IRP

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The Rt Hon Jeremy Hunt MP
Secretary of State for Health and Social Care
39 Victoria Street
London SW1H 0EU

18 June 2018

Dear Secretary of State

REFERRAL TO SECRETARY OF STATE
South Tyneside and Sunderland Healthcare Group – The Path to Excellence public consultation
South Tyneside and Sunderland Joint Health Scrutiny Committee

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Rob Dix (South Tyneside Council) and Cllr Norma Wright (Sunderland City Council), Joint Chairs, South Tyneside and Sunderland Joint Health Scrutiny Committee (JHSC). Confirmation of the documentary evidence submitted by the JHSC was received on 21 May 2018. NHS England North provided assessment information. A list of all the documents received is at Appendix One. The IRP has undertaken an assessment in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services that specifies that advice will be provided within 20 working days of the date of receipt of all required information.

In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State may be made. The IRP provides the advice below on the basis that the Department of Health and Social Care is satisfied the referral meets the requirements of the regulations.

The Panel considers each referral on its merits and concludes that:

- **Consolidation of all inpatient stroke services at Sunderland Royal Hospital (Option 1) is in the interests of local health services.**
- **Consolidation of all obstetrics, inpatient gynaecology and special care for babies at Sunderland Royal Hospital with a free-standing midwife-led unit at South Tyneside Hospital (Option 1) is in the interests of local health services.**
- **Further work is required on long term options for paediatric emergency care as part of considering the future of the whole urgent and emergency care system for the area. In the meantime, consolidation of emergency paediatric care overnight at Sunderland Royal Hospital (Option 1) will mitigate the current risks to quality and continuity of care.**

Background

The South Tyneside and Sunderland Healthcare Group (STSHG) formed in May 2016 as an alliance between City Hospitals Sunderland NHS Foundation Trust (CHSFT) and South Tyneside NHS Foundation Trust (STFT). The two trusts have formally committed to collaborating to transform services to ensure that the local communities they both serve will continue to receive high quality, safe and sustainable hospital and community health services in the future. To this end, in July 2016, whilst retaining separate statutory boards, they agreed to operate with a joint management structure under a single chief executive.

Currently, CHSFT provides a full range of hospital services, mostly from Sunderland Royal Hospital (SRH), to the population of Sunderland and some more specialist services to a larger catchment area including South Tyneside and parts of north Durham. STFT provides general hospital services to the population of South Tyneside from South Tyneside District Hospital (STDH) and community services across Gateshead, South Tyneside and Sunderland. Both organisations are in financial deficit – together some £26.5m which is about five per cent of their combined annual turnover.

Ambulance services across South Tyneside and Sunderland are delivered by the North East Ambulance Service which also provides the NHS 111 single point of access to urgent care service. Mental health services are delivered across both areas by Northumberland, Tyne and Wear Mental Health and Learning Disabilities NHS Foundation Trust.

Most of the healthcare services for the 149,000 population of South Tyneside and 277,000 population of Sunderland are commissioned by NHS South Tyneside Clinical Commissioning Group (CCG) and NHS Sunderland CCG respectively. More specialised services for both populations, including some affected by these proposals, are commissioned by NHS England (NHSE). Deprivation among the population is worse than the England average and health needs greater, with particular issues around cancers, respiratory and cardiovascular disease.

In August 2016, STSHG, working in partnership with the two CCGs, started to review and plan hospital services as part of a strategic transformation programme known as *The Path to Excellence*. Reviews of individual services by clinical teams and patient engagement started with Phase 1 of the programme covering stroke, trauma and orthopaedics, obstetrics and gynaecology, paediatrics and increasing elective work at STDH.

On 19 September 2016, the early work was presented to a Joint Meeting of South Tyneside Council: Overview and Scrutiny Co-ordinating and Call-in Committee and People Select Committee and Sunderland Council: Health and Well-being Scrutiny Committee and Scrutiny Co-ordinating Committee. At the meeting, the NHS advised that staffing issues and concerns about outcomes in stroke services had led them to consider the need to concentrate all inpatient stroke care on one site at SRH. This was supported by the Joint Meeting on the basis this move would be a temporary solution pending a full consultation about future options.

The temporary arrangement for inpatient stroke care was implemented at the start of December 2016 and remains today.

On 8 November 2016, the scrutiny members convened to receive an update from the NHS which included sharing a draft document describing the *Path to Excellence* programme. The document was subsequently published as an *Issues Document* describing the major challenges facing the NHS and how clinical staff, patients, carers, the public and other stakeholders could get involved in generating ideas and shaping solutions. Between November 2016 and January 2017, NHS leaders attended 21 meetings across Sunderland and South Tyneside to raise awareness and get feedback to inform the clinical services review programme. In the event, it was decided that, given the significant workforce pressures creating urgent problems with continuity and quality of service provision, proposals for stroke, obstetrics and gynaecology, and paediatric emergency care should take priority in a Phase 1a of the *Path to Excellence* programme.

Proposals for change came from discussions in service specific clinical review groups. Each group developed a long list of potential scenarios, including the 'do nothing' configuration. These were assessed against a set of hurdle criteria reflecting the *Path to Excellence* aims of delivering sustainable, high quality, safe and affordable services within one to two years. Only scenarios that satisfied the hurdle criteria to a reasonable extent were developed further and evaluated in terms of clinical quality and sustainability; accessibility and choice; deliverability and capacity; and affordability and financial sustainability. Alongside the process for development of clinical options, two independent impact assessments (integrated equality, health and health inequalities and travel and transport) were commissioned.

In light of the emerging proposals and potential consultation, the two local authorities affected by the proposals decided to form a joint health scrutiny committee (JHSC) and the inaugural meeting took place on 30 January 2017. The methods for public engagement to be used in the planned public consultation were presented and discussed. A subsequent update was given in the JHSC meeting on 7 March 2017 and a *Patient Insight Report* from the listening phase of the programme was published on 31 March 2107.

Three options emerged for stroke services:

- **Option 1:** provide all inpatient stroke care from the SRH stroke unit (ward E58) and close the stroke beds (Ward 8) at STDH. Patients from South Tyneside and Sunderland would have their acute stroke care at SRH before being discharged to community stroke rehabilitation teams in their respective local communities.
- **Option 2:** provide all inpatient and the majority of acute care from the SRH stroke unit (ward E58) with repatriation of South Tyneside patients to STDH for rehabilitation after seven days for those patients requiring longer stays and who are medically stable for transfer.

- **Option 3:** provide all hyper-acute stroke care from the SRH stroke unit (ward E58) with repatriation of South Tyneside patients to STDH for further acute care and rehabilitation after 72 hours for those patients requiring longer stays and who are medically stable for transfer.

For obstetrics and gynaecology, two options emerged:

- **Option 1**: develop a free-standing midwife-led unit (MLU) at STDH to deliver low risk care with all high-risk intrapartum care and an alongside MLU at SRH.
- **Option 2**: develop a single medically-led obstetric unit and alongside MLU at SRH.

As a consequence, under both options, emergency and inpatient gynaecology care would be provided at SRH, as would the single special care baby unit (SCBU), integrated with the existing neonatal intensive care unit (NICU).

For paediatric emergency care, two options emerged:

- **Option 1:** provision of 12-hour day-time paediatric emergency department service at STDH with 24/7 paediatric emergency department at SRH. The service would operate at STDH from 08.00 to 22.00 (doors closing at 20.00 to allow children to be treated and discharged). The service would continue with full medical support.
- **Option 2:** development of a nurse-led paediatric minor injury/illness service between 08.00 and 22.00 at STDH with 24/7 acute paediatric services at SRH.

Outpatient and community based paediatric services would continue to be provided within and from both hospital sites. With both the proposed options, the adult emergency department service at both STDH and SRH would remain unchanged.

As part of preparing for NHSE assurance and to meet the four tests for service change, proposed options were subject to a variety of external review and advice, including from the Northern England maternity, neonatal and child health clinical networks.

On 19 April 2017, NHSE completed its Stage 2 pre-consultation assurance, agreeing a partially assured position for the Phase 1a proposals and supporting the planned move to enter into public consultation with a number of caveats, some to be satisfied prior to consultation and others to be satisfied post-consultation and prior to any final decision being made.

With the general election purdah period intervening, the final version of the pre-consultation business case was produced on 28 June 2017 before public consultation began on 5 July 2017. The JHSC received a formal presentation of the options under consideration in the public consultation on 17 July 2017 and convened on four further occasions during the period of public consultation to take evidence. It submitted an interim response to the consultation before it closed on 15 October 2017 indicating that it would continue its scrutiny and submit a final statement before the NHS made its final decision.

Following the consultation, all of the public feedback was independently analysed and published in a draft report in December 2017. The findings were presented and discussed at

the JHSC on 12 December 2017. Further dialogue was held with the public to consider whether this report was a fair reflection of the issues and views expressed during consultation following which a final, amended, version was published in January 2018. General themes included understanding of the relative benefits of the options and preferences expressed for Option 1 in each of the three services. However, concerns about getting to services further away, the associated costs and the risks of emergency inter hospital transfers were manifest. There was also a clear view that loss of services at STDH was unfair and the future of the hospital in doubt. Concerns about the capacity of SRH to cope were also raised.

The two independent impact assessments (integrated equality, health and health inequalities and travel and transport assessments) were updated after consultation to inform the final decision. A further external review of options for paediatric emergency services was commissioned from the Northern England Clinical Senate at the end of November 2017. The JHSC provided its final response in January 2018, reflecting many of the concerns raised during the consultation and captured in the associated independent report.

NHSE provided their final assurance on 19 February 2018 before, on 21 February 2018, the two CCGs convened a meeting in common to make final decisions about the options for the three services in Phase 1a of the *Path to Excellence* programme. They approved Option 1 for stroke services, Option 1 for obstetrics and gynaecology and Option 2 for paediatric services but with Option 1 as a transitionary step with opening hours extended in the evening from 20.00 to 22.00.

On 28 February 2018, the NHS wrote collectively to the JHSC to provide information to be considered prior to a potential recommendation for referral to the Secretary of State concerning the *Path to Excellence* programme Phase 1a consultation decisions. The letter covered consultation issues, concerns about the risks of delay and their understanding of the relevant regulations.

On 9 March 2018, the JHSC resolved to refer the matter to the Secretary of State.

On 27 March 2018, Save South Tyneside Hospital Campaign Group made the CCGs aware of a pre-action letter for judicial review of the *Path to Excellence* consultation and decision-making process.

The JHSC wrote to the CCGs on 12 April 2018 seeking local resolution by their responding to the concerns raised in the draft referral letter. The CCGs responded in writing on 27 April 2018. The JHSC proceeded with the referral at its meeting on 30 April 2018.

Basis for referral

The JHSC's letter of 1 May 2018 states that:

"The Joint Health Scrutiny Committee can refer decisions to the Secretary of State under certain prescribed criteria outlined in legislation. Based on these criteria the grounds for referral are as follows:

(i) adequacy of the content of the consultation, and
(ii) that the proposals would not be in the interests of the health service in the area

IRP view

With regard to the referral by the South Tyneside and Sunderland Joint Health Scrutiny Committee, the Panel notes that:

Equality issues

- the IRP has been asked to comment on the impact of the proposals with regard to the public sector equality duty and family test.

Consultation issues

- referral on the grounds of inadequate consultation relates to consultation with the relevant scrutiny body rather than wider consultation with patients, the public and stakeholders.
- the consultation focussed on the hospital services with urgent problems of sustainability - genuine concerns have been raised about the future of other hospital services, in particular at STDH.

Stroke

- the future of inpatient stroke services is informed by evidence from elsewhere and the temporary arrangements in place locally since December 2016.

Maternity

- no options for retaining obstetrics at STDH were put forward before or during consultation – implementation of Option 1 involves significant change.

Paediatrics

- options for retaining paediatric emergency care at STDH were put forward and considered – questions remain about their relative merits and implementation.

Advice

The Panel considers each referral on its merits and concludes that:

- **Consolidation of all inpatient stroke services at Sunderland Royal Hospital (Option 1) is in the interests of local health services.**
- **Consolidation of all obstetrics, inpatient gynaecology and special care for babies at Sunderland Royal Hospital with a free-standing midwife-led unit at South Tyneside Hospital (Option 1) is in the interests of local health services.**
- **Further work is required on long term options for paediatric emergency care as part of considering the future of the whole urgent and emergency care system for the area. In the meantime, consolidation of emergency paediatric care overnight at Sunderland Royal Hospital (Option 1) will mitigate the current risks to quality and continuity of care.**

Equality issues

In his commissioning letter for this advice, the Secretary of State asked the IRP to comment on *"the impact of these proposals on different groups, specifically families, and in relation to the public sector equality duty"*. Reference is also made to the requirements of the family test. The Panel understands that the family test relates to guidance for government departments in the process of policy formulation and does not apply to the NHS in the planning or delivering of services. The Panel has therefore commented on the impact of proposals on families only in the general terms that apply to all patients and carers.

The latest NHSE guidance[1] is clear about the need to consider the impact of any proposals on different groups and health inequalities, stating that *"Commissioners should also pay due regard to the duties placed on them under the Equality Act 2010 regarding the public sector equality duty ('PSED') and the duty to reduce health inequalities, and duties under the NHS Act 2006 (as amended by the HSCA 2012)"*. Annex 4 of the guidance (Stage 2 Assurance[2] Checkpoint sample questions) poses the question *"Has an equality impact assessment taken place?"* Similar requirements were included in the previous version of the guidance that was in place at the time of the matters under consideration here.

The NHS commissioned an independent equality, health and health inequalities integrated impact assessment (IIA) in parallel with the clinical service reviews to inform the evaluation of emerging options and approach to consultation. Although using a common methodology, the impacts of proposals for stroke, maternity and paediatrics were each considered separately to reflect differences in specific groups most affected. The IIA was available to support the consultation and feedback incorporated into the final version. It identified a significant overall positive impact for each of the proposals with improved health outcomes outweighing some increased inequalities. It also identified actions to enhance benefits and mitigate drawbacks related to issues such as access, travel, continuity of care and performance of services. The final IIA was an integral part of the decision making process, informing the final decisions made about the options for services[3].

Consultation issues

The JHSC has referred this matter to the Secretary of State on two grounds – the adequacy of the consultation undertaken and that the proposals would not be in the interests of the health service in its area. In considering issues of inadequate consultation, the 2013 Regulations relate to consultation with the scrutinising body rather than wider consultation with patients, the public and stakeholders. The Panel noted that the JHSC offered no evidence about the adequacy or otherwise of consultation with itself but instead "*believes*

[1] Planning, assuring and delivering service change for patients, NHS England, updated March 2018 available at https://www.gov.uk/government/organisations/independent-reconfiguration-panel/about

[2] *"Takes place in advance of any wider public involvement or public consultation process or a decision to proceed with a particular option."* Planning, assuring and delivering service change for patients, NHS England.

[3] South Tyneside CCG & Sunderland CCG Governing bodies meeting in common, 21 February 2018, Phase 1 Path to Excellence Decision Making Report, Sections 4.5, 5.5, 6.5, Appendices 2 and 3

that the consultation process did not comply with the Gunning Principles"[4]. This advice is offered on the understanding that matters of legality or otherwise are for the courts to determine, not the IRP. The concerns expressed by the JHSC about the wider consultation process with interested parties are addressed in this advice on the basis of their not being in the interests of the health service generally.

Faced with the commitment to consult about the permanent future of inpatient stroke services and the inability to get the medical staff needed to provide some services safely, the NHS decided to phase consultation for the *Path to Excellence* programme. In the Panel's view, this was a balanced decision with predictable effects on the consultation process and decisions that followed. First, options that did not address current shortages of key staff were ruled out. Second, because SRH is much the larger of the two hospitals serving the area, with a wider range of services, it is the likely location for consolidation of inpatient acute hospital services if required. Finally, consulting on selected inpatient services exacerbated concerns about knock-on effects and future intentions towards other local hospital services and the viability of STDH.

In this context, the Panel considers that more could have been done by the NHS from the outset to explain clearly the wider strategic context and be explicit about the viability of potential options or otherwise. However, given the time and effort invested on all sides and the myriad opportunities to have addressed these gaps, before, during and after the consultation period, it is disappointing that the process appears to have ended without a shared understanding on these matters between the NHS and JHSC. It appears to the Panel that there was a marked change in the period after the CCGs' decision which was quickly followed by the JHSC decision to refer. Whether this is down to a lack of trust, a breakdown in communication or some other reason, there needs to be a clear commitment to renewed engagement about the big picture for local services and shaping their future through the *Path to Excellence* programme.

The issues described above played out differently for the services included in the consultation and each was considered on its own merits before decisions were made.

Stroke

The JHSC acknowledges that the case for centralisation of hyper-acute stroke services is in line with national policy. The clinical case and the CCG's decision is supported by external clinical assurance and the SRH is the only logical location in the area given the scale of the service and the presence of related services such as vascular surgery.

The consultation's scope covered inpatient stroke services and having considered all the evidence, the Panel concludes that centralising these at SRH is in the interests of local health services. The Panel agrees with the JHSC that the NHS must ensure the rest of

[4] Further information about Gunning principles (R v London Borough of Brent ex parte Gunning) can be found at: http://www.nhsinvolvement.co.uk/connect-and-create/consultations/the-gunning-principles

the stroke pathway outside hospital, both prevention and after care, is functioning to its full potential for the whole population, engaging primary care and community rehabilitation services particularly.

Maternity

The two options for maternity services are driven by the need to consolidate consultant-led services on one site to secure safe and sustainable medical staffing. The one site proposed is SRH, primarily because it is much the larger unit currently and has neonatal intensive care on site. External clinical assurance supported this option and highlighted the potential benefits of more hours of consultant presence for births, the larger combined neonatal and special care baby unit, and the reduction of transfers between sites for babies moving in and out of intensive care. The Panel agrees that consolidation is necessary to address workforce risks to the safety and quality of services and that SRH is the logical location.

Option 1 also proposes a free-standing MLU at STDH, providing both closer access and wider choice to local mothers-to-be in line with national policy. Although the model of care is well established in practice and supported by the evidence of a significant national study, the Panel understands the concerns raised by the JHSC about its implementation, particularly with regard to securing ambulance response, and the volume of births needed for economic viability.

However, the free-standing MLU is not a substitute for a consultant-led unit and if it were not to be present then no births would take place at STDH. **In this context, the Panel concludes that Option 1 is in the interests of local health services.** Risks identified around the free-standing MLU and its viability must be addressed in a detailed implementation plan incorporating both the necessary assurance about ambulance response and the practical external advice provided about making the free-standing MLU part of a comprehensive hub, offering the fullest possible range of pre and post-natal services, that will engage its users and give them confidence.

Paediatrics

Nowhere has the commitment of staff to services and patients been more clearly demonstrated than in the debate about paediatric emergency care. The Panel noted that the two options proposed are significantly different. Option 1 is essentially the same service as now but open for 12 hours a day rather than 24, thus easing the requirement for medical cover on site. Option 2 is for a nurse-led paediatric minor injuries and illness service 12 hours a day.

Although it better addresses sustainability of medical staffing, Option 2 came with significant caveats. The Panel noted that after consultation the CCGs commissioned a further external review of the two consultation options and a third option previously ruled out, before effectively deferring implementation of Option 2 to allow more work to be done.

The Panel shares the concerns of others about the need to understand in detail how Option 2 could work, particularly with regard to paediatric minor illness, and how it will fit safely and effectively into the overall urgent and emergency care service for children in the area. A detailed proposition must be developed and considered before a final decision to implement is made. This work should provide the opportunity to renew clinical engagement, strengthen collaboration and address the sustainability of both the medical and nursing workforce. **In the meantime, consolidation of paediatric emergency care overnight at SRH (Option 1) between the hours of 22.00 and 08.00 will mitigate the current risks to quality and continuity of care.**

Conclusion

The Panel understands how the options put forward for consultation must have appeared to the population of South Tyneside and why this has sparked genuine concerns about the future of local services at South Tyneside District Hospital. At the same time the NHS, facing risks to the safety, quality and continuity of some services, needed to act in the interests of patients.

Whatever the strengths and weaknesses of the process so far, the NHS, the JHSC and their stakeholders must step forward decisively on two priorities that will build confidence for the future. First, by addressing concerns related to implementing changes to services, notably ambulance capacity to respond, workforce development and practical mitigations to reduce negative impacts on travel for patients and carers. This requires continuing engagement in the planning, implementing, monitoring and evaluating of the changes to services to ensure they deliver what is intended for the population served. Second, by renewing engagement that will develop better understanding about the bigger picture for health and health care in the area and within it the future of the South Tyneside District Hospital. This includes building on the work done so far, including the vanguards in the area, to explore further opportunities for closer working across hospital and community services.

Yours sincerely

Lord Ribeiro CBE
Chairman, IRP

APPENDIX ONE

LIST OF DOCUMENTS RECEIVED

South Tyneside and Sunderland Joint Health Scrutiny Committee

1 Referral letter to Secretary of State for Health from Cllr Rob Dix (South Tyneside Council) and Cllr Norma Wright (Sunderland City Council), 1 May 2018.
Attachments:
2 Document – Referral to the Secretary of State for Health

NHS

1 IRP template for providing assessment information
Attachments:
2 NHS response to JHOSC re intention to refer to Secretary of State, 27 April 2018
3 Attachment 1_3_1a NE Maternity Network O&G review comments, January 2017
4 Attachment 1_3_1b NTW Local maternity System response to Path to Excellence
5 Attachment 1_3_1c NTW Local Maternity System Letter to JHOSC
6 Attachment 1_3_1d Letter from North East Neonatal Network, 2017
7 Attachment 1_3_1e Northern Neonatal Transfer Services Response
8 Attachment 1_3_1f Child Health Network response to Path to Excellence, October 2017
9 Attachment 1_3_1g NE Clinical Senate Emergency and Urgent Paediatric Services Report
10 Attachment 1_3_1h Northern England CVD Network Stroke Service Review Report
11 Attachment 1_3_1i Letter from National CD for Stroke, Prof A Rudd, August 2017
12 Attachment 1_3_1j Letter from NEAS to CCGs
13 Attachment 1_3_1k NEAS Impact Assessment
14 Attachment 1_3_2a PCBC Full Pre-Consultation Business Case
15 Attachment 1_3_2b PCBC Appendix 4_1 PCBC Communications and Engagement Strategy
16 Attachment 1_3_2c PCBC Appendix 4_2 communications and engagement group, terms of reference
17 Attachment 1_3_2d PCBC Appendix 4_3 PCBC Joint Overview and Scrutiny Committee rems of reference
18 Attachment 1_3_2e PCBC Appendix 4_4 PCBC Summary of patient insight and experience
19 Attachment 1_3_2f PCBC Appendix 5_1 PCBC Overview of Clinical Design Process
20 Attachment 1_3_2g PCBC Appendix 5_2 Five tests self-assessment
21 Attachment 1_3_2h PCBC Appendix 5_3 PCBC Internal and external assurance arrangement
22 Attachment 1_3_2i PCBC Appendix 6_1 NE CVD Network Stroke Service Review
23 Attachment 1_3_2j PCBC Appendix 6_2 Summary Integrated Impact Assessment Report
24 Attachment 1_3_3a Public Consultation Document
25 Attachment 1_3_3b Public Consultation Document Summary

26 Attachment 1_3_3c Public Consultation Easy Read
27 Attachment 1_3_3d Fact Sheet - Stroke
28 Attachment 1_3_3e Fact Sheet - Obstetrics and Gynaecology
29 Attachment 1_3_3f Fact Sheet - Urgent and Emergency Paediatrics
30 Attachment 1_3_3g FAQ Stroke
31 Attachment 1_3_3h FAQ Obstetrics and Gynaecology
32 Attachment 1_3_3i FAQ Urgent and Emergency Paediatrics
33 Attachment 1_3_3j Consulation Communications Plan
34 Attachment 1_3_4a Consultation Analysis Final Report, January 2018
35 Attachment 1_3_4b Consultation Assurance Report
36 Attachment 1_3_4c Consultation Assurance Report Appendices
37 Attachment 1_3_4d CI Best Practice Certificate
38 Attachment 1_3_5a Decision Making Report
39 Attachment 1_3_5b Decision Supporting Information
40 Attachment 1_3_7a Minutes from Decision Making CCG meeting-in-common
41 Attachment 1_3_5c Decision making process and evaluation categories
42 Attachment 1_3_5d Decision Making Process Diagram
43 Attachment 1_3_6a NHS England Stage 2 Assurance Letter, 19 April 2017
44 Attachment 1_3_6b NHS England Final Assurance Letter 19 February 2018
45 Attachment 2_3a Path to Excellence issues booklet
46 Attachment 2_3b A review of patient insight, February 2017
47 Attachment 2_3c Overview of Clinical Design Process
48 Attachment 2_3d Minutes of 19 September 2016 JHOSC meeting
49 Attachment 2_3e Minutes of 08 November 2016 JHOSC meeting
50 Attachment 2_3f Minutes of 30 January 2017 JHOSC meeting
51 Attachment 2_3g Minutes of 07 March 2017 JHSOC meeting
52 Attachment 2_3h Minutes of 17 July 2017 JHSOC meeting
53 Attachment 2_3i Minutes of 01 August 2017 JHSOC meeting
54 Attachment 2_3j Minutes of 04 September 2017 JHSOC meeting
55 Attachment 2_3k Minutes of 21 September 2017 JHSOC meeting
56 Attachment 2_3l Minutes of 10 October 2017 JHSOC meeting
57 Attachment 2_3m Minutes of 12 December 2017 JHSOC meeting
58 Attachment 2_4a Letter to Sunderland and South Tyneside JHOSC, 28 February 2018
59 Attachment 2_4b Minutes of 10 April 2018 JHOSC meeting
60 Attachment 2_4c Letter to CCG - draft Secretary of State referral, 12 April 2018
61 Attachment 2_4d CCG response to JHOSC referral to Secretary of State draft letter 27 April 2018
62 Attachment 2_4e Letter from Mr Bas Sen to support CCG response to JHOSC, 27 April 2018
63 Attachment 2_5a Health Impact Assessment - Stroke
64 Attachment 2_5b Health Impact Assessment - Obstetrics and Gynaecology
65 Attachment 2_5c Health Impact Assessment - Urgent and Emergency Paediatrics
66 Attachment 2_5d Final IIA Post-consultation Summary Report, January 2018

67 Attachment 2_5e Additional information to Integrated Impact Assessment Summary Report
68 Attachment 3_2a South Tyneside Community Health Profile
69 Attachment 3_2b Sunderland Community Health Profile
70 Attachment 3_3aTravel and Transport working group terms of reference
71 Attachment 3_3b Travel and Transport work plan
72 Attachment 3_3c Travel impact assessment scope, September 2016
73 Attachment 3_3d Travel and Transport Impact Baseline Report Executive Summary, January 2017
74 Attachment 3_3e Travel and Transport Impact Baseline Report, January 2017
75 Attachment 3_3f Travel and Transport Impact Assessment Summary Report, June 2017
76 Attachment 3_3g Travel Impact Assessment of service review options, July 2017
77 Attachment 3_3h Travel and transport impact public summary
78 Attachment 3_3i Travel Field Testing Exercise
79 Attachment 3_3j Travel Stakeholders full report, 11 October 2017
80 Attachment 3_3k Travel and transport update report, January 2018
81 Attachment 3_3l Travel and Transport Impact Assessment final, March 2018
82 Attachment 3_3m Wear Transport Report to Secretary of State, July 2012
83 Attachment 3_7a City Hospitals Sunderland CQC Report, January 2015
84 Attachment 3_7b South Tyneside Hospital CQC Report, October 2017
85 Attachment 4_4a Press Release temporary suspension at STDH SCBU 30 November 2017
86 Attachment 4_4b Press Release suspension of births, 03 December 2017
87 Attachment 4_4c Press Release maternity services 15 January 2018
88 Attachment 4_4d Save Tyneside Hospital Campaign Group JR letter, 27 March 2018
89 Attachment 4_4e PTE Response to Save Tyneside Hospital Group JR letter, 10 April 2018
90 NHS JHSC Interim Response
91 NHS JHSC - Final Report, January 2018

Other evidence

1 Letter Before Action issued by Irwin Mitchell solicitors re application for judicial review of acute hospital reconfiguration in South Tyneside and Sunderland, 27 March 2018
2 Correspondence from clinical staff at South Tyneside District Hospital, 6 June 2018