 63%, which will have significantly improved the clinical outcomes for those patients since the temporary change for South Tyneside residents which will continue to improve, if and when we are able to implement the full change.

(5.5.2) We are sorry if members feel that there has been conflicting clinical advice. In all the information the programme team have presented to the JHOSC we feel we have been consistent on the clinical view on stroke.

The clinical evidence base is definitive, from both Professor Tony Rudd, national clinical director for stroke, and Dr Stuart Huntly, Cardiovascular clinical lead for NHS Northern England Clinical Networks, at the JHOSC on 21st September 2017 on the need to create hyper acute centres.

They were unequivocal in their views: *"Prof Rudd concluded that (the P2E proposals) were in line with national policy and evidence, imperative because of the shortage of stroke physicians, would deliver quality improvements through critical mass, the specialist hyper acute stroke position would offset the travel impact, would result in shorter hospital stays and improved outcomes and recovery."*

As stated in the consultation document and highlighted to the JHOSC on 17th July as part of the presentation on the options, there was clinical consensus on the stroke options from clinical staff at both trusts. In response to (6.5.2) we append a letter from Mr Bas Sen, [Emergency Care Consultant and Associate Medical Director, RVI, Newcastle] which we hope clarifies the issue.

(5.6.1) As discussed with the JHOSC, the CCGs have sought to make decisions in best interest of both local populations, taking into account a range of evidence including clinical evidence, independent integrated health impact and public feedback in order to improve the quality of care for both populations.

This has been reviewed, challenged then subsequently confirmed and supported by external independent clinical bodies such as the North of England clinical networks and assured by NHS England. These are external checks and balances carried out by arm's length bodies that are required around significant service change.

Also discussed with the JHOSC, there continues to be significant investment in South Tyneside based services for example, the recruitment of a renal consultant who decided to join the trust directly because he was able to work across two hospitals and have access to critical mass of patients.

Also, around 500 South Tyneside eye patients who previously had to travel to Sunderland for out-patient care are now offered those appointments at South Tyneside Hospital.

Hospital trusts chief executive Ken Bremner has publicly stated how positive he is about the vibrant future of both trusts, at the JHOSC meeting on 7th March 2017 and that there is continued investment in South Tyneside District Hospital.

For example in radiology, in 2017, a new £1.5 million MRI scanner - the first of its kind in the UK – became operational and the Trust became one of the first in the country to introduce the very latest ultrasound machines. In the past two years, the Trust has also opened Haven Court, a £9 million centre of excellence for integrated health and social care for older people, and a new £1.4 million surgical centre, which

has improved patient experience and access to surgical services. Most recently work has begun on a new £5 million energy centre at South Tyneside District Hospital which will ensure the hospital can continue to serve future generations of families for many decades to come.

This represents ongoing investment in the hospital site and is firm reassurance that leaders at the Trust are committed to investing in South Tyneside and is a clear signal for staff, patients and the local community of the positive and bright future for South Tyneside District Hospital.

(5.6.2) We hope that the information above sets out reassurance of a strong and vibrant future for South Tyneside District Hospital. In terms of capacity at the Sunderland site, this was addressed in a question and answer document developed as part of the consultation process and shared with the JHOSC committee.

This set out how the stroke unit at Sunderland was previously providing medical beds, since the temporary change these beds have become dedicated for stroke patients. Stroke services for South Tyneside and Sunderland patients are already being provided at Sunderland Royal Hospital as part of the temporary service arrangements.

While we constantly monitor service capacity across all our services, we are certain that the 39-beds at Sunderland will be sufficient to accommodate the estimated annual number of strokes. The stroke unit at SRH is the biggest in the regions and these beds will be used exclusively for stroke patients as previously they also included other medical patients.

We are also sure that there will be enough capacity to accommodate the extra births identified in the maternity modelling with the Delivery Suite at SRH designed to deliver 4000 babies annually

Also, the emergency department was built to allow future additional capacity, again highlighted in the Q&A document shared with JHSOC members. Capacity and demand planning are key considerations for option development in order to ensure options are credible and viable for the future in order to meet the expectations of Gunning 1. Whilst not designed with the intention to take the additional expected paediatric activity, extra capacity was included in the new emergency department for paediatric cases. More details on the specifics of assurances around capacity is included in the response to section (6.6.1).

In recognition of demand on parking spaces at Sunderland Royal Hospital, the Trust has secured a number of additional staff car parking spaces at Clanny House.

Clanny House is situated on Peacock Street West which is 3 minutes walking distance from Sunderland Royal Hospital. It is owned by Sunderland University, who let out parking spaces to the Trust. This will free up capacity on the hospital site for patients and visitors, and is part of the overall transport and travel stakeholder work we are taking forward in direct response to this public consultation.

Section 6 - evidence to support the referral

(6.1.1) As set out in detail to the response to (1.2) our interpretation of the regulations around inadequate consultation relate to consultation with the scrutinising body rather than wider consultation with patients, the public and stakeholders.

Also, we would note that the Gunning Principles are legal considerations rather than issues for the scrutiny regulations, however we hope the information contained in (1.2) gives reassurance that only viable and credible options were developed in line with the Gunning Principles, it is unlawful to consult on options that are not genuinely deliverable.

For reasons discussed with the JHOSC, we only included options that met the hurdle criteria as being credible. This was explained at JHOSC meetings prior to public consultation along with the hurdle criteria. Also to note that the service changes relate to the in-hospital element of care, all the services will not be changing as community services will still be delivered locally e.g. pre and post-natal care, community stroke rehabilitation etc.

We also note that concerns around being in breach of the Gunning principles were not raised in the formal responses from the JHOSC received in October 2017 and January 2018.

(6.1.1) We have been consistent throughout the process about making decisions in the best interests of our local populations, supported by the views from our external clinical experts of which the JHOSC has heard from in particular on 21st September 2017.

For the public consultation we put forward credible options that could be implemented by April 2019, this was important given the very fragile nature of the services that were consulted on.

There were more options for partial consolidation of services at Sunderland as the physical infrastructure for the services under consultation at South Tyneside simply would not be able to accommodate the extra activity from Sunderland. Therefore to offer options of consolidation of services at South Tyneside District Hospital would have been disingenuous and a breach of Gunning 1 of taking proposals to consultation that are not viable.

(6.1.2) In line with Gunning 4, and explained elsewhere in this letter, it would not be appropriate to consult on non-viable options as this may confuse or mislead the public.

The consultation activity was developed via the communications and engagement group, membership included Health Watch organisations and communications and engagement specialist staff. As highlighted in (5.1.2) a ‘third option’ for paediatrics was developed by staff and this was discussed with the chairs of JHOSC on 25th August 2017. The conclusion drawn by the clinical senate about the third option, was that it was not deemed safe or viable, therefore would not have been a credible option to take to public consultation.

As part of option development, long lists are developed which consider a broad list of options, which are then shortlisted against an agreed set of hurdle criteria, and consultation only on viable options (otherwise this would breach Gunning 4).

As part of their decision making deliberations, the CCG governing body members, gave consideration to issues around recruitment, skill mix and training. Innovative steps have been taken wherever possible, such as the development of Advanced Paediatric Nurse Practitioners, however this does not resolve the issue of senior medical cover in the out of hours period.

In terms of cross-site working, CCG governing body members made the point that there should be one clinical team across two sites, however, with services requiring urgent response and 24/7 cover, it is not possible for staff to be in two places at once – and again this underpins the reasons for making changes to services directly linked clinical workforce availability, and therefore safety of the care given to patients and the outcomes they have.

(6.1.4) In order to develop key engagement tools, an independent specialist research company (SMP) was appointed to provide advice on survey and discussion guide development. Two JHOSC members attended a workshop session where the parameters of this work was agreed. Focus groups were carried out by community and voluntary sector organisations, who were supported with tools and training in order to ensure they were able to put the consultation issues into context.

The objective of focus group activity was to provide a qualitative feedback opportunity for special interest groups, this involved appraising the options and giving their views. Participating organisations provided a feedback report, which was independently thematically analysed by SMP, along with the consultation events feedback, the consultation survey responses and other responses and submissions.

For all consultation feedback mechanisms tools, it was emphasised that participants should respond after reading any of the consultation documentation or attending a public event.

The focus group toolkit was published on the programme website on the following link. https://pathtoexcellence.org.uk/get-involved/hold-focus-group/

(6.1.5) The consultation feedback report set out the many positive and negative comments collected throughout the process. This is a key element of the consultation process in order to provide an opportunity for people to receive information about the issues, the different options that had been developed by clinical design teams and proposed for solving the problems being faced, have opportunities to feedback their views on how those options could be improved or for alternative ideas to be proposed.

Information was published alongside each option from the independent combined health and inequalities impact assessments which gave quality indicator scores which demonstrated how health could be positively impacted.

The feedback report was independently analysed and presented to CCG governing body members, it is important that they had full sight of this report, time for consideration of the issues it raised through dedicated workshops and sessions, in order for them to conscientiously take the information into account in their deliberations in decision making. This is a key element of Gunning 4.

As highlighted in our response to (6.1.5) we feel we have been mindful of our statutory, legal and NHS policy requirements including the Gunning principles. In addition, we have provided opportunities for others to put forward alternative models (cited in 6.1.2) and have been very clear that the proposals were open to influence. Also, changes and conditions have been stipulated in the final decisions that the CCGs made, which have come as a direct result of the consultation process and feedback gained.

For example: changes to the opening times of the paediatric service, and in response to concerns about clinical capacity a transitionary model for the paediatric service in order to provide time and opportunity to train staff. In relation to the Free Standing Midwife Led Unit, the requirement of a stakeholder group to oversee its development and the commitment to promote and market the benefits of a new birthing centre, this is in direct response to concerns about viability and to change perceptions.

Taking all this information into account we are steadfast in our view that the options were formative. Wherever feasible we have sought to keep services as local as possible within the significant workforce constraints that exist.

(6.2.1) As highlighted in (5.3.1) we sought to engage key clinical staff in the development of proposals. This was described in detail at the session on 25th August 2017 with JHOSC chairs and at the subsequent meeting with JHOSC members, clinical staff and programme management representatives on 11th October 2017. We have sought to involve key clinical staff as much as possible, and this has also been reliant on their participation. In particular they have been invited to clinical service workshops in the options development phase.

In the formal public consultation phase we have actively encouraged staff participation, hence alternative models which have been considered.

(6.2.2) Whilst it is true that some of the consultants (but not all) have expressed concerns about the options being put forward, we would respectfully remind the committee of the impartial information that they have already seen that states that the options put forward are safe, in line with current clinical evidence (rather than opinion), and that there are no other options that could meet the challenges that we are faced.

For example in the feedback from the Child Health network:

“We have identified no reasons that question the safety and clinical efficacy of the proposals and believe they will provide a safer, more sustainable alternative to what

is delivered at present, given the current service configuration's reliance on a succession of locum medical staff. We cannot suggest any other service configuration option that might potentially achieve as good an outcome as those likely to be delivered from the change proposals outlined, without further, more radical service reconfiguration."

We would also like the JHOSC to note that both before and during the consultation senior hospital trust and CCG representatives clearly communicated to the paediatric staff that alternative options would be considered, as all proposals up until the end of the consultation period were at a formative stage and open to change and influence.

As part of our regular engagement with the JHOSC, information has also been provided to the chairs regarding a third option that was developed by some of the paediatric consultants at South Tyneside prior to the start of public consultation. This option was not considered safe or sustainable by members of the Clinical Service Review Group and therefore this option did not progress to public consultation. However to ensure absolute impartiality the Northern Clinical Senate was asked to review this option in addition to the options that were consulted on. Their report was appended to the final decision making report as appendix 13 and is referred to in the main report itself. The senate concluded that:

That the "Third Option" remains discounted during the decision-making process as it does not provide a viable solution to ensuring a clinically sustainable solution for Urgent and Emergency Paediatric Services across Sunderland and South Tyneside."

In relation to the safeguarding point raised it is unclear what is meant by the (in) adequacy of the safeguarding arrangements, but we would ask members of the committee to note that there are already well established pathways in place for patients transferring between the two hospital trusts, as all children requiring longer than a 24 hour stay already transfer to Sunderland Royal Hospital for their care. Staff working within emergency care are trained to level 2 children's safeguarding, which covers the identification of safeguarding issues in children and the processes to enact concerns. Adult Emergency Department staff are already one of the most common groups that refer children for safeguarding concerns.

Also, as both local authorities are aware through discussion at Local Safeguarding Children's Board, there have been changes to safeguarding arrangements for a consultant paediatrician assessment already and these now take place in Sunderland.

(6.2.3) There are no plans to have specialist nurse practitioners out of hours in either of the paediatric options. However, as explained in response to the concern expressed in point (5.3.2) both senior medical and senior nursing staff in the adult emergency department will have updates on the necessary resuscitation training to ensure that sick children are safely cared for and stabilised in an emergency situation before they are transferred to another hospital. For those patients who aren't acutely unwell but require assessment by a senior paediatric doctor, these patients will be discussed with the paediatric emergency department medical staff at Sunderland Royal Hospital and transferred to Sunderland if required.

(6.2.4) The independent health and inequalities impact assessments carried out by Dr Jackie Gray show that these changes will improve health inequalities for both populations. This was specifically presented to the JHOSC on 21st September 2017 by Dr Gray, who gave assurances to the JHOSC on the impartiality of the assessments carried out. Also highlighted in the consultation documentation is how many patients who live in South Tyneside already use services in Gateshead, Sunderland and Newcastle.

(6.2.5) Following the meeting with the chairs of the JHOSC on the evening of the 11th October 2017 at South Shields Town Hall, members of the programme team gave a commitment to engage and work with paediatric consultants and senior nursing staff to look at the feedback from public consultation and take this information forward in any further development of the paediatric options.

The department and assistant department manager (senior nursing staff) who attended the meeting on the 11th October 2017 plus a number of the paediatric nurse practitioners and one of the consultant team at South Tyneside Foundation Trust, did take part in post consultation meetings and also inputted their views into the clinical services review group and the clinical commissioning groups decision making preparation workshops (four took place in total). The remaining consultant staff however didn't take up any of the invitations to be involved in this work although they did attend a meeting during the visit of the Northern Clinical Senate, where they had their views considered and were included in the senate's report.

The programme team has provided the time and opportunities for those clinical staff who expressed concerns about previous involvement to be involved if they wished to do so as the JHOSC members in attendance at the session on 11th October 2017 had discussed.

(6.2.6) As outlined in a previous response, the impartial clinical advice given to the CCG Governing Bodies is that both of the clinical models that were consulted are safe. We would also like to remind the JHOSC that the current service at South Tyneside is perilously fragile with only 40% of the middle grade medical on call rota recruited to with little or no scope for additional successful recruitment and therefore safety and quality cannot be guaranteed unless there is a significant change in the service.

(6.3.1) As referenced in (5.4.1) by way of mitigation of North East Ambulance Service (NEAS) concerns within the CCG decision making report, NEAS confirmed that that the volume of journeys anticipated as a consequence of the maternity changes would be nominal and manageable within current resources. They also stated that the journey time between STDH and SRH was approximately 12 minutes, which based upon national evidence, is well within safety thresholds for urgent maternity transfers.

NEAS also confirmed that the response category allocated to a call for a distressed baby would be given a *category one* response (i.e. eight minute target). We would like the JHOSC to note that, based upon latest available data (March 2018), NEAS is

the *only* ambulance Trust in the country delivering the category one "urgent response" standard.

With regard to the wider phase one proposals, we would wish to refer members to the letter received from NEAS' Medical Director, Dr Matthew Beattie, which states that *"…we can confirm that NEAS can deliver the required changes to support the implementation of the proposed options..."*

The full letter is appended for your reference.

We would also like to assure the JHOSC that we recognise that there is more work to do to ensure that NEAS is resilient and able to deliver the ambulance response programme (ARP) standards sustainably. To that end, commissioners across the North East have recently agreed to invest an additional £2.6m into NEAS over and above their already guaranteed contract uplift for 2018/19. The total funding increase for NEAS this year (18/19) equating to an additional £5m (approx), much of which is dedicated to ensuring delivery of the ARP.

(6.4.1) The Path to excellence proposals for maternity services have been reviewed and endorsed by the the Northumberland, Tyne, Wear and North Durham Local Maternity System (LMS) chair and clinical lead on behalf of the LMS Board and in their formal response to the consultation they conclude "*that both options for the future of maternity services within the 'Path to Excellence' are clinically justified, safe, in accordance with national standards of care – and will lead to improved outcomes for mothers and their babies in the local area."*

Whilst there are concerns from some members of the public about the safety of Freestanding Midwife Led Units (FMLUs), comprehensive research and evidence has also been used in helping inform the option development, with for example, the Birthplace Cohort Study, which demonstrates that there is no significant differences in perinatal morbidity observed between obstetric unit and midwifery led units.

Adverse outcomes were rare but occurred in both groups. However some additional benefits were seen in midwife led units where women were significantly less likely to experience complications compared with women in obstetric units. In addition, significant reductions were found for the midwife led group in use of caesarean section and instrumental delivery when compared to obstetric units.

In relation to clinical sustainability both options provide a high level of confidence that this will be improved with the consolidation of all high risk intrapartum care onto a single site. The main reason for this is that the proposed centralisation of obstetric care onto a single site will address the longer term problem of non-consultant grade medical staffing shortages experienced by both services (for example currently 6.5 whole-time equivalent middle grade gaps across both units).

The need for the services to function as one team has been made clear by CCG Governing Body members and supported by the clinical design teams throughout the post-consultation, pre-decision workshops. A willingness for the teams to work across both sites has been demonstrated during this time.

(6.4.2) We understood from the JHOSC consultation submission in January 2018 they wished the decision makers to consider data from a free standing midwife led unit(s) (FMLU) with a similar area profile in terms of deprivation and poverty to add to their evidence base before making any final decisions. We can confirm that the CCGs took consideration data from a wide range of FMLUs in the pre-decision making governing body workshop.

The Northumberland, Tyne, Wear and North Durham Local Maternity System Board paper was included as an appendix to the CCG decision making report.

It stated*: "The network group felt that it was entirely reasonable to believe that the findings of the Birthplace study are directly transferable to the anticipated outcomes of women choosing to give birth in a potential FMU at South Tyneside (in Option 1) on the basis that the demographics of the local population, as well as the transfer times to the nearest obstetric unit are within the range of general characteristics associated with the large number of FMUs surveyed for the Birthplace study."*

(6.4.3) as referred to previously in (5.4.2) the long term sustainability of the proposed FMLU in option 1 has been raised during the public consultation and, as such, the clinical teams and programme board have given this further consideration.

In order to ensure sustainability, as part of the decision making the CCGs set the condition of the establishment of a stakeholder overview group, made up of women, staff, third sector partners and elected members would be welcomed to join. This group would also set the communications and marketing activity that the trusts and CCGs have also committed to.

At the JHOSC meeting on 21st September 2017 where Dr Steve Sturgiss first presented, JHOSC members were offered further assurance by the arrangement of a dedicated workshop session to focus specifically on issues related to the maternity proposals. This took place on 6th November 2017. Members were also offered the opportunity to visit the Friarage Free Standing Midwife Led Unit as a comparable unit. To date, this visit has not been undertaken, but the CCGs remain very keen to keep this opportunity open, should the committee wish to avail itself of the offer at a later date.

The study Freestanding Midwife-led Units in England and Wales 2001-2013 by the Royal College of Midwifes detailed a number of FMLUs that have closed. During this time there had been an additional 30 units opening with closures of 21 units. Interestingly whilst the majority of the 21 closures during the period are of well-established FMLUs, a significant number of the closures were of FMLUs which had been set up to replace obstetric services. In some cases these midwife-led services have been moved alongside midwife-led services at sites where obstetric services had been centralised.

(6.4.4) The most recent data in relation to the number of FMLU was published by the Royal College of Obstetricians and Gynaecologists (RCOG) in August 2017. There are now 63 free-standing midwifery led units. More information about these are included in the link below: Read most recent FMLU study

On page 25 of the report it states: *"In England, for which historical data were available from previous organisational surveys, the number of alongside midwife-led units quadrupled between 2007 and 2017, from 26 to 106. The number of obstetric units decreased by 13% and although individual freestanding midwife-led units opened and closed and their proportion remained static, the overall number increased by 13% during this period.*

(6.4.5) There are many FMLUs that are successful, and the ambition as referred to in previous responses, the ambition would be to provide an exciting new opportunity for both South Tyneside and Sunderland women as they said they wanted the choice of a home away from home birthing experience, a birthing centre for pre and post-natal care, with more holistic therapies. This new centre will be developed with staff, women and other interested partners, and the ambition would be to create a vibrant new birthing centre at South Tyneside District Hospital which offers more choice for women across both South Tyneside and Sunderland.

The Northumberland, Tyne, Wear and Durham Local Maternity System report noted, that it's only recently that maternity healthcare providers have had the evidence they need to (a) assure women about the safety of opting to give birth in a FMU (or alongside MLU), as well as (b) promote the significant benefits in doing so.
It's possible that a greater evidence-based confidence amongst midwives (about the safety and benefits of MLUs) when counselling women about place of birth might lead to a greater take up of this option.

There was a feeling amongst the network that the developing Maternity Voice Partnerships across the region might have a role to play in promoting the benefits of midwife-led intrapartum care for healthy women. Moreover, not all FMUs experience a substantial reduction in the numbers of births over time – and it's noticeable (from local experience) that those with higher levels of activity (or the least reduction in numbers of birth) tend to be characterised by the on-site provision of other aspects of antenatal and postnatal maternity care, such that they become a busy, vibrant focus of maternity care in the local community.

(6.4.6) There were two options for maternity care in the consultation, the second was to fully consolidate all care in Sunderland which was a viable option. However the CCGs decided in taking feedback into account they wished to provide women from both South Tyneside and Sunderland (and wider) the opportunity to have a new community FMLU which has not been previously available.

We would very much want a FMLU to be a success, during many conversations with the JHOSC we recognise members concerns about sustainability.
We are keen to work with the local community and elected members to ensure that it is a success, we have had conversations now and are making links with a number of other areas who have done similar things very successfully and there are great co-production examples to draw from.

It's important to note that success is not just about numbers, but about the broader benefit to broader benefit to tackling health inequalities, such as addressing the very high rates of smoking in pregnancy and very low rates of breastfeeding initiation

smoking in pregnancy. The plan would be to create a new community asset, not just a place to give birth but a centre for pre-natal and post-natal care and other activities in relation to childbirth. We would welcome scrutiny members to work with us on this in the future.

(6.4.7) Neither of the options has a high dependency unit at South Tyneside District Hospital included. As previously highlighted, an option for SCBU was developed but did not meet the hurdle criteria. The Neonatal Network recognised these interdependencies in its response to the consultation which said:

"The network fully accepts the case for change in relation to acute maternity and paediatric services across South Tyneside and Sunderland as a result of workforce pressures that clearly cannot be sustained within current service arrangements. The Path to Excellence programme has rightly acknowledged the clinical interdependencies across obstetrics, paediatrics and SCBU and, as such, we fully support the change to SCBU that the maternity and paediatrics' proposals necessitate."

(6.4.8) we would like to reassure members that that the vast majority of transfers out of an FMLU do not occur in acute emergency situations, with continuing risk assessment being carried out by the midwives throughout labour to ensure early transfers where required. The Birthplace study shows that for women having a first baby there is around a 36% chance of transferring to an obstetric unit during labour or immediately afterwards. For those having a second or subsequent baby, the transfer rate is around 10%. Further analysis of the Birthplace findings and local delivery data has been undertaken to quantify the future likely risk of transfers.

The main reasons for transfer out of the FMLU are for failure of the labour to progress and for pain relief (epidural). The Birthplace study showed that the average time from a women being transferred to an obstetric unit and them giving birth was 4.5 hours, suggesting that there is a low threshold for transfer to avoid emergency transfers in the later stages of labour.

The number of emergency transfers between the proposed FMLU at STDH in option 1 and the obstetrics unit at SRH would depend on the proportion of first time mothers using the unit, although it is accepted that a greater proportion of women who have already given birth use FMLUs rather than first time mothers.
The expected emergency transfer rate would be less than one patient every two months. Through discussions with other FMLU sites, via the Northern England Maternity Network we have confirmed total transfer rates to be in keeping with national evidence.

In summary, whilst it is understandable that there are concerns about women requiring the emergency transfers from the FMLU, the evidence suggests the actual numbers requiring emergency transfers are very small. However for those who do require emergency transfer, these would be prioritised for transfer as per the clinical need and there are assurances from NEAS that it would respond based on the clinical need of the transfer as assessed by the midwives within the unit. A midwife would also accompany the woman during transfer.

(6.5.1) as highlighted in (5.5.1) the aftercare stroke arrangements for stroke were out of scope for the public consultation and therefore the models in both localities remain unchanged. This means there are still community stroke teams in both South Tyneside and Sunderland that facilitate early supported discharges for suitable patients back their home for ongoing rehabilitation.

(6.5.2) We have asked Mr Sen to clarify his remarks and he has provided a letter which is appended to this response. In summary he states that common emergencies will continue to go to local A&E departments however time critical emergencies, and stroke is one, will be taken to specialist stroke centres also known as hyper-acute stroke units (HASU) where they can get the highest quality of care.

In discussions with the National Clinical Director for Stroke on 21st September 2017, the JHOSC was also assured that Option 1 would deliver quality improvements through critical mass, and the specialist hyper-acute stroke position would offset the travel impact, resulting in shorter hospital stays and improved outcomes and recovery.

(6.5.3) We hope this resolves any issues in regard to conflicting clinical advice.

(6.6.1) A summary of the assurances around the adequate capacity at SRH across all the services was contained in the CCG decision making report, this is also one of the key NHS England assurance tests for NHS service reform.

Specifically for Stroke, the implementation of the temporary stroke model has allowed the service to test if the capacity concerns raised during consultation have been a real issue. The stroke clinical and operational teams at SRH have confirmed there have been no capacity constraints since the temporary model's introduction in December 2016. During winter pressures, SRH still maintain some of the lowest rates of delayed transfers of care in the country, whilst opening a similar amount of contingency beds as in previous year (i.e. before temporary change).

The number of stroke beds has been sufficient, evidenced through the amount of time patients have spent on the stroke ward. This is measured through domain 2 of the SSNAP audit: *2.3 Percentage of patients who spent at least 90% of their stay on stroke unit.* The tables below shows this metric over the last 4-5 years and confirms an improvement since the temporary stroke service consolidation, particularly for South Tyneside residents.

Table 2 Performance over time at SRH for the percentage of patients who spent at least 90% of their stay on stroke unit.

Apr 2013-Mar 2014	Apr 2014-Mar 2015	Apr 2015-Mar 2016	Apr 2016-Mar 2017
86.4%	90.2%	91.9%	91.7%

Table 3 Performance over time for the percentage of patients who spent at least 90% of their stay on stroke unit for South Tyneside residents.

Apr-Jul 2016	Aug-Nov 2016	Dec 2016-Mar 2017	Apr-Jul 2017
52.5%	71.3%	88.0%	95.4%

As identified above, patients across both South Tyneside and Sunderland are spending more time on a specialist stroke unit which supports the view of the clinical team that there are no capacity constraints for stroke patients at SRH.

In relation to non-stroke patients who previously occupied beds on the stroke ward, an extra 12 medical beds have been provided on a separate ward on the SRH site to accommodate these patients and senior managers and clinicians from SRH have confirmed these to be sufficient during the temporary stroke change.

(6.6.2) in reference to increased car demand at Sunderland Royal Hospital as mentioned in (5.6.2) there has also been a substantial amount of travel and transport research as well as work that is underway. JHOSC received a report on this work and JHOSC members and other elected members are part of the working group. We are happy to discuss how the JHOSC can be updated in these plans as they develop.

(6.6.3) Building on information provided (5.6.1) the chief executive of the trusts has advised the JHOSC that there is strong future for South Tyneside District Hospital. In relation to phase two, we would want to engage and work with staff and stakeholders, but that there isn't a plan of which services would be delivered at each site and this would need to be developed through engagement, we would not wish to predetermine the output of this work. We are currently in the pre-engagement option development phase and look forward to briefing the committee on these plans.

(6.7.1) We have provided information to the committee about how staff were involved in including providing minutes and further evidence as a direct consequence of the meeting with chairs and Path to Excellence programme team on 25th August 2017 where programme staff went through a timeline of how key clinical staff were asked to be involved in the clinical service reviews.

We also acknowledge the JHOSC response to the consultation in January 2018 which said: "*The Joint Committee is pleased to acknowledge that the SCBU staff at South Tyneside have been working on an alternative option, assisted by the path to Excellence project team, and it is hoped that this option is also presented to the CCG Decision Makers along with the established options.*"

Also, during the formal public consultation phase, there have been staff events as well as public events which staff attended, and have been encouraged to participate. Once we have concluded the Secretary of State process, subject to that outcome we are happy to provide updates on implementation.

(6.7.2) The training and development of staff was a key consideration for the CCG governing body members in their decision making process.

Section 7 – Steps taken to reach agreement with Sunderland and South Tyneside CCGs on the proposals

(7.3) We would entirely agree that the content of the consultation with JHOSC has been substantial, both in breadth and depth. We have addressed all resolutions raised by JHOSC through the course of the process and we have committed significant time to ensuring that the NHS consultation and dialogue with JHOSC has been robust. (7.4) during this time, we believe that we have provided the JHOSC with information, as acknowledged in the JHOSC final submission to the consultation in January which said: *"It is important that the Committee recognises and acknowledges the cooperation and commitment of key staff from the NHS who have provided the Joint Health Scrutiny Committee with the information and evidence requested on numerous occasions."*

7.5 We do not agree with the view that the CCGs made a decision without adequate assurances in place. As highlighted throughout this letter, the process has generated a large amount of information, feedback, research and evidence – in line with an anticipated certified best practice consultation process. To support their decision making, the CCG governing body members undertook a significant amount of pre-reading and research of available programme materials, participated in dedicated 'decision making' sessions and bespoke workshops in order to be appraised of the issues as they emerged through the consultation process.

There have been regular briefings and updates at Governing Body meetings and executive committee meetings, full assurance gained through the NHS England assurance process, and the CCG decision making report sets out clear measures and considerations for the Governing Bodies in making their decisions.

(7.6) Again, as highlighted we have demonstrated that Sunderland Royal Hospital has the capacity for the increased patients.

(7.7) In relation to concerns over media coverage, we would like to reassure JHOSC that no press release was issued.

The letter from the South Tyneside and Sunderland Healthcare Partnership to the JHOSC dated 28th February was made available on the Path to Excellence website. This is in-keeping with the spirit of transparency of the programme, and is congruent with what we have done with key documents for the whole programme regarding our commitment to a publication scheme of information and evidence.

This letter was subsequently seen on the website by specialist media health publication, Health Service Journal, who had previously published articles about the Path to Excellence programme. The HSJ ran a story on 7th March 2017 and cited the letter on the programme website as the source.

This media coverage was then picked up by local media who ran the story the next day on 8th March 2017.

We would like to apologise if the committee felt it was inappropriate, threatening and inflammatory to write to them as this was not our intention. However, we would continue to stand by the content of the letter as it reflects our genuine and continuing concern about the fragility of the vulnerable services.

(7.8, 7.9. 7.10) We are disappointed that the JHOSC has lost confidence in the CCGs, we would welcome a discussion as part of local resolution in order to continue to work together in order to best serve local people and communities.

We are very happy to meet with JHOSC to discuss the outstanding concerns in line with the regulations, following consideration of this response and prior to any onward referral. We hope that there would be potential for local resolution and welcome the opportunity to meet together to do so in the best interests of the population that we collectively serve.

We hope that our response helps to address at least some of the concerns set out by the JHOSC and would be very happy to meet to seek local resolution on any outstanding issues.

Yours sincerely,

Dr David Hambleton
Accountable officer – NHS South Tyneside Clinical Commissioning Group

David Gallagher
Accountable officer – NHS Sunderland Clinical Commissioning Group

Enclosed:

Letter from North East Ambulance Service
Letter from Mr Bas Sen, Emergency Care Clinical Director, Newcastle upon Tyne Hospitals NHS Foundation Trust and Clinical Chair North East and North Cumbria Urgent and Emergency Care Network.